AAA Medics Ltd

Leylands Rest Home

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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We inspected Leylands Rest Home on 18 January 2016 and the visit was unannounced. This was the first inspection of this service since the change in ownership in April 2015.

Leylands Rest Home is registered to provide accommodation and personal care for up to 17 older people, including people living with dementia. There are nine single and four shared bedrooms, each with en suite facilities. There are two lounges, a dining room and a bathroom on the ground floor. On the day of the inspection there were 16 people living at the home.

The registered manager has been at the service since it's registration with the Care Quality Commission in April 2015 and was the registered manager of the home under the previous registration. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People who lived at the home, staff and visitors told us they had confidence in the registered manager.

People who used the service told us they felt safe and thought there were enough staff available to meet their needs. However, we found issues in relation to the safe management of medicines, lack of effective risk assessments and safety of the environment.

Recruitment processes were followed to make sure new staff were safe and suitable to work in the care sector. Staff told us they felt supported by the manager. People and relatives we spoke with told us they liked the staff.

Staff were in need of training updates to make sure they had the knowledge and skills to carry out their roles effectively.

Although homely, the environment was in need of refurbishment and redecoration.

The service was compliant with the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards.

People told us they enjoyed the food at the home but felt restricted in choices. Mealtimes were not always managed in a way to make sure people enjoyed the mealtime experience.

People were supported by community healthcare professionals and these services were accessed in a timely way to make sure people's health care needs were met.

Staff were caring in their approach but people's privacy and dignity were sometimes compromised.

Care records were not up date.

Visitors told us they were always made to feel welcome and if they had any concerns or complaints they would feel able to take these up with the staff or registered manager. However the complaints procedure lacked detail and was not up to date.

The registered manager was knowledgeable about their role and provided good leadership to staff.

Systems for auditing the quality and safety of the home were not always up to date, robust or effective.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures 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 time frame.

If not enough improvement is made within this time frame so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We recommend the service looks at ways in which all of the people living at the home can be engaged in appropriate and meaningful activities of their choice.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Systems for managing medicines were not always safe.

People were not protected by systems to make sure the environment was safe and infection control measures in place.

Staff were recruited safely.

Risks to individuals had been assessed and plans put in place to minimise the risk. However there were no personal emergency evacuation plans in place.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not had up to date training to ensure they had the skills and knowledge to meet people's needs.

The service was meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

People were not always offered choice and the mealtime experience was not always positive.

Records showed people had regular access to healthcare professionals, such as GPs, and district nurses.

Is the service caring?

Requires Improvement

The service was caring but some improvements were required.

People told us staff were nice and staff appeared to know people well.

Staff did not always consider people's privacy and dignity.

Records of advanced decisions were in place.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records were not always up to date.

There were activities on offer but did not engage all of people living at the home.

People said they would be confident their complaints would be listened to but the complaints procedure did not include sufficient or up to date details.

Is the service well-led?

Inadequate

The service was not well-led.

There was a registered manager in post who provided leadership to the staff team.

The registered manager was not supported by the provider in making sure effective auditing of the quality and safety of the service took place.

Leylands Rest Home

Detailed findings

Background to this inspection

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

This inspection took place on 18 January 2016 and was unannounced.

The inspection team consisted of one inspector, a specialist adviser looking at medicine management and compliance with the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this instance the person had experience of older people and people living with dementia.

Before the inspection we reviewed the information we held about the service. This included speaking with the local authority contracts and safeguarding teams. On this occasion we had not asked the provider to complete Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

On the day of our inspection we spoke with six people who lived at Leylands Rest Home, four visitors, the registered manager, five care workers, the cook and two district nurses.

