HICA

Riverside Grange - Care Home

Inspection report

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Ratings

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

Overall summary

We undertook this unannounced inspection on the 23 and 24 February 2015. The last full inspection took place on 6 and 7 May 2014 and the registered provider was non complaint in three of the areas we assessed. These included how people's nutritional needs were met, staffing numbers and how the service was managed overall. Some improvements had been made but there remained concerns regarding the management of the service.

Riverside Grange is a two storey building situated on the outskirts of Hull. It is registered to provide accommodation and personal care to 33 older people, specifically those people living with complex dementia care needs. On the day of the inspection there were 25 people living in the home. Fifteen people lived on the ground floor and 10 lived on the first floor. Bedrooms, communal areas and bathrooms are located on both floors.

Summary of findings

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During the inspection we had concerns about the overall management of the service. This had impacted on areas of care and support provided to people who used the service. This is being followed up and we will report on any action when it is complete. The quality of the service had not been monitored effectively and shortfalls had not been dealt with or had not been identified.

Policies and procedures were in place to guide staff in how to protect vulnerable from abuse and harm and how to make sure senior managers and relevant agencies were alerted to concerns. The procedures had not been consistently followed, although we found some staff had raised concerns when required.

We found some people did not have risk assessments in place for specific concerns and incidents and accidents had not been analysed to help find ways to reduce them.

We found there was a lot of important and personalised information in care plans although some of them had not been updated when people's needs had changed. Some care had not been delivered effectively to ensure people's care and welfare.

We found some parts of the environment required attention to make sure they were hygienic.

The above areas breached regulations in safeguarding people from abuse, care and welfare, cleanliness and infection control and monitoring the quality of the service. You can see what action we told the registered provider to take at the back of the full version of the report.

We found there had been improvements in people's nutritional intake and their dining experience. New equipment such as tables, to use when eating meals whilst sitting in easy chairs, had been purchased. The dining area had been rearranged and people encouraged to use the dining tables for meals.

We found most people had their medicines given to them as prescribed although one person's preferences and times of rising had affected their administration. The area manager told us this would be discussed with the person's GP.

Staff understood the need to gain consent from people prior to carrying out care and support tasks. When people were unable to give consent, the staff acted within best interest principles of the Mental Capacity Act 2005.

There were activities available to help people maintain skills and previous interests.

New staff were recruited safely and employment checks were carried out before they started work in the service. We found staffing numbers had been increased following the last inspection but a recent reduction in staffing numbers had an impact on the care received by some people who used the service. This was addressed by the operations director on the second day of the inspection.

Staff had access to a range of training to help them develop knowledge and the skills required to support people. They had supervision meetings with their line manager but some staff felt they required more support but this had not always been available at the time it was needed.

There were systems in place to manage complaints and relatives told us they felt able to raise concerns and complaints.

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 always safe.

There were policies and procedures to guide staff in how to keep people safe and how to raise alerts with the local safeguarding team. There were occasions when these policies and procedures had not been followed.

A recent reduction in staffing had impacted on the safety and care provided to people who used the service. This was addressed during the second day of the inspection.

Risk had not always been managed effectively. Some incidents had occurred that posed a risk for people but actions had not been taken to minimise the risk of reoccurrence.

The system to ensure the service was clean and hygienic had not been fully effective.

Medicines were administered to people in a person-centred way in line with their daily routines. On some occasions for one person, this had caused omissions and checks had not been made with the prescriber to review their medicines.

Is the service effective?

Inadequate

The service was not always effective.

There had been occasions when care and welfare provided to people who used the service had been inconsistent.

People's nutritional needs were met and the meals provided to them looked well presented.

The registered manager and staff had received training in the Mental Capacity Act 2005. Some documentation used to assess people's capacity to make important decisions could be completed in a clearer way. Staff knew the importance of gaining consent for tasks on a day to day basis.

Staff had access to supervision meetings with their line manager. Some staff did not feel supported at present.

The registered provider had a training department and staff had access to a range of training courses to help them support people's assessed needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was not always respected with regards to the care of their appearance, clothing, footwear and cleanliness of bedrooms.

Summary of findings

Staff approach to people during interactions with them was kind and caring.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people had assessments and care plans which were not consistently kept up to date when changes occurred in their needs. This meant there was a risk of important care being overlooked.

