Park View Nursing Home Limited

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Inspection report

Lee Mount Road
Ovenden, Halifax HX3 5BX

Date of inspection visit: 26 November 2014
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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

Overall summary

Park View Nursing Home provides accommodation and nursing care for up to 43 older people at any one time. On the date of the inspection, 26 November 2014, 33 people were living in the service. This included 12 people receiving residential care, nine people receiving nursing care and 12 people receiving intermediate care. Intermediate care aims to help re-able people to allow them to return home following a hospital admission or to prevent the need for long term residential care.

This was an unannounced inspection. At the last inspection in October 2013 the home met all the regulations we looked at.

A registered manager was in place. 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 and associated Regulations about how the service is run.

Medicines were not safely managed. Appropriate arrangements were not in place to give people their medicines at a time that met their individual needs. Arrangements for the ordering, storage, and disposal of medication were not sufficient to keep people safe.

Summary of findings

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Risk assessments were in place which considered the risks associated with caring for each person. However we found some risks to people's health and safety such as risks associated with the building had not been identified and managed to keep people safe. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's capacity was assessed under the Mental Capacity Act 2005 (MCA). We found care records considered people's capacity to make decisions for themselves and best interest decisions were made where people lacked capacity. Further work was required to meet the requirements of the Mental Capacity Act Deprivation of Liberty Safeguards (DoLS). Restrictions on people's liberties had not been considered through the care planning process. The manager agreed to take immediate action to speak with the local authority DoLS team to determine whether any applications were required.

People told us they felt safe in the home and told us they were happy with the level of care and support they received. People said the food was good. People praised the staff team and said they were kind and compassionate. However there was a lack of involvement of people and/or their relatives in care planning.

People's individual health and support needs were met as staff completed assessments and planned and delivered appropriate care. However, record keeping evidencing the care people received was inconsistent. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw some activities were available to people. However, because the activities co-ordinator was on extended absence, there was a lack of structure to daily activities and some people told us that staff did not always have the time to engage in activities.

Staff and people who used the service praised the manager and said they were effective in dealing with any issues. However there was a lack of quality assurance systems in place to assess and monitor the quality of care provided. We found several areas of risk, such as to the medication management system, care records and environmental hazards which could have been identified and rectified through a robust system of audits/checks. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

You can see what action we told the provider to take at the back of the full version of the report

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not managed safely. People did not always receive their medication at the time they required them. Medicines were not obtained in a timely manner, some people ran out of key medications which meant there was a risk to their health.

Recruitment procedures were not followed. Satisfactory checks on people's backgrounds had not always been carried out prior to employing people which meant there was a risk unsuitable persons would be employed.

Although people told us they felt safe in the home, risks to people's health, safety and welfare were not always identified and managed to keep people safe. We noted a number of hazards which the provider had not identified prior to the inspection.

Is the service effective?

Requires Improvement

The service was not always effective. People told us the food was good and we saw a variety of food was on offer which gave people sufficient choice. We found staff understood how to meet people's individual nutritional needs.

People's capacity was assessed in line with the requirements of the mental capacity act (MCA) and best interest decisions held where appropriate. The home had assessed three people who did not have capacity to make decisions for themselves; however no Deprivation of Liberty Safeguards (DoLS) had been submitted to the local authority. The manager agreed to immediately speak with the DoLS team to seek clarity over whether DoLS applications were required for these individuals.

A range of training was provided to staff and people said staff had the skills and knowledge to undertake their role effectively. However new staff had not received a full induction which meant there was a risk new staff did not understand the services policies and procedures and ways of working.

Is the service caring?

Requires Improvement

The service was not always caring. People told us staff were caring, kind and treated them with dignity and respect. We saw the majority of the interactions were positive between staff and people, although we found the lunchtime experience could have been improved for some people.

Although people said staff listened to them, there was no formal mechanism to seek people's views and actively involve them in decisions in relation to their care.

Summary of findings

Is the service responsive?