We spent time observing care in the lounge and dining room and observed the midday meal. We looked around the building including bedrooms, bathrooms and communal areas. We also spent time looking at records, which included; three people's care records, four staff recruitment files and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

We asked people who live at the home if they felt safe. One person told us: "Everyone looks after me. I feel safe. I get my tablets on time." When we spoke about safety to visiting relatives they said: "My dad is absolutely safe here compared to when he was at home" and "(relative's) safe. It's a small place so staff are aware of where everyone is all the time. If (relative) has an infection they're onto it straight away" and "My (relative) is safe. I wouldn't leave (relative) if I didn't think (relative) was safe."

Medicines were administered to people by appropriately trained care staff, however our observations demonstrated the care staff did not always demonstrate good practice. We saw no evidence of specific mental capacity assessments to judge people's capabilities to self-administer medicines.

During the morning we observed a care staff member administering medicines. We asked the staff member about the safe handling of medicines to ensure people received the correct medication. Answers given along with our observations demonstrated medicines were not consistently administered in a competent manner or in a manner which protected people's dignity. On one occasion we witnessed the staff member speaking in a loud voice to a person sitting in the lounge, saying, "These tablets are for your urine infection." Whilst we appreciated the person was hard of hearing and the person was being informed of newly prescribed medicines this action did not preserve privacy.

We found on a number of occasions medicines were not administered in line with the prescriber's intentions. For example, one person was prescribed an antibiotic to be administered before food; however the medicine was administered after breakfast. On another occasion we found one person had been prescribed an inhaler to be used four times a day. We saw staff had recorded the medicine was not required and was being administered as if the prescriber had intended it to be given 'as necessary' (PRN). The care files for this person showed no evidence as to why this decision had been made by care staff, nor any direction from the person's GP. We also saw prescribed food supplements were not being administered as prescribed. One person was prescribed their supplement twice a day, yet the medicine administration record (MAR) chart showed it was being administered only once a day.

We asked the care staff member about the administration of PRN medicines. Whilst they had an understanding of why the medicine might be administered they had little understanding of the frequency the medicines may be given nor the maximum therapeutic dose over a 24 hour period. Furthermore ambiguity of prescriber's wishes led to possible confusion. For example, we saw one person was prescribed a medicine "on a night when absolutely necessary". Two senior care assistants and the registered manager agreed with us the instructions were open to interpretation. PRN medicines were not supported by written protocols which would ensure people's needs for these medicines would consistently be met. We saw the results of an audit conducted by the registered manager in June 2015 found an absence of PRN protocols. We saw action had been taken to remedy the issue at the time and an indication senior care assistants had been involved. However, there were no protocols in place at the time of our inspection.

We carried out a random sample of seven boxed medicines to account for the quantities dispensed against

the record of administration. On six occasions the stock level balanced. On one occasion we found one person had been prescribed half a tablet twice day. When we counted the stock of tablets against the records of administration there were only two tablets left when there should have been four. This suggested on two occasions a full tablet had been given instead of the half tablet prescribed. Our conclusion was that on two occasions a full tablet of 1mg had been administered instead of 0.5mgs (half a tablet).

We inspected the storage facilities for medicines. We found the fridge temperatures were taken and recorded but examination of the contents showed inappropriately stored medicines. We found a preparation of eye drops stored in the fridge yet the storage requirements on the box indicated storage at room temperature. We were told prescribed creams were kept in people's rooms to be applied when dressing. Whilst looking in a downstairs bathroom we found a cupboard with five containers of prescribed cream for individual people and one unnamed container of cream. We brought this to the attention of the registered manager who removed the creams. This meant management of medicines was not always safe and is a breach of Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some prescription medicines contain drugs which are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs. We saw controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff. A senior care assistant showed us the medication administration records (MAR) sheet was complete and contained no gaps in signatures. We saw any known allergies were recorded.