There was a range of activities provided to people who used the service. These were available on a daily basis although had been temporarily affected by the recent staffing issue.

There was a policy and procedure in place which assisted people to make complaints or raise concerns. Relatives told us they felt able to raise complaints.

Is the service well-led?

Inadequate

The service was not well led.

There was a quality monitoring system in place but this had not been used effectively. Audits had not picked up concerns or when shortfalls were highlighted, they had not been addressed.

There was a lack of analysing and learning from incidents and accidents that occurred in the service so that practice could be changed and risks minimised.

There was a lack of overall management of the service to ensure care was delivered to a safe and acceptable standard.

There was an inconsistency in notifying appropriate agencies when incidents had occurred. This meant the agencies did not have the opportunity to check out how they were managed.

Meetings were held to enable people who used the service, their relatives and staff to express their views about the service.

Riverside Grange - Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered 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 23 and 24 February 2015 and was unannounced.

The inspection was completed by two adult social care inspectors who were accompanied by 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. The expert by experience had expertise in dementia care.

Prior to the inspection we spoke with the local safeguarding team and the local authority contracts and commissioning team about their views of the service.

Because of the complexity of people's needs, we were unable to speak with them about how care was provided to them. Instead we spoke with four relatives who were visiting during the inspection and we observed how staff interacted with people who used the service. We received information from a health professional visiting the service during the inspection.

We spoke with the registered manager, the deputy manager and eight members of staff from a range of roles. We also spoke with an area manager, a quality assurance manager and a director of operations to feedback the concerns we found during the inspection.

We looked at five care files which belonged to people who used the service. We also looked at other important documentation relating to people who used the service such as medication administration records (MARs). We looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty code of practice to ensure that when people were deprived of their liberty or assessed as lacking capacity to make their own decisions, actions were taken in line with the legislation.

We looked at a selection of documentation relating to the management and running of the service. These included two staff recruitment files, the training record, the staff rotas, minutes of meetings with staff and people who used the service, quality assurance audits and maintenance of equipment records.

Inadequate

Is the service safe?

Our findings

Some visitors told us they had concerns about staffing levels. When asked if there were enough staff, they said, "Not anymore – they have reduced staff. No, definitely not enough", "They are understaffed recently" and "Most of the time; even then they are looked after." One visitor told us their relative should have had a sensor mat by their bed. They said, "Sometimes it is there but sometimes not." This was addressed during the inspection. Visitors told us they thought their relatives were safe. They said, "I think so; seems pretty safe here. The doors have entry codes" and "She is safe; there is always someone around and she has never had any accidents."

At the last inspection on 6 and 7 May 2014 we issued a compliance action as we had concerns that the number of care staff on duty was insufficient to meet the needs of people who used the service. Following that inspection staffing numbers had increased and had remained at an appropriate level until approximately two to three weeks prior to the inspection. At this point staffing numbers were reduced which had an effect on the care people had received. Six people who used the service had individual one to one support, for varying hours each day, which was commissioned by health services or the local authority. We saw agency staff were employed to provide the one to one support or back-fill the core care staff team whilst they carried out the support. The shortfall in staffing numbers had occurred when agency staff were not available or when it was decided not to employ them and the core care staff team were used to provide the one to one support. This left the core care staff team depleted who then relied on the activity coordinator or domestic and laundry staff to support with care tasks. This in turn had an impact on the activities provided to people and the ability of ancillary staff to fully complete their tasks.

The director of operations and quality assurance manager told us there had been a misunderstanding and staffing levels should not have been reduced in this way; staffing numbers were reinstated to their original level straight away on the second day of the inspection. We were also told the staffing situation would continue to be monitored and have received assurances from the director of operations that there are now clear directions as to the minimum core care staffing requirements. There is also to be a full analysis of staffing needs to be undertaken which will include how the use of one to one support is being used. In discussions with staff they confirmed the concerns about staffing numbers had been for a short time only. They said, "Not enough staff; they have been cut and we are using the one to one staff" and "No, the last two to three weeks there has been only one carer upstairs and one carer downstairs, previously we had two downstairs. They use one to one carers to assist with residents (when they are commissioned to provide individual one to one support)."