Requires Improvement 

The service was not always responsive. Staff had a good understanding of the people we asked them about and the care required to meet their needs.

Care plan documentation was not consistently completed for example some care plans were missing evidence that routine care had been delivered and completion of sections such as life histories, and health professional input was inconsistent.

People told us the service was good at dealing with any concerns and complaints. Although through conversations with staff and the manager, we concluded complaints were dealt with to a satisfactory standard, it was often difficult to establish actions and learning from complaints as record keeping was not sufficiently robust.

Is the service well-led?

Inadequate 

The service was not always well led. There was a lack of audits in place to assess the quality of care provision. This meant there was a risk that poor care and support was not promptly identified. We found several concerns during the inspection, such as to the medicine management system and record keeping which could have been identified and rectified sooner through a proper system of audit.

Where issues had been identified by audits conducted by other organisations, action had not always been taken to address these risks.

Park View Nursing Home Limited

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, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 26 November 2014 and was unannounced. The inspection team consisted of an adult social care inspector, a pharmacy inspector, a specialist advisor with a nursing background 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

We used a number of different methods to help us understand the experiences of people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with 13 people who used the service, a registered nurse, five members of care staff, a laundry assistant, a catering assistant and the chef. We also spoke with the registered manager and owner of the service. We spent time observing care and support being delivered. We looked at four people's care records and other records which related to the management of the service such as training records and policies and procedures.

Before the inspection, the provider completed a 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. We reviewed this information along with other information we held about the provider. We contacted the local authority safeguarding team, clinical commissioning group and local healthwatch organisation to ask them for their views on the service and if they had any concerns. As part of the inspection we also spoke with two health care professionals who regularly visited the service.

Is the service safe?

Our findings

We found that people were not protected against the risks associated with the unsafe use and management of medicines. We looked at medication for 16 people who were living in the home. We found concerns about the administration of medicines or the records relating to medicines for all those people.

The timing of the medicines rounds were too close together to ensure that there was a safe time interval between doses of medicines. This meant that people were at risk of being given doses of some medicines such as Paracetamol unsafely. Arrangements to give people their medication as directed by the prescriber, especially with regard to food were poor. We saw that medicines which needed to be given half an hour before food were given with medicines which should be given with or after meals. Medicines must be given at the correct times to make sure they work properly. We found that when tablets were discontinued arrangements were not made to ensure that the discontinued medicines were not given in error. We found that some medication was supplied in such a way that nurses could not easily identify each individual tablet; this meant nurses could not always be certain which tablets were being administered. We saw that nurses sometimes failed to follow the prescribers' direction fully and people were not given their medicines properly.

Some people were prescribed medicines to be taken when required. We found that medicines prescribed in this way did not have adequate information available to guide staff as to how to give them. We found there was no information recorded to guide staff which dose to give when a variable dose was prescribed. It is important that this information is recorded to ensure people were given their medicines safely and consistently at all times.

Medicines were not obtained in a timely manner. We found that five people had run out of one or more of their medicines for periods between one and 21 days. If people miss doses of their prescribed medication their health may be at risk.

The quantity of medicines in the home was not always recorded. This made it impossible to audit medication to ensure that it could be accounted for and to ensure people had been given their medication as prescribed. The records showed that medicines had been signed for but had not been given and in other cases given but not signed for. There were missing signatures on records and it was unclear if medicines had been given or omitted on those days. We found that there were no records about the administration of creams for some people. Accurate records must be made about the administration of medicines to ensure people were not given too much or too little medication.

Medicines were not stored safely. Medicines must be locked away securely at all times to ensure that they are not misused. We saw that medicines were left out in the dining room and in an unlocked office during our inspection. We also noted the room was very warm but no records had been kept about the temperatures of either the room or the fridge to ensure that medicines were stored at the correct temperatures. We saw that prescribed creams were kept in people's bedrooms without assessments to show it was safe to do so.