We spoke with a senior care assistant and two care assistants about their understanding of safeguarding and what they would do if they thought people who lived at the home were at risk of abuse. None of the staff were clear about what might constitute abuse and when we gave examples of possible physical or verbal abusive situations between people who lived at the home, staff did not recognise these as safeguarding matters and thought they were to be expected when people were living with dementia. None of the staff could recall having had training in safeguarding or protecting vulnerable adults but did know where they could find information about in the home. One member of staff told us they would not hesitate to ring the number they had for safeguarding if they thought someone was being abused. The registered manager told us all staff had received safeguarding training but said, as they had failed to demonstrate a good knowledge, they would organise further training as soon as possible. We saw from training records that staff had received training.

We completed a tour of the premises as part of our inspection. We looked at 12 people's bedrooms, bath and shower rooms, various communal living spaces, the kitchen and the laundry. We found in the downstairs bathroom a container of oven and grill cleaner. The label indicated this was a caustic substance yet this was freely available for vulnerable people to access. We immediately brought this to the attention of the registered manager who removed the substance. We also found the bath in this room to be dirty and in need of repair.

Some radiators in the home were covered to protect vulnerable people from the risk of injury. However we found one radiator in the lounge/dining area and radiators in three bedrooms along with a toilet on the first floor were not protected nor were of a cool panel design. We also saw the door to the cupboard housing the hot water tank was not locked. The registered manager told us the door to the cupboard should be locked at all times to prevent people burning themselves. We saw fire-fighting equipment was available and emergency lighting was in place. During our inspection we found all fire escapes were kept clear of obstructions.

We found some of the floor coverings particularly in the lounge/dining room, were showing signs of wear and tear and there was evidence of ingrained dirt which was unlikely to be removed by general cleaning. In addition we saw an area of corridor with vinyl flooring adjacent to a bathroom on the ground floor had ingrained dirt extending up the skirting boards. We found hand washing facilities including the provision of liquid soap and paper towels were not available in all of the bedrooms and communal toilets. The registered manager told us they were trying to source new liquid soap dispensers and told us the lock to the room where replacement paper towels were kept had become jammed on the day of our inspection and they were therefore unable to access it. However we considered alternative arrangements for liquid soap could have been made and felt it was unlikely that supplies of paper towels had run out on that day in all of the areas we found. We saw dirty and soiled laundry left on the bathroom floor. This meant that the premises were not always safe and that systems for controlling the spread of infection were not being followed. This is a breach of Regulation 12 (1) (2)(d) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

None of the people we spoke with raised concerns about staffing levels in the home and staff felt there were enough of them to meet people's needs safely. We looked at four staff files which demonstrated the provider was employing effective staff recruitment and selection systems. We saw there was a clear process which ensured appropriate checks such as, proof of identity, references and satisfactory outcomes of Disclosure and Barring Service (DBS) were carried out before staff began work. These checks helped the service to make sure job applicants were suitable to work with vulnerable people. None of the people we spoke with raised any concerns about staffing levels but did say staff were always very busy. On the day of our visit we saw two work experience students working in the home. Although they were engaging people in activities rather than supporting people with personal care, we observed they were left working together without any supervision from the home's own staff.

We saw some risks to people's safety had been assessed. For example, falls risk assessments were in place. However where risks associated with poor nutrition or poor personal hygiene had been identified, plans of care had not always been put in place to address them. We did not see personal emergency evacuation plans (PEEPs) had been put in place. It is important that these are available so that staff know exactly how to evacuate people from the home safely should the need arise. The registered manager said they would start work immediately on PEEPs.

We saw accident forms were completed, however we did not see any evidence that accident records were analysed to identify any possible themes and trends. The registered manager told us they were aware of the need to analyse accidents and showed us the preparations they had made to start doing this.

Requires Improvement

Is the service effective?

