P.A.R. Nursing Homes Limited

Atherton Lodge

Inspection report

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Ratings

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

Overall summary

We carried out an inspection on 21 May 2015 and it was unannounced.

Atherton Lodge is a privately owned two-storey detached property that has been converted and extended into a care home. It is registered with Care Quality Commission (CQC) to provide accommodation for 40 people. At the time of the inspection there were 25 people living at the Home. There are two units within the home. One unit supports people who require nursing and/or personal care. The other has nine bedrooms and supports people who are living with dementia.

At the time of our inspection there was no registered manager 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 2008 and associated Regulations about how the service is run. There was manager who had been at the service since March 2015 but they had not yet applied to the CQC to become the registered manager.

Summary of findings

At the last inspection on 11 and 12 December 2014, we found that there were a number of improvements needed in relation to: people's rights in decision making, medication administration, dignity and respect, planning care and support, safety and suitability of premises and monitoring systems in place around the quality and safety of the service.

We asked the registered provider to take action to make a number of improvements. After the inspection, the registered provider wrote to us to say what they would do to meet legal requirements in relation to the breaches identified. They informed us they would meet all the relevant legal requirements by 16 March 2015. However, whilst the registered provider had made some improvements, they had not fully met their own action plan; we found a number of breaches and continued breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. We also identified some additional concerns. You can see the action we have told the provider to take at the end of the report.

People who used the service told us that they felt safe and cared for. Relatives were happy with the care that their loved ones received and those we spoke with had no ongoing concerns. However, we found that the service was not safe because there were ongoing concerns about the safe administration of medication and the monitoring of some health conditions.

The manager had made improvements in the recording of accidents, incidents, and risks to health and safety. Remedial action had been taken place to minimise some risks for example falls. However, during the inspection, we saw that people were not always protected from risk of potential harm such as being left in wheelchairs without footplates or with no brakes applied.

At the last inspection the registered provider was required to ensure that people, who were deprived of their liberty, were done so in accordance with the requirements of the Mental Capacity Act 2005. Where a person's liberty was being restricted or they were under continuous supervision, we found that the manager had made the appropriate application to the supervisory body under Deprivation of Liberty Safeguards. However, where a person lacked capacity to make a specific decision or choice, staff failed to document why decisions had been taken in somebody's best interest. Staff had not followed the MCA 2005 code of practice. This meant there was a risk that the rights of people, who were not always able to make or communicate their own decisions, were not protected.

People told us that they liked the food; however, there was a limited selection of fresh vegetables, fruit and healthy snacks available. We saw that people did not always receive the help they required with eating and drinking and their independence was not promoted.

Activities were reported to take place, we saw no evidence of this during our visit and there was little social stimulation for people using the service. The television was on during the period of inspection in all of the lounges and people did not take an interest in it.

The registered provider had made some improvements to the quality audit system. However, we found that it was still not robust and failed to identify concerns such as those around medication management. The registered provider had not sought the opinion of those who used or visited the service.

We had asked the provider to take action to make improvements in regards to the safety and cleanliness of the premises. This has now been completed. People lived in an environment that was clean and so the risks of acquired infection were minimised. The registered provider had made some improvements to the building and further renovation was planned.

The registered provider had not previously ensured that staff were recruited in a safe way. On this inspection, there were improvements and we found that people were cared for by staff that had undergone the appropriate recruitment and selection checks to ensure that they were of suitable character for the job.

The registered provider had a safeguarding policy in place that staff were aware of. Staff were able to identify safeguarding concerns. The manager had reported safeguarding incidents to the local authority and to the CQC.

You will see that the overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

Summary of findings

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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.

People were still not protected against the risks associated with the administration and management of medicines. People did not always receive their oral or topical medicines at the times they needed them or in a safe way. Medicines were not stored, administered or recorded properly.

People lived in an environment that was clean and the registered provider had plans in place to further improve the facilities.

People received their care from staff that had been through appropriate recruitment processes to ensure they were suitable to do the job.

People told us that they felt safe and staff were able to tell us about safeguarding those that they looked after.

Is the service effective?

Requires improvement

The service was not always effective

The capacity of people was not assessed in line with the requirements of the

Mental Capacity Act 2005 (MCA). However, the manager had submitted a number of applications to the supervisory body for consideration under the Deprivation of Liberty Safeguards (DoLS).