Staff had received training in how to protect vulnerable people from the risk of abuse and harm and the service had policies and procedures to guide staff. There were plans in place for any emergency situation and staff had names and numbers of people to contact as required. However, a situation occurred on the day prior to the inspection, which was very difficult for the staff on duty to deal with and we found the incident had a direct impact on some of the people who used the service. For example, we were told some people did not receive breakfast and some missed lunch that day as staff were so busy supporting one other person who used the service. The incident resulted in a request for support from the police and Intensive Homecare Support Team, although staff did not contact senior managers for advice and support. A member of staff reported the incident after the event and the quality assurance manager visited on the day of the inspection to check how it was managed. We have asked that this incident, including the lack of breakfasts and lunch for some people be thoroughly analysed and an alert sent to the local safeguarding team. We will monitor this and check the outcome from the local safeguarding team.

Generally, the registered manager contacted the local safeguarding team when there were incidents between people who used the service and they used a matrix tool to gauge risk and determine if a safeguarding alert form was required. However, we found there had been situations when incidents had occurred between people who used the service or unexplained bruising had been found on people but these had not been followed up with the local safeguarding team. This meant the local safeguarding policies and procedures had not been followed in these instances and also meant the local safeguarding team did not have the opportunity to comment on the incidents, provide advice or take any action.

Inadequate

Is the service safe?

Risk assessments had been carried out when staff identified areas of concern. However, we found some instances when risk had been identified following an incident but this had not been followed up with a proper assessment and managed appropriately. For example two people had experienced choking incidents (one of these people had two incidents of choking), but risk assessments had not been completed to guide staff in how to minimise the risks in future. One incident described how a person had cut their finger on a safety razor in their toilet bag; we found the razor was still in the toilet bag, which meant the accident could be repeated. One person had spilled hot soup on themselves but on the day of the inspection, we observed they ate their lunch and drank their tea unassisted. We saw people moved about the service in wheelchairs that did not have foot rests on. This could potentially cause injury to their feet. We were told a sensor mat, required at the side of one person's bed due to their high risk of falls, had been removed. We mentioned these points to senior managers to address. The sensor mat was returned to the person's bedroom on the second day of the inspection. We observed two staff supported a person to transfer between wheelchair and easy chair using a hoist. When the manoeuvre was completed, staff allowed another person who used the service to pull the hoist back and away from the chair. This had the potential to cause injury to the person.

The impact of how the emergency situation was managed, the shortfalls in using the local safeguarding policies and procedures to the full and the management of risk meant there was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the registered provider to take can be found at the back of this report.

During the inspection we completed a tour of the environment and found concerns with hygiene and cleanliness in some parts of the service. We found infection prevention and control systems were not wholly adequate to prevent the spread of infection. The concerns included an odour of urine in two bedrooms, wheelchairs stained with food and other debris, inadequate bins in toilets, prescribed creams without lids, storage issues in linen rooms, a leak on the floor of one ensuite toilet, some toilet bowls badly stained, a stained bed base and hygiene issues in several other bedrooms. These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the registered provider to take can be found at the back of this report. Following the inspection we received an interim action plan which stated a full environmental audit had been completed and an action plan formulated to address concerns, which included a review and update of cleaning schedules.

We found that medicines were stored safely and recorded appropriately when received into the service and when administered to people. There was a separate treatment room with a sink for personal hygiene and plenty of storage room. On the day of the inspection, we observed the morning medicine 'round' did not finish until 11.45am. This was because people arose at different times of the morning. We observed the senior support worker who administered the medicines documented when the times of administration were overdue the set prescribed time, so that the next dose would take account of this. Generally, when people were prescribed medicines to be taken when required (PRN), for example as pain relief, there were instructions for staff about this. However, we found two people who had PRN medicines to help calm them and reduce anxiety did not have clear directions in place. This was mentioned during feedback to senior management so it could be addressed.