Our findings

The training matrix showed the majority of staff were up to date with training in areas such as moving and handling, fire safety and health and safety. We also saw fourteen of the eighteen staff had achieved a National Vocational Qualification (NVQ) between levels two and four. However we noted that only one member of staff had received training in care planning within the last five years with only four other staff having completed the training. We saw staff had received training in first aid awareness but the registered manager confirmed that none of the staff working at the home were qualified first aiders. We also noted seven of the eight staff who would administer medicines had not received any training updates for over two years. The majority of staff had received up to date training in safeguarding but as they were unable to demonstrate an understanding of this to us, the registered manager said they would book updates as soon as possible. Staff had not received training in supporting people living with dementia for over two years. This was of particular concern as the service is advertised as specialising in supporting people living with dementia. Only three staff had received training in the Mental Capacity Act and this had not been updated for over four years. There was no record within the training matrix of any staff having received training in Deprivation of Liberty Safeguards (DoLS). The registered manager told us they were aware training needed to be organised and were in the process of doing this.
The lack of up to date training demonstrated a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us the registered manager was very supportive and often worked with them. They said they had regular opportunities for discussion and supervision with the registered manager.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw six people living at the home were subject to authorised DoLS. We looked at three of the authorised DoLS regarding conditions attached to the authorisation. Our discussions with the registered manager and our observations of care and recordings in the care plans showed the conditions were being met. We spoke with the registered manager with regard to a further eight authorisations recently submitted to the supervisory body. Our discussion demonstrated they had a good understanding of the requirements of Mental Capacity Act 2005 and the code of practice with regard to DoLS. We saw they had a robust system to trigger a reapplication in sufficient time to ensure no gaps in authorisation occurred. We saw email evidence the manager promptly notified the Commission of authorised DoLS.

We spoke with the registered manager about the use of restraint which included the use of bed-rails. Our discussion demonstrated bed-rail assessments were used to ensure people who may roll out of bed or have an anxiety about doing so would be protected from harm. The registered manager demonstrated a good understanding of how inappropriate use of bed-rails may constitute unlawful restraint. We looked at a care plan for a person with bed-rails in place. We saw appropriate risk assessments had been conducted prior to the use of bed-rails. We saw bed rails were correctly fitted to ensure people were not at risk of entrapment.

We saw where issues around lasting powers of attorney (LPA) required consideration in care planning this was clearly recorded in the care file. We saw evidence from the Office of the Public Guardian detailing named attorneys for people. Care plans showed the registered manager was making sure the consent of the person with the LPA was sought when determining people's care needs.

Care plans for people who did not have LPA's did not include evidence of the involvement or consent of the person or, where appropriate, their relative in the development of the care plan.

Some people who lived at the home gave us some examples of them not feeling as though their opinion or consent was sought. For example, one person said, "The staff tell me when it's time for a bath. It's a bit quick for me. It's only 5 or 10 minutes. Every day I take my clothes off they wash them. The staff tell you what to wear. They look out your clothes."

Other people told us staff did give them choices. We observed these differences during our inspection. For example, we saw staff sometimes asked people if they would like to wear a clothing protector at mealtimes whilst other times they just put the protectors on people without asking. We also saw people were given drinks and biscuits without being offered any choice, whilst another person was offered a sandwich rather than biscuits. When we asked staff why they had not given people choices, they told us they knew what the person liked. People we spoke with confirmed staff knew their preferences; however, we would consider good practice would be to routinely offer people choices.

People gave us mixed responses about the mealtime experience at the home. One person said, "I don't care for the meal times. They're a bit rowdy and quick. I feel rushed. They take your plate away before you're finished if you are taking a long time. The food is very good. I had a beautiful breakfast this morning. I had bacon and scrambled egg. Another person told us, "You get your food served regularly. The food is quite nice. They do a pot of porridge which is quite good. We don't get a choice. They just bring what there is." One person's relative told us they thought the food always looked nice.

We saw people were served their meals at different times. People who needed support went to the dining room at 11.30am with other people served their meals as places became available at the dining tables. Tables were set with table cloths, mats and cutlery but there were no condiments or serviettes available to people. Staff support differed, for example some staff spent time with people encouraging with their meal whilst we observed one staff member support a person with their meal without speaking to them at all.