People did not receive adequate support to take ensure that they had adequate food and drink and their dining experience was poor.

Small changes had been made to order to make the environment more suitable to people living with dementia but further improvements were required.

Staff received training relevant to their role and the manager was due to commence a programme of supervision and appraisal

Is the service caring?

Requires improvement

The service was not always caring.

Whilst we observed some positive and caring interactions with staff, we also saw that some people using the service had very little contact or interaction with care staff.

Staff did not always listen to what people asked of them and so their choices were not always respected.

People we spoke to told us they felt cared for and that the staff were nice to them.

Summary of findings

Is the service responsive?

Inadequate 

The service was not always responsive

Improvements had been made to care plans so that they gave a more accurate reflection of a person's care needs. Staff were now better able to identify those at risk of weight loss or dehydration.

Staff did not always keep an accurate record of some health needs such as elimination and this meant that care and medication might not be delivered in the way that it was required.

We saw that many of the people who used the service did not move from the same chair all day and so had little pressure relief or physical stimulation.

Is the service well-led?

Inadequate 

The service was not well led.

There was a new manager in place whom staff said was receptive, ready to make changes and who challenged poor practice.

There was a quality assurance system in place and evidence that some matters of concern were followed though. However, the quality audit system was still not robust and had not picked up on significant concerns such as medication.

The views and opinions of people using the service and their relatives had not been sought and people told us that there were not made aware of the concerns raised at the last inspection.

Atherton Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 21 May 2015 and was unannounced.

The inspection was carried out by a team that comprised of an adult social care inspector, a pharmacy inspector and a specialist advisor with experience in nursing care. They were also supported 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 person had expertise in dementia care.

Before the inspection, we reviewed the information that the provider had given us following our last inspection. They had provided us with an action plan that gave details of how they were going to make improvements. They had indicated that all of the improvements were to be completed by the time of this inspection. We also reviewed the notifications, safeguarding information and complaints that we had been informed of.

During the inspection we spoke to nine people who used the service, five relatives and six members of staff. We also observed the care being provided to people throughout the day.

We looked at the records of nine people who used the service. We looked at the recruitment records for six staff members as well as other key information such as training records, quality assurance audits and maintenance logs.

We also spoke to a number of staff from other agencies to seek their views on the service such as the local authority safeguarding contracts teams and infection, prevention and control. They expressed a view that improvements had been made to the quality and safety of the service.

Inadequate

Is the service safe?

Our findings

People who used the service told us that they still "Felt safe" and that "Staff knew how to help" them. Relatives we spoke to were also confident that the care being provided was "Safe "and "Acceptable". However, we found that people were not always kept safe.

At our inspection in December 2014 we asked the registered provider to take action to ensure that the care provided was safe and that improvements were made to the living environment. We asked the registered provider to send us an action plan telling what action they had taken.

When we inspected the home in August and December 2014, we identified concerns about the way medicines were managed. Following our visit in December 2014, we issued a warning notice requiring the registered provider to take swift action to become compliant with Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. On this inspection, we found that improvements had not been made and there were still concerns about the management of medicines.

Some people were prescribed medicines to be taken only when required e.g. laxatives and painkillers One person prescribed pain relief told us that staff did not always ask if pain relief was required saying "sometimes my painkillers are in the pot [of tablets] and sometimes they're not".. We found there was not enough information available to guide nurses as to when these medicines should be given and in some cases, where a variable dose was prescribed, how much medicine should be given. For example, one person had been prescribed lorazepam to help with their agitation, but there was no information to help nurses decide when to give this. It is important that this information is recorded and readily available to ensure people are given their medicines safely, consistently and with regard to their individual needs and preferences. Failing to administer medicines safely and in a way that meets peoples' needs means people are at risk of suffering unnecessary pain and places the health and wellbeing of people living in the home at risk of harm.

Some people were at risk of being given their medicines, particularly Paracetamol, without a safe time interval between doses because the time of administration of medication was not accurately recorded. Other medicines were not always given at the right time with regard to meals. The nurse on duty told us that some people were woken at 7am to take medicines that needed to be given before breakfast. The manufacturers' guidance stated only that the medicines needed to be taken 30-60 minutes before food and not necessarily at 7am. This meant that people's individual needs and preferences were not being considered when administering medicines. Medicines must be given at the correct time in order to make sure they work properly and avoid unnecessary side effects.