We also found that it was recorded that one person had refused their medication for three weeks, the nurse on duty confirmed this was the case. However the home had not taken appropriate arrangements to ensure a review of this person's medication took place. This put the person at risk as they were not receiving their prescribed medicines.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Following the inspection we made a safeguarding referral to the local authority for the five people who had not received doses of their medication due to stocks running out. This was because the lack of a proper medicine management arrangements put these people's health at risk. We judged the provider had failed to take reasonable steps to prevent neglect of these people in terms of their medication care and support. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Recruitment was not always carried out in line with legal requirements. This meant there was a risk that unsuitable staff were recruited. We looked at personnel files of three care workers recruited in 2014. In two of the files, old style Criminal Reference Bureau (CRB) checks carried out in 2012 and 2013 by a previous employer had been used as the check on these people's backgrounds. This was not in line with legal requirements. Only the new Disclosure and Barring Service (DBS) checks which are specific to the

Is the service safe?

individual and can be transferred from one employer to another. In one staff record we noted their start date was 16 days before the date their references were received. We looked at staff rotas which confirmed this person had completed a number of shifts before the written references were received. This meant that satisfactory checks were not undertaken on this person before they started work to ensure they were suitable for the role. The manager told us people's qualifications and/or relevant training was also checked prior to commencing employment. However, in the files we looked at there was no evidence of any qualifications and the manager was unable to locate them for us when we asked to see them. There were no skill or competency checks on new employees to ensure they had the skills to keep people safe.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they liked their bedrooms and we did not receive any negative comments about the building. For example one person said, "My room is lovely, comfortable, clean and warm." We looked around the premises and found there was adequate space to enable people to live their daily lives. This included a large communal lounge and two smaller, more intimate lounges where people could spend their time. We observed that the main lounge/dining area was very noisy and busy. For example call buzzers sounded regularly in this area from other areas of the building, and due to the building layout it was a thoroughfare used by staff and other health professionals who worked/visited the building. As such this area did not have a very homely feel.

Bedrooms were homely and well maintained with people's personal possessions displayed. Two maintenance workers was employed and we saw they were responsible for undertaking a range of tasks such as routine maintenance, and checks on the fire and nurse call systems. We looked at records which confirmed these checks took place. A health and safety company was also employed to provide advice on health and safety matters. We found the décor in some areas of the building was tired, especially the corridors, however we saw there was a plan in place to refurbish these areas.

We found several risks to people's health, safety and welfare which had not been appropriately managed. The registered manager told us that window restrictors should be installed on all bedroom windows above the ground floor to keep people safe. However, we found three bedrooms which had no restrictors installed. This meant there was a risk people could fall from these windows. The top floor of the building had a keypad restricting access to the main staircase. This reduced the risk of people becoming disorientated around the staircases and falling. However, there was unrestricted access to a steep staircase through another door which meant there was a risk people could venture into this area and fall. Sharps boxes containing used syringes and other potential contaminated objects and medicines were also stored in open view in the dining room. The sharps boxes in particular posed a risk to anyone who may have inadvertently accessed them. There was no documentation which demonstrated the provider had identified these risks prior to us pointing them out to them and there were no systems or audits in place to routinely check the premises for hazards such as these. We raised these issues with the registered manager and owner who agreed to take immediate action to address them. Although the manager had begun completing personal evacuation plans for each person in the event of a fire, these had not been completed for everybody, which meant there was a risk the evacuation route and method for each person had not been evaluated to ensure it was practical and achievable.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Emergency resuscitation equipment was in place, in the nursing office; however the suction machine was kept in a locked cupboard in the (locked) clinical room. In the event of suction being required this would cause an unnecessary delay.

Risk assessments were in place where risks to people's health were identified. These included mobility, nutrition and pressure area care. We saw where risks were identified detailed plans of care were put in place which enabled staff to deliver appropriate care. Where people displayed behaviour that challenged, care plans were put in place to manage their behaviour. Staff we spoke with understood people's behavioural triggers and how to keep them and others safe.