There was a noticeboard in the dining room showing the planned meals for the day. On the day of our inspection there was grapefruit on the menu but we did not see anybody being offered this as a starter. The main meal was corned beef hash with potatoes and vegetables. The pudding was described as Eve's pudding but it was apple crumble. There were various alternative food options listed on the menu board but none of these were offered. Meals were plated up by the staff and presented to people which meant there was no choice in practice. Orange squash was served to people at the table with no choice offered.

The cook told us they made the meals from scratch and told us they catered for a person who ate Halal

food. They said they pureed food for some people. We saw this was served separately so people could taste each component of the meal. The cook said there were no special diets. However we had seen one person was diabetic and required a diabetic diet. We noted this person was provided with a diabetic diet at lunchtime.

We looked at the care records for a person who had lost weight. Whilst their nutritional needs had been assessed, a care plan had not been developed to inform staff of the actions they should take to minimise the risk of further weight loss. We looked at the nutritional intake records for this person and saw whilst meals were recorded; there was no record of any intake after five pm. There was no evidence of senior staff having an overview of the intake records to make sure people had received the nutrition they needed. Whilst this person's weight loss had been reported to the GP and supplements had been prescribed, it is important that staff maintain an overview of the person's nutritional intake records so that possible causes for any further weight loss can be identified.

We saw from care records people living at the home had been seen by a range of health care professionals, including GPs, district nurses and opticians. We spoke with two district nurses who regularly visit the home. They told us they had no concerns about the quality of care delivery. They told us the advice they gave regarding certain elements of care delivery were always followed. Two visiting relatives told us staff were quick to act if their relation was not well. One relative said, "The doctor comes once a fortnight. Nurses come twice a week."

We did not see any evidence of any adaptations or signage to support the orientation around the home of people living with dementia.

Requires Improvement

Is the service caring?

Our findings

People who lived at the home were complimentary of the staff and the care they received. One person said, "The staff are very nice." Visitors we spoke with were also complimentary of the way staff looked after their family member. They told us: "The staff are great with the residents. The residents are allowed to do what they want," and "The atmosphere is great. I'm always made welcome. The staff chat to me" and "The staff are very good. They took (relative) to St Luke's for an appointment. The staff stayed with (my relative) when they were being admitted until they went on the ward."

Staff knew people well and demonstrated genuine fondness for people. However, staff were inconsistent in the way they offered people support and choice. For example, we observed one staff member saying, "I'm just going to push you in a little bit" when seating a person at the table, whilst others did not offer an explanation when supporting people with their care. For example, we saw a staff member asking a person to go with them without offering any explanation about where they were going.

We saw staff did not always consider the privacy and dignity of people living at the home. For example, we saw people with food spills on their clothing and one person told us they really would like to be clean shaven but said staff had not supported them with that. We saw staff knocked on people's doors, but on one occasion, went into the room without giving the person chance to respond.

On the day of our visit the hairdresser was in the home. We saw they used a person's bedroom for cutting and setting people's hair. When we spoke with a district nurse they told us staff used that room for them to see people. There was no evidence the person who occupied that room had been consulted about their room being used for communal activity.

We saw intercoms in people's bedrooms. When we asked about these the registered manager said they could be turned on so staff in the dining room could hear people in their bedrooms. We asked if people living at the home or their relatives were informed about these intercoms. The registered manager said they were not and said they were rarely used. However, as people were not informed about these and there was no indication in the room when they were in use, they had not been given the opportunity to agree to their use or to ask for them to be removed. We also saw CCTV was used on both staircases and partially covered the landings at the top of the stairs. CCTV was also used at the back and front doors of the home. Again there was no evidence that people had been informed of this. The images from the CCTV were seen on a monitor situated in the dining room and could be seen by any person in that room. This meant there was a risk to people's privacy being invaded.