We looked at the arrangements for managing Controlled Drugs. Controlled Drugs are strong medicines with additional storage and recording requirements because they are at risk of being abused. The nurse on duty told us that there were currently no Controlled Drugs kept at the home; however we found a supply of a Controlled Drugs used to manage seizures. There was no record of this medication on the person's MARs and no information available to nurses regarding how or when this medication should be given. This placed the person at risk of harm and not being given the correct treatment should they have a prolonged epileptic seizure.

The nurse on duty told us that two people were given their medicines covertly i.e. hidden in food or drinks without the person's knowledge or consent. However, we saw records in a third person's care plan showing that they were also to be given their medicines covertly. By disguising medication in food or drink, the person is being led to believe that they are not receiving medication, when in fact they are. Although a policy was in place for determining mental capacity, the assessment tool and documents used did not clearly show what, if any, other options had been considered or which medicines the covert arrangements referred to. Crushing tablets and mixing medicines in food and drink may alter the way in which the medicines work and may make them ineffective or dangerous to use. There was no evidence that a pharmacist had been consulted about the safety of giving the medicines in this way. There was no information with the MARs to tell nurses which medicines were to be given covertly and no information in the care plans or with the MARs detailing exactly how and in what circumstances they should be given. It was impossible to see from records which medicines had been given covertly and which had been given with the person's knowledge and consent. Safe arrangements for the covert administration of medication were still not in place.

Inadequate

Is the service safe?

Where someone was refusing to take medication on a regular basis, there had been no mental capacity assessment or risk assessment completed to consider what further action was required to ensure that harm did not occur. For example, we saw that a person refused a medication for dry eyes on 50 occasions between 20 April and 17 May 2015.

There were missing signatures on some records and it was unclear if medicines had been given or not on those occasions. The health of people living in the home is placed at unnecessary risk of harm when medicines records are inaccurate.

Medicines were stored safely and were locked away securely to ensure that they were not misused. There was no evidence to suggest that refrigerated medicines were constantly stored at the correct temperature, because the temperature range displayed on the thermometer was outside the recognised 'safe range' of 2-8C. Creams were not kept safely .We saw two tubes of cream stored at room temperature when they should be kept in the fridge. Medicines may not work properly or become unfit for use if they are not kept at the correct temperature. We found six tubes of prescribed creams where the dispensing labels were illegible and it was impossible to see who the cream should be used for. We also saw tubs of cream and supplies of Paracetamol 500mg tablets and Senna 7.5mg tablets where the labels had been partially removed and, in two cases, another person's name written on the label. The nurse on duty told us that the tablets were for general use as 'homely remedies'. It is unacceptable to use prescribed medication, including creams, for anyone other than the person it was prescribed for.

The quantities of medicine received into the home, or brought forward from the previous month had not always been accurately recorded This made it impossible to calculate how much medication should be present and therefore whether or not medicines had been given correctly. We saw records that showed that some medicines had been signed for, but had not actually been given, whilst others had been given, but not signed for.

This is a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) 2014 because medicines were not managed in a safe way.

Six people who used the service were sat in the dining room at breakfast time and all remained in wheelchairs. The area was not always supervised and three people were sat in wheelchairs without the brakes applied: there was a risk that the wheelchair would move if the person stood to try to get out of the chair. One person was taken out of the dining room without the foot plates being used and their feet dragged on the floor. This meant that were at risk of injury whilst being moved or left alone.

This was a breach Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were placed at risk of avoidable harm. People using the service were not protected against the risk of receiving care that is inappropriate or unsafe.

Previously, we had concern that the environment was unsafe and did not meet the needs of the people who lived there. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and we issued a warning notice. We saw that the registered provider had made some improvements to make the environment safer for the people that lived there.

New windows had been fitted on the ground and upper floor in order to improve appearance but also to help keep the premises warm. However, the windows were not fitted with restrictors that would meet the Health and Safety Executive guidance "Falls from windows or balconies in health and social care ". Following the inspection, we received confirmation from the manager that the registered provider has ordered restrictors and they would be fitted as soon as possible.