We looked at two staff recruitment files and saw staff were only employed after appropriate checks had been carried out. These included references, gaps in employment, an interview and checks with the disclosure and barring service to make sure staff were safe to work with vulnerable people. We saw there were profiles for each member of the employment agency that worked within the service. These indicated the agency had carried out an appropriate police check and they stated what training courses each agency worker had completed. There were no training certificates to confirm the training. These would provide assurances to the registered manager that the training was up to the required standard and how long ago it had taken place. The area manager told us they would follow this up with the employment agency. The interim action plan we received indicated recruitment had commenced for care staff in order to reduce the need for agency staff.

Inadequate

Is the service safe?

We found equipment used in the service, such as moving and handling, for catering purposes, hot and cold water outlets, fire safety, call bells and the lift was checked and maintained. We were told the mobile sensory equipment was broken and awaiting repair and we found a toilet seat was loose in one of the ensuite toilets. These were mentioned to senior managers to address.

Inadequate

Is the service effective?

Our findings

Visitors told us their relatives saw health professionals when required and said they were included in decisions about their care and treatment. They said, "I am always at her meetings and I make all decisions along with the home" and "I feel they would contact the GP if needed."

At the last inspection on 6 and 7 May 2014 we issued a compliance action as we had concerns people's nutritional intake was not being monitored properly and some people had lost weight. We found some improvements had been made in this area. The service continued to employ catering staff but the main meals at lunchtime and in the evening were provided by an external company. The prepared meals provided a fortified or textured diet as required and were calorie controlled to help people gain or maintain a healthy weight. Nutritional screening was carried out and people's weight was monitored on a risk based approach using a recognised nutritional risk tool. New tables had been provided for when people chose to eat their meal sitting in the lounge and dining arrangements had been improved. We observed the lunchtime and tea-time experience and saw this had improved. The meals looked appetising and well presented.

We saw people had access to a range of health care professionals for advice and treatment such as GPs, consultants, dieticians, speech and language therapists, community and specialist nurses, emergency care practitioners, the falls team, the crisis intervention team and opticians. A visiting health professional told us staff followed their instructions and they felt the person they were visiting had their health care needs met. However, we found concerns in the way some people's care and welfare was managed. For example, one person had a catheter insitu and records stated they had a risk of urine infections and urinary retention. Catheter care was provided by staff at the service and overseen by the district nurse who was frequently called to recatheterise the person due to it blocking. We found the person's fluid intake and output had not been managed well and it was unclear whether this had had a direct impact on the need for recatheterisation. They did not have their catheter leg bag positioned correctly and the tap on the bag touched the floor as they walked about the service. This had the potential to cause infection.

The same person had very long toe nails with blood on one of them and was observed walking about without any footwear on. It was recorded the person had declined to have their toe nails cut. It was also recorded the person had falls and on at least two occasions had bumped into the door frame when walking into rooms. It was unclear whether the condition of the person's toe nails was impacting on their mobility. This had not been discussed with the person's GP to see if further action was required. We observed several other people walking about the service in either no footwear or inadequate footwear. One person had oedematous feet and ankles and was at risk of knocking them causing injury.

One person who was at risk of choking, and whose care support plan stated they were to have a soft option, was observed eating sausages for lunch. They were cut into inch size pieces but posed a potential risk for the person. They were commissioned to have one to one support at lunchtime but the member of staff designated to support them was assisting another person.

On the first day of the inspection, we saw a person who used the service had a small wound on their leg. We mentioned this to the registered manager but it had not been attended to when we checked the following morning. We raised the concern again with staff and they contacted a district nurse to provide treatment. This meant treatment had been delayed by a day.

We found one person had times when they slept for long periods. This resulted in the person missing some medicines and a discussion with their GP would have provided them with the opportunity to review their treatment regime; we found staff had not sought advice from the person's GP during these times. There were also missed opportunities to administer the medicines when care staff were supporting the person to get washed and dressed. The person frequently chose to return to bed fully clothed but there was a window of opportunity during these care tasks and an improvement in communication between care staff and the senior administering medicines could help the situation. This was mentioned to the senior who administered medicines and senior managers to look into.

These above issues affecting people's health and welfare were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which

Inadequate

Is the service effective?

corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the back of this report.

The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards (DoLS). DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. There were two people subject to a DoLS at the time of this inspection and another application for a DoLS had been submitted to the local authority. The area manager told us they were to review people's needs as they felt other people may meet DoLS criteria and applications would be submitted to the local authority.