This meant the privacy of people living at the home was not always ensured and is a breach of Regulation 10 (1) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw care plans recorded whether someone had made an advanced decision on receiving care and treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and was fully completed recording the person's name, an assessment of

capacity, communication with relatives and the names and positions held of the healthcare professional completing the form.

Requires Improvement

Is the service responsive?

Our findings

The registered manager told us they were aware that many of the care plans were not up to date and they were in the process of reviewing them. We looked at three people's care plans in detail.

We saw the care files included a document titled Care plan/risk assessment. The registered manager told us this document was completed when a person came to live at the home. We found the information recorded on this document was not always specific and therefore did not provide staff with the information they would need to give the person the support they needed safely and in the way they preferred. For example, in a section titled 'Medical Condition' the information for one person stated, 'I need 24 hour supervision, I need a balanced diet, I need to be stimulated regularly'. The risks identified were 'Falls, poor personal hygiene may lead to infection, poor fluid and meal intake may lead to infections.' No detail of what support the person needed to mitigate the risks identified had been included. Some of the sections of the document had not been completed at all. For example, the sections about the person's needs in relation to hearing and oral care had been left blank. Care staff told us this person was suffering from a urinary tract infection at the time of our visit which was affecting their behaviour. There was no care plan in place in relation to the urine infection. We had also seen from records that this person had lost weight. Again there was no care plan in place in relation to weight loss.

In another person's file we found the 'Care plan/risk assessment' had not been completed at all. However we saw some information about the person's preferences had been recorded. For example we saw staff had recorded the size of clothes the person wore with the statement, 'I like to wear dresses and skirts with tops, I like to look smart.'

We saw all of the care files included a number of assessments of need. However, these had not always been fully completed and did not give an accurate picture of the person's needs or risks to their well-being. For example, the assessment in relation to the risk of pressure sores or skin damage was scored numerically. However, there was no guidance to inform staff what the numerical score related to. We asked the registered manager about this who said there should be a guide explaining the risk score as part of the assessment but could not find this in any of the files we looked at.

In one person's file we saw a memory test for people from minority ethnic groups. However, the person concerned was not from an ethnic minority group and therefore the test was not relevant to them.

We did not find any moving and handling assessments within the care files. We had observed one person who required staff to assist them to move from chair to wheelchair in a particular manner. However when we looked in their care file we saw the only information relating to moving and handling was on a physical health assessment which said only 'wheelchair, one helper.' When we asked staff about this they said they all knew how to support the person. However the lack of moving and handling assessments and information about people's needs in this area could put people at risk if being supported by staff not familiar with their needs.

We saw from one person's care plan that they were at risk of being incontinent and included the statement 'Are there any other ways of letting you know I need the toilet.' Whilst this could have been a positive way of reducing the risk of incontinence the only information given in this regard was 'shuffling, wet clothes and strong odour' and was therefore a list of signs the person had been incontinent rather than a means of reducing the risk.

This meant people's care needs had not been appropriately assessed and care had not been planned to make sure their care needs were met. This demonstrated a breach of Regulation 9 (3)(a and b)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visitors told us staff were responsive to people's needs and let them know of anything their relative needed.

When we asked people about how they spent their time and the activities on offer at the home responses were mixed. One person said "They get me up in a morning. We're just here to watch television and eat" and another said "I get sick of watching Jeremy Kyle. I'd sooner watch Coronation Street and EastEnders." One person said "At breakfast time they have a board up about everything that's happening. I don't have to join in if I don't want." Whilst another told us, "The home put activities down but I'm not sure how many get carried out." One person told us they went out to church every week with their friend and staff told us about how they supported another person to have private services with their minister in the home.