The fire door on the top floor had been fitted with an alarm so that staff would be aware if someone left the building. It was brought to our attention that the fire door leading off the dining area to the outside space was not alarmed. The manager told us that, as a result, people deemed unsafe to leave without supervision, were not able to use the dining room as staff could not provide constant supervision. We asked the manager to remedy this so that all persons could use the dining room.

We saw that safety checks had been carried out on utility supplies and equipment. We looked at the PAT tests and saw that these had been completed in January 2015.

Inadequate

Is the service safe?

However, we saw that a suction machine in the medication room had not been tested since 2005. We spoke to the nurse on shift who confirmed that it would be removed or tested to ensure that it was safe

In December 2014 we found that people lived in an environment that was unclean and placed them at risk of acquiring an infection. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2010. We found on this inspection that improvements had been made and the risks the people who lived there were reduced.

Following the inspection in December 2014, we asked the infection prevention and control team from Cheshire and Wirral Partnership (CWP) NHS Foundation Trust to carry out an audit. They visited on 26 January 2015 and highlighted several of the same issues that we had found during our visit. They carried out a further review on 20 May 2015 and told us they were satisfied with improvements made to date. We found that the premises was clean and that it was mainly odour free. There was a sufficient supply of protective equipment and cleaning materials available that staff used appropriately. New equipment such as single use slings had been purchased in order to minimise the risk of infection. The registered provider told us they planned to carry out further refurbishment and upgrade to the premises in the near future. Environmental Health have also awarded a 5* rating for the kitchen facilities.

People had previously received their care from staff that had not been through appropriate recruitment processes to ensure they were suitable to do the job and this placed people at risk of harm. This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) and we issued a warning notice. On this inspection we found that the registered provider had taken remedial action and followed safe recruitment guidance. This meant that people were now being cared for by staff deemed suitable to work with them.

We looked at the recruitment files for six people and saw that all had the required references, Disclosure and Barring Service checks taken prior to commencement of employment. The manager demonstrated an awareness of safe recruitment though our discussion with her.

People told us that sometimes they felt that there were "Not enough staff" and that "They appear to be tired". One relative said "I don't like to say but they are rushed off their feet", "They're short of staff". People who used the service and relatives said that sometimes there were less staff working on any one shift than is usual and thought this was due to the fact that the numbers of those on duty had decreased in line with the occupancy levels. We saw that there were sufficient staff on duty on the day of the inspection to meet the assessed needs of the people they cared for

There was a policy and procedure in place to record accidents. Accidents were logged but the manager had identified that staff had not recorded other types of incident. The manager had introduced a new reporting form to ensure that both accidents and incidents were logged along with any action required to minimise further likelihood and risk. The manager had started to analyse the information collated for themes and trends. For example, she had noted that for a number of people there was an increased number of falls at night. The frequency of night time checks for those persons was increased and as the level of supervision increased, the number of falls decreased. This meant that effective monitoring and robust risk management plans had reduced the risk of falls for people who used the service.

Staff we spoke with were able to tell us about the safeguarding processes in place and were aware of the issues that they would need to report. The manager had identified where there were safeguarding concerns and had reported these to the local authority and where appropriate the Care Quality Commission (CQC).

Requires improvement

Is the service effective?

Our findings

At our inspection in December 2014 we asked the registered provider to take action to ensure that staff were supported, competent and aware of their legal responsibilities under the Mental Capacity Act 2005 (MCA). We asked the registered provider to send us an action plan telling what action they had taken.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005(MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA 2005 is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. DoLS is part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken

We found in December 2014 that the capacity of people was not assessed in line with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We found care records did not consider people's capacity to make decisions and there was a risk their rights were not being protected. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Whilst the registered provider, has made improvements in meeting the requirements associated with the Deprivation of Liberty Safeguards, we identified on-going concern with understanding of the MCA 2005.

On this inspection, we found that some people who lived at Atherton Lodge were under constant supervision, were not able to leave unattended or had their liberty restricted in some way. In these instances, we saw that the registered provider had made applications to the supervisory body in order to ensure that any actions taken were in line with the Deprivation of Liberty Safeguards (DoLS).