We found the application of the Mental Capacity Act 2005 (MCA) in regards to assessments of capacity, best interest decision making and care planning was applied well in some cases but could be improved in others. For example, assessments of capacity had been completed and meetings to discuss what decisions were to be made in the person's best interest had taken place with relevant people consulted. One person had a plan of care to support them with personal care tasks and the least restrictive options for their care had been considered. This guided staff on actions to take when risks to the person's health and welfare became too great and they had to intervene to support the person with holding techniques. However, records showed that one person, who did not have any relatives, had their capacity assessed and decisions made by the staff alone. We could not see other health or social care professionals were involved in the decisions. Records could also be clearer about the decision under review. We mentioned this to senior managers during feedback and they confirmed they would complete a check of MCA assessments and decision-making documents to check for consistency.

We saw staff had access to a range of training considered essential by the registered provider such as fire safety, infection prevention and control, moving and handling, food hygiene, safeguarding people from abuse, health and safety, MCA and first aid. There was also training specific to the needs of people who used the service, such as dementia care, managing behaviours that could be challenging to the person, other people and the service, nutritional risk management and pressure area care. There was an induction process that consisted of a set number of training days and shadowing more experienced staff. Staff confirmed they received training. Comments included, "I have had plenty of training" and "I feel I am trained enough."

Staff confirmed they had supervision meetings with their line manager every six weeks. However, some staff told us they did not feel supported at present.

We found the design of the building was not wholly appropriate for people living with dementia. People who lived downstairs had plenty of space to move about freely but people with more complex needs were supported upstairs. There was nowhere for them to walk around in the fresh air unless staff escorted them downstairs and into the garden. The lounge area upstairs, which was also the dining room, was small to accommodate ten people safely. There was another small seating area, which was used by one person. We did see that bedroom doors were painted different colours and had name plates to help people identify their own bedroom and toilet/bathroom doors were painted yellow with signs for ease of recognition. We also saw the service had grab rails in toilets, hand rails in corridors and specialist sit-in baths. Staff told us some of the assisted baths were no longer used as people often declined to use the hoist to transfer them in and out. This was to be discussed when the environmental audit was completed.

Requires Improvement

Is the service caring?

Our findings

Relatives told us they thought staff respected people's privacy and dignity and helped them to be independent. Comments included, "She can walk about on her own; they do give her the opportunity to make some decisions", "I think they do (promote independence); he can walk around on his own and he can dress himself some days", "I think they do (respect privacy and dignity)", "I would say so – no complaints" and "90% of staff are excellent." The person did say the service used agency staff to support their relative with one to one care, which could mean different staff each time. One relative said food spillages were not cleared away from floors as quickly as they would like them to be. Another visitor told us they thought some staff did not always care about how their relative looked.

A visiting health professionals said, "I have been impressed with staff attitude towards patients and they treat them with respect and as individuals."

In discussions with staff and from observations of their practice, it was clear the core staff team knew people's needs very well. There was a key worker system which enabled staff to form relationships with people who used the service and their relatives.

We observed some very positive interactions between staff and the people who used the service but we also observed an interaction involving an agency worker that could be improved. This latter was mentioned to senior managers at the time of the inspection. We observed a member of staff deal with a very difficult situation in a calm and supportive way. They spoke with the person for a long time until they became calm and less distressed. The member of staff showed they knew the person's needs well and how to communicate with them.

We observed staff provided information to people prior to tasks being completed. For example, prior to transferring people from a wheelchair to chair using a hoist, offering a choice of meals at lunchtime, guiding them when supervising walking around the service and assisting people to the toilet. There was a menu board on display which provided information about the meals available each day. This was in pictorial format to remind people of the choices. There was also a notice board in reception which had information in pictorial format about the activities available.

Care plans prompted staff to promote privacy, dignity and independence. There was information in care plans regarding people's preferences for male or female care worker. Each person had their own bedroom with an ensuite sink and toilet. This afforded them privacy and space if they wanted to spend time alone in their room. We saw bedrooms, bathrooms and communal toilets had privacy locks.