On the day of our inspection we saw televisions were on in the two lounges and in the dining room. We did not see people being asked what they would like to watch and at one point saw a member of staff turn a television down to an almost inaudible level without asking anybody if they were watching the television or if they could hear it. During the afternoon we saw a work experience student engaging people in one of the lounges in playing games. Whilst people appeared to enjoy this we did not see people seated in other areas of the home invited to join in with the activity. Although the service is advertised as specialising in the care of people living with dementia, we did not see any evidence of a research based approach to sourcing activities appropriate to this client group.

Visitors told us they were able to visit at any time and were made to feel welcome.

People told us they would raise any concerns they might have with the care staff or with the registered manager. One visitor told us staff had responded well to a complaint they had made. However we did not see any records of this complaint. The registered manager told us complaints or concerns would usually be recorded in the individual care files.

We saw the complaints procedure on display in the home said any complaints should be discussed with the senior care assistant in the first instance and if not satisfactorily resolved, reported to the registered manager. There was no information about how the complaint would be responded to or how the outcome would be communicated. We also saw the contact details for the provider were incorrect as they had not been updated and were for the previous provider.
We recommend the provider ensures a formal process is introduced to ensure policies and procedures are consistently reviewed, updated and reflect up to date details and best practice.

We recommend the service looks at ways in which all of the people living at the home can be engaged in appropriate and meaningful activities of their choice.

Inadequate

Is the service well-led?

Our findings

People told us they knew who the registered manager of the home was. One person said, "I have every confidence in the manager." Another person told us they had met with the new owners and said, "They leave the running to the manager and staff. I know the manager. I see her quite regular. She comes and speaks."

We spoke with the registered manager regarding auditing processes to ensure safety and quality remained at the forefront of care delivery. The evidence we saw and a discussion with the registered manager indicated their workload was having a negative impact on the audit programme. Furthermore audits carried out were not been followed up with the result that identified problems were recurring. For example, a medicine audit in June 2015 identified a lack of PRN protocols yet on our inspection we found they still had not been put in place. We were told a medicines audit had also revealed a lack of accountability of medicines in use which had resulted in the senior care staff auditing boxed medicines every Sunday. Our inspection took place on a Monday yet we found discrepancies in stock accounting which had not been identified through the home's own auditing system.

We did not see any recent environmental audits or plans for refurbishment or redecoration despite the environment and furnishings appearing tired and worn and, in some places, unclean. We asked the registered manager if the providers had conducted any quality monitoring visits to the home from which a report had been produced. The registered manager said they had not.

The registered manager was aware of the need to audit accidents and incidents but said they had not been able to start this due to pressure of work. The registered manager said that annual satisfaction surveys were sent to people involved in the service but we did not see any analysis of results.

The registered manager had conducted an audit of Do not attempt Cardio-pulmonary Resuscitation (DNACPR) forms which had shown some were not fully completed or people's health status had changed. We found the audit had resulted in significant improvement as all DNACPR forms were correctly completed.

We saw staff meetings were held on a monthly basis for senior staff and annually for all staff. The registered manager said there had not been any recent service user/relative meetings.

The registered manager told us that information relating to the use of CCTV and bedroom intercoms was not in the service user guide and we did not see any information on display to advise people about the use of this equipment.

The complaints procedure had not been reviewed to include up to date contact details.
Many of the concerns we identified during our inspection had not been identified through the providers own auditing systems. Those that had, for example the issues identified within the medicines audit, had not been addressed. This meant that auditing was not effective.

The lack of regular and effective auditing of the safety and quality of the service demonstrates a breach of

Regulation 17(1)(2)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care needs had not been assessed and care had not been planned in a way that would ensure their care needs would be met. Regulation 9 (3)(a and b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's privacy was not always respected. Regulation 10 (1) and (2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely. Regulation 12 (g) People living at the home were not always protected by safe systems make sure the premises were safe and infection control measures adequately followed. Regulation 12 (d and h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Not all staff had received the training they needed to support them in their role. Regulation 18 (2)(a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not in place to ensure effective auditing of the quality and safety of the service.

The enforcement action we took:

Warning notice provider and manager