People told us they felt safe in the home. For example one person said, "I feel safe, the home is easy to navigate around, and spacious." Another person said, "I do feel safe here; I've never seen anything that caused me to worry about myself or others." A large number of people living at

Is the service safe?

the home had physical disabilities and they told us they were given mobility assistance appropriately, for example when transferring from chair to wheelchair. One person said, "They always make sure I am comfy first before they lift me, I've never been hurt."

We found staffing levels were adequate to ensure people's needs were met. The registered manager told us safe staffing levels were seven care workers during the day and one registered nurse, as well as the registered manager who assisted with nursing duties during busy times. One registered nurse and three care workers were on duty at night. We looked at the rota's which confirmed these staffing levels were maintained. People told us that they did not have to wait too long when they needed assistance for example one person said, "They come straight away if I buzz, very rarely had to do it twice." Our observations confirmed there were enough staff on duty to attend to people's needs, for example in supervising communal areas and attending to call bells within appropriate times. We noted staff were busy and had only limited time to spend quality time with people to meet their social and emotional needs. This was confirmed by some comments we received, for example one person said, "Sometimes they are really busy and don't have time to chat." We also found the registered nurse spent a large proportion of the day administering medication, which left little time to attend to other nursing needs. The registered manager told us they normally helped out to reduce this burden and showed us plans were in place to develop care staff's responsibilities in regards to medicines management which would alleviate some pressure from nursing staff.

The home had a safeguarding policy in place and copy of the local safeguarding procedures. Staff we spoke with had an understanding of how to identify and act on allegations of abuse. They told us they would have no problem raising concerns with the manager. The manager demonstrated a good understanding of safeguarding. However we found concerns raised had not always been robustly documented. For example, after the inspection we spoke with the local authority safeguarding team, and they told us about a recent allegation of one person's possessions going missing. This information and subsequent investigation was not present in the safeguarding file or made available to us during the inspection when we asked to see all recent safeguarding alerts or concerns.

Is the service effective?

Our findings

People said staff had the correct skills to undertake their role. For example one person said they found staff competent when helping them to transfer using lifting equipment and felt confident and safe during the process. People who used the service said the majority of staff were, "Familiar faces" who knew them and their needs. The registered manager told us care workers were encouraged to undertake national qualifications in Health and Social Care and this was confirmed by the records. The manager had undertaken specialist training in management, pressure care and tissue viability and it was clear from discussions with them that they had a good knowledge base in these areas to enable them to plan and deliver effective care.

Staff told us that regular training was provided and it gave them the necessary skills to undertake their role. We saw mandatory training was provided in a number of areas which included manual handling, health and safety, safeguarding and fire evacuation. Specialist training was also provided which included end of life, tissue viability and PEG (Percutaneous Endoscopic Gastrostomy). However, when we looked at the provider's training matrix but we found gaps where staff had not received any training. For example, no manual handling training had been held since March 2013 although we saw sessions were booked in for December 2014. This meant there may be inconsistencies in moving and handling practices in the home as no recent training had been provided. Only five staff had completed safeguarding training and the matrix showed no staff had completed health and safety training which was identified by the provider as mandatory. There was no provision for training in the Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DoLS) and the staff we spoke with did not understand MCA or DoLS. There was also no clear plan which indicated how often training was required to be refreshed, nor any competency checks to assess staff performance on training.

We looked at three new employee files. There was no evidence they had received a local induction such as going through the service's policies and procedures and signing to demonstrate understanding. A new staff member who had been working at the service for six weeks said they had not yet been shown the provider's policies and procedures. This risked they did not know the agreed ways of working.

The registered manager said that some new employees did not require training such as moving and handling training as they had received the training at another care provider. However, there was no evidence that the training certificates had been checked and they were not held on file. Training undertaken at a previous employer had also not been evaluated to ensure it was accredited or recognised as suitable training.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they had choices with regards to daily routines. For example one lady told us, "I can get up when I want, if I don't want to get up early they leave me in bed." We observed staff gave people choices, for example where they wanted to sit and what they wanted to eat.