Despite the good interactions we observed there were areas to improve regarding promoting people's dignity. For example, we saw people walking about with no footwear or incorrect footwear, one person was walking around with only one slipper on, some people looked unkempt and were sitting in dirty wheelchairs, some people looked as if their hair had not been brushed that day, some people had long and unclean fingernails and others had not been shaved. We saw one person was wearing odd socks and when we asked staff about this, they said they were the only ones available that morning. One visitor told us they had observed an agency worker approach their relative and put a sausage roll straight into their mouth, without offering it to them on a plate or giving it to them in their hand. They said this was the wrong approach for them and they just spat the sausage roll out. The visitor told us they spoke to a senior care worker about this and they addressed it with the agency worker.

We found toiletries belonging to some people who used the service in other people's ensuite rooms.

There were instances when people's clothes had not been cared for properly. During a check of bedrooms we found clothes had not always been put away tidily in wardrobes and drawers; they were found crumpled on the floor of the wardrobe or stuffed into drawers. Visitors told us the care of their relative's clothes and laundry could be improved, as clothes had gone missing. We found there had not been time for key workers to attend to people's clothes properly. There was a collection of odd slippers in one of the linen rooms, which needed to be sorted and returned to their rightful owners or thrown away.

We found some people's bedrooms also required attention to make them look homely, comfortable, lived in and to provide stimulation for people living with dementia. For example, some beds had been made with single sheets that were not fitted to the mattress. As the mattress had a protective covering, the sheets slipped off easily or rucked up, which would make them uncomfortable to sleep on.

Requires Improvement

Is the service caring?

Some quilt covers and sheets were marked and needed changing. We found some bedrooms looked very personalised with pictures, photographs of family and memorabilia to aid stimulation and memory recall. However, other bedrooms looked quite stark with few ornaments, pictures and personal items; one bedroom did not have a shade for the light and a bulb had gone in another person's ensuite. One person had precious items wrapped in newspaper in tins on top of their chest of drawers and wardrobe. When we asked a member of staff why they were not on display in the bedroom, we were told other people who used the service may enter the bedroom and take them away. We spoke with the operations director about this and they advised shelves would be fitted to the walls, of sufficient height to display the items but also to prevent people from taking them out of the room.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us they felt able to complain and named specific staff they would speak with if they had any concerns. They said, "I would see the manager; I don't know their name but I have never had to" and "I would see a carer first or the manager and if I was still not happy, I would go to CQC." Some relatives told us they had seen activities taking part but most said they would like to see more. One relative said, "I've never seen them do baking; that would be nice." Minutes of a meeting showed us that some baking took place. We spoke with an area manager about the relative's comments to ensure the person who used the service was invited to participate in baking when next arranged. Another relative said, "They said they would take him for walks outside but they never do."

We saw assessments were completed prior to people's admission to the service and there were some good examples of how person centred care was recorded in care files. These included people's likes, dislikes, preferences for how care was to be carried out, routines that worked for them and a map of their life to highlight important relationships, places of interest and previous hobbies.

However, there were instances when assessments, risk assessments and plans of care had not been evaluated and updated when incidents had occurred or people's needs had changed. For example, one person had a catheter insitu but the plan of care did not provide staff with sufficient information about how to manage their fluid intake or what level of output would constitute concern and discussion with the district nurse. Monitoring charts regarding their fluid intake were not completed properly and either the person was not receiving adequate amounts of fluid or the charts did not give an accurate picture of fluid intake and output. The person was at risk of urinary retention and information about fluid intake and output was crucial to their personalised care.

Another person's care plan regarding their nutritional intake had not been evaluated and updated following two choking incidents in January and February 2015 and a hot soup spillage incident in February 2015. Their initial assessment in December 2012 stated the person required assistance to cut up their food and an update in January 2014 did not provide any additional information. The person's care plan formulated in January 2013 mentions the assistance required with cutting up food and an update in April 2014 refers to 'softer options' and 'soft meats to be blended to make them more manageable'. An evaluation in May 2014 states the person had no difficulty swallowing. There were no risk assessment to guide staff in how to minimise the risk of the person choking and spilling hot food on themselves.

We checked bathing records and found lots of gaps. This meant it was difficult to audit whether people were receiving showers or baths in line with their preferences. We were unsure if this was a recording issue or a practice issue. A member of staff told us the staffing issue that had affected the service over the last two to three weeks had impacted on timings for people's preferences for bathing.