There was evidence that people had mental capacity assessments in place but these were not always accurate and did not provide the evidence of why the conclusion or decision had been reached as they were a 'tick box' assessment . Not all of the people who used the service were able to make complex decisions for themselves, such as where they wanted to live, whether to take medication or how to keep themselves safe. Staff recorded that a decision was made in a person's "best interest" but did not show how or why that decision was made. For example, where it was deemed appropriate to administer covert medication staff had sought the consent of the persons' family and GP but did not demonstrate why a "best interest decision" was made to give medication this way. There was also no evidence that the pharmacist had been consulted to ensure medication was safe to be administered in that way. Where there was a restriction or deprivation of liberty identified, records did not demonstrate that staff had considered other least restrictive options. For example, there was nothing in the documentation to state what had been considered, to keep someone safe, before the use of bedrails.

Staff that we spoke with were not able to tell us what the MCA 2005 meant to them in their day to day work and not all, including the manager and deputy manager, had received recent training. The term 'next of kin' was often used but staff did not fully understand what this meant. Staff that we spoke to believed that families were able to make decisions on behalf of their relatives and therefore had requested that they sign consent forms authorising interventions such as covert medication or use of bed rails when there was no evidence of a legal authority (such as a Lasting Power of Attorney) in place.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as care and treatment should only be provided in accordance with the MCA 2005 and associated code of practice.

When we inspected in December 2014, we found people were not supported to take adequate food and drink and were at risk of weight-loss and dehydration. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. On this inspection we found that the registered provider had not fully met their action plan and people did not receive the required level of support.

People told us that they "Like the food" but we saw that many people did not eat their lunch. A number of people required assistance or encouragement with eating and drinking but this was not always offered. In the main lounge, three lunch time meals were barely touched and went cold.

We observed two carers in the unit for those living with dementia: one person who used the service pushed their

Is the service effective?

plate away, the carer asked "have you finished?" and then took the plate away before the person could respond. The other carer was sat down with a person, encouraged them to eat, and helped them with use their fork. They gave the person plenty of time to eat each mouthful and didn't rush them. We observed one person's assistance with food was interrupted a number of times as the member of staff assisting them also had to attend to a person who was ill and being sick in the lounge. This meant that people who required assistance did not always get the level of support required as there was an inconsistent approach from staff.

Some people only finished breakfast at eleven o clock and were served lunch around 12.30. The length of time between meals would impact upon a person's level of hunger and dietary intake. For example: good practice guidelines from the Public Health Agency suggest that there should be regular intervals between meals and ,ideally, no more than a 12 hour interval between evening snacks and breakfast. We observed that many people did not eat their vegetables and one person told us that they "Do not like frozen carrots". We asked the cook if they prepared and served fresh vegetables. They told us "No frozen" but that "On Sunday they get a roast dinner with two fresh veg." We asked the cook if they provided fresh fruit or healthy snacks but were advised just "Bananas" and "Sometimes strawberries when they are in season." People were served tinned fruit, in syrup or juice. People had sandwiches and soup at tea time. We asked if the soup was made fresh but told "Only on Sundays, otherwise it's powdered soup." We also saw that the cook continued to blend all foods together in a bowl where a pureed diet was required and this was not appetizing. The manager told us that she was not aware that the majority of vegetables were frozen and would review this. There was no provision of healthy snacks throughout the day or finger foods for those people who found it difficult to use cutlery. This meant that the nutritional needs and wishes of people were not always planned or monitored.

We saw improvements in record keeping had been made and staff recorded people's weights, where appropriate, on a regular basis. A number of people were identified as having a low Body Mass Index or weight loss. They were appropriately referred to the GP and dietician for advice and guidance.

We recommend that the service consider current guidance on meeting the nutritional needs of those persons living in a care home such as those published by the Public Health Agency or those referenced by the Royal College of Nursing in Nutrition - core nutritional care resources.

In December 2014, people living with dementia were not been cared for in an environment best suited to meet their needs or to promote their independence. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and we issued a warning notice. On this inspection, we saw that some improvements had been made but the registered provider had not completed fully their action plan.