Care plans recorded whether people had made advanced decisions on receiving care and treatment. Some care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and fully completed. Care plans considered people's capacity to make decisions in relation to their care and support. For example their capacity to consent to personal care. The registered manager told us most people in the home had the capacity to make decisions for themselves and that three people had been judged to not have capacity. We looked at one of these people's care plans and saw capacity assessments were in place and evidence the provider had arranged a best interest meeting and acted in their best interest. This showed the correct procedures had been followed to protect people's rights.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We were told by the manager that no people were subject to DoLS authorisations and no applications had been made. We found some restrictions on people's liberties which could constitute a deprivation of people's liberty, namely a keypad on the entrance and stairs restricting access. This meant the three people who had been judged to lack capacity could be subject to DoLS. No risk assessments had

Is the service effective?

been done considering the restrictions to these people. The manager agreed to immediately speak with the DoLS team regarding the restrictions posed on the three people to determine whether any applications were needed.

Nine out of 10 people we spoke with about the food said they enjoyed the food which was plentiful and offered variety. For example one person told us, "I've had two eggs and toast this morning and it was lovely." Another told us, "The food is lovely, not as good as at home but you get a nice variety, always vegetables, they ask what you what you want and you choose." Breakfast was staggered through the morning to suit people's preferences and we observed food being served throughout the morning. We saw people in the home were given snacks such as biscuits and drinks throughout the day to help meet people's nutritional needs. We observed the lunchtime meal. There were seven care workers on duty and we saw them going around the tables chatting and encouraging people to eat and helping people who needed assistance to eat. . We saw care workers were familiar with people and called them by their first names. We saw an appropriate level of support was given to people, with care workers assisting people patiently.

We spoke with the chef who demonstrated a good understanding of people's individual dietary requirements such as people with diabetes and those that required a pureed diet. We saw that a variety of food was served over the course of the week. The service was flexible in cooking additional items if people did not like the menu. However, the chef told us that there was no formal structure to the menu, and they made meals each day based on, "What was available." This arrangement meant that people who lived at the home did not always have a say in the creation of the menu.

Nutritional risk assessments were in place and care plans created where risks to people were identified; this helped to ensure people's needs were met. Where weight loss had been identified we saw appropriate action had been taken. For example, following weight loss in one person, the dietician had been contacted who had prescribed a supplement and we saw evidence the person had gained weight.

People's healthcare needs were assessed and staff were aware of how to meet their healthcare needs. For people receiving nursing care, detailed nursing assessments of care needs were in place and there was evidence that individual aspects of peoples care plans were reviewed on a regular basis. We saw clear lines of communication were in place with other health professionals to help ensure effective care. For example weekly meetings were held with the intermediate care team to review people's care and support. Health professionals spoke positively about the relationship with the home and said it had allowed care to progress and to meet people's needs. We saw people received regular care and support from a range of health professionals which included the Respiratory Nurse Advisor, the Palliative Care Team and , Speech and Language Therapy. However records of their visits and the care advice they gave was not consistently documented within care records which meant there was a risk that their advice was not always followed.

Is the service caring?

Our findings

People said they felt listened to by staff and the registered manager and if they asked to make changes they were usually complied with. We saw people's decisions were listened to with regards to their daily lives such as what they wanted to eat and what activities they wanted to be involved in. However, there was a lack of evidence of people being actively involved in making decisions about their care and support. Care plans were not signed by people or their relatives and their views in relation to the care and support they received was not recorded.

People spoke positively about staff and said they were treated well. For example one person told us, "We have a laugh and a joke" and another person said, "I've loved every minute here. They are kind and friendly, will do anything for you. They are wonderful." People said they were treated with dignity and respect by staff when providing personal care. They told us they did not feel uncomfortable or embarrassed and staff respected their privacy, for example in ensuring doors were closed when bathing or showering was underway. People told us staff were sensitive to their needs, such as respecting their preferences regarding the gender of care workers supporting them.