There were 'patient passports' in each person's care file. These provided information to hospital staff when people were admitted for treatment. Some of the patient passports had not been updated with relevant information.

There were two activity coordinators employed to work in the service, although only one had been available for the last five weeks. The recent staffing issues had affected the amount of activities that had been available to people, as the activity coordinator was called upon to oversee people whilst care staff were busy. This was observed on the day of the inspection.

However, generally there was a range of activities available for people when they felt able to participate. Staff told us they had activities such as entertainers, gardening and indoor games. They said they had supported people with individual activities reflecting their interests, for example one person was supported to football matches and another had gone to the park as they enjoyed bird watching. Six people received varying amounts of one to one support and there was evidence that during these times people were able to access the local community for a walk to the shops or to participate in indoor occupations. The quality assurance manager told us the service was linked in to a 'heritage programme'. This was externally facilitated and involved training staff and teaching them techniques in how to deliver activities to people. There was also a centralised fund set up by the registered provider and staff could make bids for funds to buy equipment.

The minutes of a meeting held in December 2014 between an activity coordinator and seven people who used the service, indicated people were asked about activities. The minutes stated people had enjoyed baking ginger bread

Requires Improvement

Is the service responsive?

men and mince pies. Those activities planned for the coming months included church services, local singers, themed meals, 'pat the dog', trips out to a pub a museum and a traditional sweet shop. The minutes included information about plans to buy a popcorn maker and a chocolate fountain. There were also plans for Valentine's Day and Pancake Day. We obtained information from the activity coordinator as to whether these activities had taken place. This indicated most of these activities had been completed but the trips out to a pub and a museum did not take place for various reasons.

We saw there was a complaints policy and procedure and a log maintained when complaints were received and investigated. There were forms for people to complete if they wanted to make a complaint. Staff were aware of the complaints procedures. They said they tried to ensure concerns were dealt with quickly before they escalated into more formal complaints.

Inadequate

Is the service well-led?

Our findings

At the last inspection on 6 and 7 May 2014 we issued a compliance action as we had concerns about how the quality of the service was monitored. During this current inspection we continued to have concerns about how the registered provider's quality monitoring systems were followed. Some audits and checks were carried out and action plans formulated which were discussed with senior managers. Some had resulted in improvements, for example the dining experience for people who used the service. However, we raised concerns about the management and leadership of the service and we discussed these with the operations director during the inspection. The registered provider has taken immediate action, reorganised the management structure within the service and produced an interim action plan to improve the service.

We found there had been an issue regarding the reduction of staffing levels over a two to three week period that had not been managed well and concerns raised by staff had not been listened to. There had been health and welfare impacts on the people who used the service as a result of the staffing changes. The operations director reversed the decision about staffing levels during their visit on the second day of the inspection. We accept there had been a misunderstanding about how core staff and staff employed for one to one work with people, had been managed.

Learning from incidents or accidents was inconsistent. For example, the person who sustained a laceration to their finger from a safety razor in their toilet bag continued to be at risk of further injury as the razor was found still in the toilet bag during the inspection. This razor was removed and staff were to support the person with shaving each day.

We found accidents and incidents were recorded on individual forms and on a monthly return to senior managers. When these were checked there were some inconsistencies. Some incidents that had occurred between people who used the service and some additional incidents had not been reported to senior managers. For example, in January 2015, two people were recorded as having pressure damage to their skin and their individual records documented the extent of the sores. However, the end of month return for January 2015 recorded there were no people with pressure ulcers and it only had a minor description of one of them as an incident. This meant senior managers may be unaware two people had pressure damage and may be unable to monitor how they were managed. The one recorded on the monthly return stated the district nurse had been made aware.

We had concerns about risk management and follow through to ensure all staff were aware of risks posed to people who used the service. For example, risk assessments had not been completed following some important incidents and there was no system to analyse the incident, check whether a risk assessment was needed, follow this up with staff to ensure it had been completed and cascade information to staff. People had information sheets to be used when they were admitted to hospital so nursing staff would have information about their needs. However, we found these were not always updated to reflect changes in people's needs or risks that had been identified.