Some people who lived on the unit now had their name and photo placed on the wall next to their door in order to help orientation but this was not consistent. We asked a carer if they were going to complete this with everyone and were told "The others all know where they are going". Some signage had also been replaced. The registered provider told us in their action plan that by 16 March 2015 "doors are to be painted different colours to improve identification" but this had not taken place. The manager told us that people had chosen colours for their own bedrooms but that the contractor had not returned to carry out the work.

During our previous inspection of the home in December 2014, we found that although staff received some training, supervision and appraisal, there was a lack of clinical oversight for the nursing staff. Staff were not aware of current best practice. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

On this inspection, we found that the two monthly supervisions as per registered provider's action plan had not taken place for all staff. Staff told us that they had not received supervision and did not know when this was to take place. The manager confirmed that supervisions had commenced and that they hoped the first individual supervision for all staff would be completed within six weeks of the inspection. The manager informed us that she had spent time working alongside staff to carry out direct observations their skill and ability. Records were provided following the inspection to reflect the supervision provided to nursing staff. However, staff were not clear about current clinical guidelines such as the National Institute for Clinical Evidence (NICE) guidance for pressure care and prevention. For example, a care plan dated 16 April 2015 stated "objectives to aid healing of the pressure ulcer keep

Requires improvement

Is the service effective?

clean and dry". Current practice promotes all wounds need "moist wound healing". This demonstrated a limited knowledge and understanding of the wound healing process and lack of clinical oversight.

We saw that there were a number of new staff employed to work at the home since last visit and there was evidence that they had or were completing an induction programme. Other staff were being supported to complete their National Vocational Qualifications. There was evidence that other relevant training had been undertaken and was up to date.

Requires improvement

Is the service caring?

Our findings

At our inspection in December 2014 we asked the registered provider to take action on how they demonstrated a caring approach to people. We asked the registered provider to send us an action plan telling what action they had taken.

We found in December 2014 that staff failed to treat people with dignity and respect. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People made positive comments on this inspection about the care they received "I can't complain about them", "It's alright, but I didn't want to come here", "I'm very happy; I'm more cared for than I would be at home", "It's very good, I can't do much for myself, I'm grateful for what they do". However, we found that care was not always delivered with dignity and respect.

One person we spoke with told us that they would like to "Walk more" and that they had a "Frame but could only walk in the bedroom". We saw that the same person had asked for assistance to use the toilet but the staff had not returned and so they had wet themselves in a pad. They, and their family, told us that this happens when staff do not come soon enough.

People were not always supported to be independent and this compromised their dignity. In the unit for those living with dementia we saw, as on the last inspection, that people remained seated sitting in their arm chairs for lunch and staff told us " This is what they preferred." We did not observe people being offered a choice. The lack of appropriate seating and tables may fail to give people the freedom to sit when and where they wish to eat their meals. There were no menus were on display this unit and when we asked a carer how people made a choice they said "We read it out and they nod". We saw that there were limited picture menus in a file in the main dining room but the carer said they "Didn't use it." We observed four people struggle to use a knife and fork they pushed food onto the fork with their fingers. Staff did not attempt to assist and the provision of appropriate equipment or tools to help them eat with dignity and independence were not available. These people had not been assisted to wash their hands prior to eating and we observed that they had dirty nails and hands.

When a person using the service tried to speak to the carer they had to shout over the volume of the TV and the carer proceeded to shout back when they could have got up and sat with the person to have a discussion. There was still little evidence of meaningful engagement with staff and people who used the service and that care was very "task orientated". On the unit for those living with dementia staff did not make the most of opportunities to engage with people and we observed a staff member sat at the dining table whilst people sat in chairs staring into space.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people did not always have the support they required to be independent and care was not provided in a way that ensured care, dignity and respect.

In December 2014, we saw that people were not protected against the risk of receiving care or treatment that would be deemed appropriate especially at the end of their lives. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. It was evident that a review had begun of the end of life wishes of those within the home. We observed staff interacting with a doctor and discussing concerns about a person in the latter stages of their life and this was done in a caring and compassionate manner.

Inadequate

Is the service responsive?

Our findings

At our inspection in December 2014 we asked the registered provider to take action on how they assessed, planned and responded to the needs of people who used the service. We asked the registered provider to send us an action plan telling what action they had taken.

In December 2014, people did not have care that was planned and delivered in a way that met individual needs and kept them safe. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2010. During this inspection, people did not always have their choice respected and their care not meet their assessed needs.