We used the Short Observational Framework for Inspection (SOFI) to observe interactions and activities in the service. We observed some good interactions between staff and people, for example staff took the time to make conversation with people before undertaking tasks such as getting them breakfast. Throughout the day we observed that staff treated people kindly and with care and that interactions were comfortable and relaxed. We judged the atmosphere in the home was good natured, sociable and positive. We observed staff crouching down to the same eye level as the people they were speaking to and lowering the tone of their voices. We saw where people became upset staff offered them an appropriate level of comfort.

We saw staff had a good awareness of protecting people's dignity, for example adjusting their clothing appropriately. Where double rooms were used, privacy curtains were in place to maintain people's privacy, for example during personal care.

We noted some people's care experience at mealtimes could have been improved. For example, one person who needed help had to wait a long time, with their food left in front of them, for one of the staff to assist them. By the time staff arrived the porridge was cold and had to be heated up. The care worker kept breaking off and leaving the table during the meal and mainly talked to another person rather than the person they were supporting. In all it took about an hour for the person to have their breakfast. We also saw at lunchtime care staff shouted across the room to provide people with updates on when their food was coming which made the atmosphere noisy and less homely.

Staff we spoke with demonstrated a good understanding of the people they were caring for and their individual preferences such as who liked sugar in their tea. Care plans contained information personalised to individuals such as the triggers for causing them emotional upset. This allowed staff to deliver personalised care. We noted that some care plans were missing information on people's life histories which can be used to better understand the person. Care records were kept locked away to maintain people's confidentiality.

The manager and staff told us there were no restrictions on visiting times to the home and people we spoke with confirmed this was the case

Health and care services are legally required to make 'reasonable adjustments' for people under the Equality Act (2010) to ensure equal and fair treatment and promote independence. We saw that the provider had installed a passenger lift to enable greater freedom and mobility within the home. We saw that people had specific equipment to meet their individual needs such as reclining chairs and wheelchairs. We noted adjustments were made with equipment to meet individual needs and no one was excluded from the dining room at lunchtime. We saw one person had a blow up cushion under their feet and another was brought into the dining room in a large recliner chair so they could have their meal with other people.

Appropriate arrangements were in place for end of life care. The home had met The Gold Standards Framework for Palliative / End of life care. Staff had received training in palliative care. Staff we spoke with demonstrated a good understanding of how to ensure good quality and dignified end of life care.

Is the service responsive?

Our findings

People told us the care was responsive to their needs and staff made adjustments to their care and support to meet their individual needs. For example one person told us staff had moved them to a more suitable room with more space as they kept falling in their previous room. People said the service met their needs, for example one person told us, "I get everything I want."

The registered manager told us they undertook all pre-assessments prior to people moving into the home. We saw these were in place and looked at people's medical histories and included a thorough assessment of their needs in a range of areas to ensure the service met their needs as soon as they moved into the home. Care plans were then developed by nursing staff to instruct staff to deliver appropriate care. These included skin integrity care plans, communication, continence and moving and handling. These were regularly updated to ensure staff had the most recent information on meeting people's individual needs. We saw staff followed the advice in people's care plans for example using the correct lifting equipment and transferring people using the safe methods identified within their care plans. Prior to the inspection, we received a concern that people were not being given the right support with moving and handling, for example when transferring from a chair to a wheelchair. We did not see any evidence of this through our observations of care, discussions with people, staff and health professionals about handling techniques. However, we raised this concern with the registered manager and asked them to continue to monitor moving and handling practices in the home.

We found care plan documentation was not always consistently completed which made it difficult to establish the care and support people were receiving. In three care plans, we found the life history section was missing. In three others the activities care plan and log had not been updated since July 2014 which meant we could not assess the activities people were involved in. Charts which demonstrated people's washing and bathing regimes were poorly completed. Some care plans were missing and the recording of information about the input of other health care professionals in people's care was inconsistent. In another person's records there were no weight entries in September 2014 and October 2014 and no explanation as to why their weight hadn't been checked. We noted some risk scores had not been calculated on risk assessments nutrition risk assessments which meant the risk level was not being consistently monitored.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The manager conducted regular care plan reviews which showed changes had been made to people's care on a regular basis; this helped to ensure responsive care was provided. However there was a lack of formal mechanism to involve people and/or their relatives in care plan reviews. Care plan reviews were undertaken by the manager, but there was no evidence that people and/or relatives were involved in these, for example there were not signatures to confirm attendance at reviews or any feedback/comments from people or their relatives evaluating the effectiveness of care.