There was a system to sign off that cleaning schedules had been completed each day but no system to check monitoring charts for areas such as food and fluid intake or pressure relief had been completed at the end of each shift. We found some gaps in recording and the monitoring of one person's urine output was incomplete and on a form used for recording the application of cream. This meant staff were not prompted to record the urine output properly. A checking system would have picked these issues up and they could have been addressed. Without the checking system it was difficult to audit the correct care had been given to people. During the inspection an area manager printed out a correct copy of a urine output monitoring chart which was used by the registered provider and available to all registered managers. They told us they would ensure staff completed it properly in future.

Environmental audits were carried out but these had not been effective or completed in a timely way to monitor the level of support some people required whilst in their bedrooms. For example, we found issues with the state of some people's clothes in wardrobes and drawers and a lack of monitoring when sheets, towels and bedding required changing. There was a lack of checking on crockery left in bedrooms (we found used plates under a chair in one person's bedroom), empty suitcases were left in bedrooms, rubbish such as empty boxes and sweet wrappers had not been cleared out or people's bedside lockers and some people had not been supported to make their bedroom homely. Some bedrooms had not been

Inadequate

Is the service well-led?

deep cleaned, some bathrooms were used as storerooms, we found a bed had a leg broken and a bulb was broken in one ensuite toilet which meant the person would not be able to see to use the facilities. An area manager told us a full environmental audit was to be carried out as soon as possible.

The registered provider is required to send the Care Quality Commission (CQC) notifications of incidents which affect the safety and wellbeing of people who used the service. We found there had been at least 10 occasions in January and February 2015 when incidents had occurred which required a notification to CQC and six others that may have required a notification but our records indicate we did not receive them. Notifying the CQC of incidents which affect the health and welfare of people who use the service enables us to check with the registered manager how these are being dealt with. We have written to the registered provider advising them of the need to notify CQC as required by regulation.

The registered manager's office and staff office were quite untidy. We found recruitment records were disorganised and there were piles of incident records on a floor under a desk in the staff office. During the inspection we found this made some records difficult to locate quickly.

The above issues regarding the lack of effective quality monitoring means there has been a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the registered provider to take can be found at the back of this report. We have judged the concerns about the management of the service to be a breach of Regulation 6 HSCA 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Requirements relating to registered managers. This is being followed up and we will report on any action when it is complete.

Visitors and staff gave mixed views about the management of the service and whether their suggestions would be listened to and acted upon. Visitors felt they could approach staff and said they listen to them, but one said, "They don't always follow it up." One visitor said, "The management is good, easy-going and their door is always open." Staff told us they required more support and guidance at times but this had not always been available when they needed it. Staff meetings were held and minutes were seen of those held in January 2015.

There was evidence that people's views were sought in surveys and meetings. One visitor told us they thought they had completed a survey about meals. They said, "I am sure I have at some point; I filled one in about food and they have now changed the supplier." Other visitors told us they had not completed a survey or couldn't remember if they had completed one. Meetings were held for relatives and one visitor told us they were to attend one later in the week. They confirmed they were able to express their views about the service at these meetings and during care plan review meetings. We saw minutes of a meeting held for people who used the service which indicated they were asked their views about activities.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 How the regulation was not being met: People who use services were not protected against the risks of receiving care or treatment that was inappropriate or unsafe. Some people had not received professional advice and treatment in a timely way. Care had not been planned effectively for some people. Regulation 9 (3) (a) (b) - (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People who use services were not protected against the risks of acquiring a health care associated infection as the system in place to prevent such infections was not wholly effective. Regulation 12 (2) (h)

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 How the regulation was not being met: People who use services were not protected against the risks of abuse and harm. There had been physical assaults between service users which could potentially cause harm and injury. Safeguarding policies and procedures had not been followed. Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe care and treatment, by means of an effective operation of systems designed to monitor the quality of the service. Identifying, assessing and managing risks relating to the health and welfare of service users had not been effective. Regulation 17

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 7 HSCA (RA) Regulations 2014 Requirements relating to registered managers Service users health and welfare were not protected because the registered manager did not have the necessary skills and experience to carry on the regulated activity. Regulation 7 (1) (2) (b)

The enforcement action we took:
This is being followed up and we will report on any action when it is complete.