One person was served a large portion of main course and asked for a smaller portion of rice pudding. The carer gave them a very large portion and when the person commented that it was "Too big" the carer replied, "Better too much than too little". The person did not eat it all. Another person asked for a cup of tea at 2.30 but was told "You can have a cold drink as tea is not coming until 3 o'clock". This meant that care was not based upon individual choice and preference.

Some people who used the service said that staff knew their likes and dislikes "Yes I tell them what I like; they asked me when I came in", "It's Ok, but you do have to tell them what you want. You always have to remind them", "I think they do, I can't complain". One person said it depended on the staff on duty "Some do some don't." One person said "I get up at 4 a.m., and go to bed at 9 p.m. I've always got up very early." They come and ask you if you want to go to bed early. Another person felt that they were not asked "I go to bed at 10 p.m. but wish I could go to bed earlier because my legs are aching," The manager overheard this remark and told the person that "If you had told me that I would have put a note in the diary."

In the main lounge, all people sat in their chairs for lunch and therefore the majority had not moved since early that morning. We saw that staff asked if they wanted to go into the dining room but it was not done in a way that was enabling and encouraging. People were asked at the point that lunch was served so there was little time to assist people to the dining area if they had made that choice as people in the lounge required assistance to transfer. We noted that the dining room had not been set out for lunch.

Following the last inspection the registered provider told us in their action plan that people, in the unit for those living with dementia, would have the opportunity to eat in the main dining area and that "meal times will becomes a social and enjoyable occasion for people to look forward to". There was no evidence that this aspiration had been met. The manager also told us that at present they could give the opportunity for everyone to use the dining room as the fire door was not alarmed and people would be at risk of wandering out.

There was still a lack of activity and stimulation. People expressed disappointment that "School pupils (from the school next door) used to come in and sing but they haven't done that for "a couple of years." The carer couldn't tell us why they stopped coming or why they stopped inviting residents to their concerts. Following the inspection, the manager told us that this is due to 'cut backs' in the school. We were told that there was "Pet therapy is twice a week when a lady brings a dog into the home, and the residents really enjoy this". There was an activity planner on the wall that covered a four week period but it failed to indicate which week we were in and staff could not tell us. None of the people who carried out the inspection observed any activity taking place. The television was constantly on in three of the lounges throughout the day but people were not actively involved in watching or listening to it. We spoke with the person, usually responsible for activities, and they told us that at the moment their time is "Mainly taken up with care." Care staff told us that they arrange trips out but that there "Is no budget for activities, the residents pay for themselves, or we use the comfort fund." When people have trips out the staff volunteer for these in their own time.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people failed to receive care and treatment was based upon an assessment of need and personal preferences.

At this inspection, we observed that a number of people, in the main lounge, were sat on pressure relieving cushions due to being at high risk of pressure ulcers. We did not see that they were repositioned regularly for pressure relief. The NICE Guidelines recommends repositioning every two hours for those persons at high risk. For example, records at 2.20 pm showed that a person had been brought to the lounge at 9.52 am but since that time their position had not

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been changed although they were at high risk of a developing a pressure ulcer. Another person had been brought down from bedroom on the 20 May at 9.40 am but there was no record of positional changes until they were taken back to bed at 3.30 pm. We did not observe staff encourage or assist people to move during a period of 90 minutes. The manager told us that people "May not be stood or lifted off their bottoms" but that they were able to "Move from side to side" in their chairs. A memo was sent to staff from the manager following the inspection that stated "I know when residents are in the lounge they are moved only slightly to reduce risk of pressure wounds; however, it is not being shown in the documentation". The charts had not been "ticked" to indicate that repositioning had been undertaken place every two hours. Following lunch, many people in the lounge had slid down in their chairs and looked uncomfortable. We brought one person to the attention of staff and asked that they be assisted as it looked like they may slide onto the floor. The staff member said "They are able to push themselves up" and failed to take remedial action.