People told us that some activities took place such as bingo and singing and we observed bingo was played on the afternoon of our visit. However, two people told us they would like more activities to be available. For example, one person told us there used to be entertainment but the person who organised it had left and the care staff did not have time. Another person also said this was a problem stating, "There's nothing going on here, there's sometimes bingo on Friday but only if the carers have time." They said they would like to see some board games organised. The home employed an activities co-ordinator during the day however they were on long term absence. We found their absence meant there was a lack of structured activities, for example no activities went on during the morning session when we were at the home. The registered manager told us that all staff were now responsible for ensuring a range of activities were undertaken, but through our observations and discussions with people we concluded that the absence of the activities co-ordinator and structured activity regime meant staff did not always have time to spend with people

A complaints system was in place. People told us they would have no problem in raising an issue with the manager. One person said, "If I had a problem I would soon tell them." People knew who to complain to, for example they knew the registered manager's name and knew they were responsible for dealing with complaints. People said they would be comfortable raising complaints. One person said, "Yes (Managers name). She's the boss so I just tell her."

Is the service responsive?

However documentation relating to complaints was poor; we could not always clearly establish what action had been taken following complaints received and within what timescales. Through conversations with the registered manager and people we concluded that complaints had been appropriately dealt with, for example setting up a multidisciplinary meeting to address concerns. However, robust documentation of the meetings, responses and learning was not always available.

Is the service well-led?

Our findings

There was a lack of formal mechanisms to assess and monitor the quality of care. Information returns were undertaken to satisfy the requirements of the local authority such as a "self-service audit" which asked the provider to submit information in a number of areas such recruitment, supervision and training and safeguarding. However, no service specific audits were undertaken by the providers to assess and manage the quality of care provided. The presence of robust systems could have identified and rectified some of the risks we identified during the inspection. For example, there were no medication audits undertaken and we found medicines were not given safely. No care plan audits were undertaken, which could have identified some of the issues we found with documentation, although we saw evidence the manager was planning to introduce these early in 2015. No audits assessing the overall quality of care provision were carried out which meant there was a risk poor care would not be identified. No form of environmental checks had been undertaken; if completed these might have identified some of the hazards we found prior to them becoming a risk to people. Work had been done to assess people's dependencies but this had not been linked to a tool to determine safe staffing levels. The time taken to respond to the nursing call bell was also recorded but this information was not regularly analysed to look at the average time people were waiting. This meant there was a risk that the service may not always detect when staffing levels were not sufficient following changes in people's dependencies.

We found systems relating to the management of the service lacked structure and organisation. There was no system to monitor whether staff were up-to-date in training, supervision or appraisal We found gaps in the training system and it was not clear how often training updates were required. Completion of records relating to the management of the service was poor including the completion of recruitment files. Some policies and procedures were also out of date and required review, for example the medicines management policy. Where complaints had been received it was often difficult to track the outcomes as clear documentation was not maintained.

We were also concerned that some risks identified by the local clinical commissioning group (CCG) had not been addressed. In February 2014 a 'Clinical Quality Audit' had been undertaken by the CCG but many of the actions had not been resolved. This included inconsistencies in the recording of care records, missing care plan documentation, lack of people's involvement in care plan reviews and failures in the medicine management system. We also saw sight of a local authority contracting visit in July 2014 which identified some similar issues which had not been fully addressed. The lack of progress in addressing these issues showed a failure to manage identified risks properly and improve service delivery.

There was no formal mechanism in place to seek feedback from people who used the service. Most of the people we spoke with said they knew who the registered manager was and knew their name. However, none said that the manager made a point of chatting to them one to one to ask what they thought about the home and if there were any problems or changes they would like to see. None of the people we spoke with had ever attended or heard of any residents meetings. The registered manager confirmed to us that the last residents or relatives meeting had taken place before Christmas 2013; almost a year ago. We saw that a planned quality survey asking people and/or their relatives for comments on the quality of the service had not been undertaken. This meant that inadequate mechanisms were in place to seek the feedback of people that used the service.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager told us incidents and accidents were analysed as part of monthly quality returns to the local authority. We looked at the accident and incident records. Where more serious incidents had taken place we saw evidence the cause had been investigated and the action taken documented to enable learning. Although incident and accident data was collated for return to the local authority, there was no analysis done by the provider to look for themes or trends over periods of months, for example regarding falls or hospital admissions. This meant they were missing an opportunity to identify risks and take action to reduce any common trends.

People told us the registered manager was visible and most people knew their name. They said the manager and their deputy dealt with any problems or concerns raised. One person said, "The manager is very nice to us, very sociable." Staff also said the manager was supportive and that if they raised issues, effective action was taken.

Is the service well-led?

People said the registered manager regularly got involved in care and support activities and we saw they worked a weekly nursing shift. This helped them to experience care and support issues first hand. During the inspection our observations confirmed the registered manager was heavily involved in care and support and we saw they spent time attending to people's needs. The registered manager demonstrated a good understanding of people's individual care and nursing needs which indicated they spent time interacting with and supporting people. The manager completed all care plans and reviews themselves and did not delegate to other nursing staff, we found this combined with the hands on approach meant the manager did not have a great deal of time to focus on systems and processes such as developing up-to-date policies and procedures and undertaking audits.

We saw the staff team worked well together this included the management, care workers and ancillary staff, who all had clear roles and responsibilities. People we spoke with said they thought staff got on well together and they had never seen any instances of them falling out or not working well together. For example their comments included, "I've never seen any disappointment they all seem to get on" and, "They seem to work well together, work as a team, never seen anything else, they are cheerful."

There was strong input from a range of health professionals such as the QUEST Matron and intermediate care team. Quest matrons are part of an initiative to improve the quality of care in care homes set up by the local clinical commissioning group. This brought a range of skills and experience to the home and helped working practices to be continuously improved. Health professionals we spoke with told us that communication with the service was good. They said that the service listened to their advice and any recommendations they made regarding improving working practices. One health professional told us how communication had improved recently and the service was now more receptive to challenges to its practice.

Periodic staff meetings were held these were a forum for staff to raise their views and for quality issues to be discussed. Staff told us they felt able to raise things and felt listened to by management.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **The registered person had not ensured that that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them as there were inconsistencies in the maintenance of an accurate record of their daily lives.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person did not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity were appropriately supported in relation to their responsibilities by receiving appropriate training.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The registered person did not operate effective recruitment procedures in order to ensure that people employed for the purposes of carrying out the regulation activity are of good character and have the necessary qualifications and skills.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury	The registered person had not made suitable arrangements to ensure that service users were safeguarded against the risk of abuse as they had not taken reasonable steps to identify the possibility of abuse and prevent it before it occurred

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person was not protecting service users against the risks associated with the unsafe use and management of medicines, as appropriate arrangements were not in place for the recording, handling, using, safe keeping and safe administration of medicines

The enforcement action we took:
A warning notice was issued to the provider requested that the provider become compliant with the regulation by 15 January 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person had not protected service users against the risks of inappropriate or unsafe care and treatment, as they were not regularly assessing and monitoring the quality of services provided, nor identifying, assessing and managing all risks relating to the health, welfare and safety of service users. The registered person was not regularly seeking the views of people who used the service and those acting on their behalf.

The enforcement action we took:
A warning notice was issued to the provider requesting the provider becomes compliant with the regulation by 16 February 2014.