Staff did not always take action where there was an identified health concern. For example we saw that a number of people were at risk of constipation and their care plan indicated that staff were to monitor and record bowel movements. One person had no bowel movements recorded for 10 days and another person for 41 days. The manager told us that one of these persons had developed loose bowels but it was "overflow" from constipation. This showed that there was a lack of effective monitoring. Whilst it was acknowledged, that staff were not always able to monitor when someone was self-caring, the care plans did not address this factor or indicate what other signs and symptoms may be an indicator of constipation. Staff had not looked at reviewing compliance or administration of medication already prescribed to help with this condition. This lack of monitoring could place a person at risk of harm.

These examples demonstrate a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were placed at risk of avoidable harm.

The inspection in December 2014 also found that people were not protected against the risks of unsafe or inappropriate care and treatment arising from a lack of accurate records. This was a breach Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2010. We found on this inspection some improvement had been made.

People, who could tell us, said that they did not have involvement in care planning and review and had not seen their care plans "No I haven't, I would like to see it", "I must have seen it, I don't take any notice of it" and "They asked a few questions". This meant that people, where appropriate, were not actively involved in the decisions about their care and treatment. However, the registered provider had ensured that care plans and risk assessments were updated to better reflect the needs of the person who used the service.

The registered provider had not recorded any complaints since the last inspection and the manager was not aware of any on-going complaints. People we spoke to and their relatives told us that they would go directly to a senior member of staff if they had a concern and they were aware that there was a complaints procedure.

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Our findings

At our inspection in December 2014 we asked the registered provider to take action on how the service people received was assessed and monitored. We asked the registered provider to send us an action plan telling what action they had taken. The initial action plan that the registered provider submitted was rejected by the CQC as it did not contain sufficient detail about the improvements that were to be made.

At this inspection, there was not a manager in post who was registered with the Care Quality Commission. The registered manager left the service in March 2015 and the registered provider had failed, at the time, to notify us of this in a timely manner. The current manager told us they had not yet applied to be registered with the CQC but that they intended to do so once their position had been confirmed.

Some of the people that we spoke to and relatives were not aware of who the new manager was and felt that "It would have been good to have had a letter or formal introduction." People told us they were aware of the new deputy manager as he was "On the floor most of the time". The registered provider should consider how best to communicate significant changes to those who live at or visit the service.

They also told us that they were unaware of the concerns that had been identified at the last CQC inspection and that the registered provider had not informed them about these. We could not see that the previous rating of "inadequate" was displayed or a copy of the report available.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as providers must ensure that their ratings are displayed conspicuously and legibly at the location delivering the regulated activity.

In December 2014, the registered provider did not have quality assurance systems that were effective in highlighting issues of concern and the views of those using the service had not been sought. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and we issued a warning notice. Whilst some improvements had been made, the registered provider had not fully completed their action plan.

At this inspection, we found that area manager had visited the home three times a week when the new manager had started and this was subsequently reduced to a weekly visit. We were told that she undertakes a walk of the home to check on the managers weekly audit and also samples other documents such as care plan audits, accidents/ incidents etc. The manager carried out a weekly walk around of the home in order to ensure that it was clean and adequately maintained. She also reviewed of a sample of care plans on a weekly basis. She recorded her findings and highlighted remedial actions required. These were reviewed by the area manager and signed off when completed. The manager also told us, and staff confirmed, that she worked "On the floor" in order to directly monitor performance. She had already addressed concerns observed around moving and handling by direct observation and a focused supervision.

However, some elements of the quality assurance process were still not robust as they did not pick up concerns such as those around medication management and supplementary care plan documentation. The deputy manager had carried out audits (checks) on medicines; however these failed to address many aspects of medicines management within the home. This meant that the audits had failed to highlight and address many of the concerns and discrepancies that we found during our visit. The manager and the area manager had also failed to check that the audits were robust and accurate.

The registered provider had stated in their action plan, that staff knowledge and training would be monitored through supervision and that this would be in place by 16 March 2015. For example: "the home manager will test staff knowledge (on mental capacity and DoLS) ... through supervision. The area manager will audit that the correct procedure has been carried out". We found that staff's knowledge, including that of the manager and deputy manager, was limited, that supervisions had not taken place and the audit process had failed to identify on-going concerns.

The action plan from the registered provider indicated that they were going to carry out a quality assurance questionnaire on 30 April 2015 to ascertain the views and

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opinions of the people who used the service, relatives and professionals. The manager informed us that this had not been done as amendments were required to the questionnaire. She informed us that this would be completed within the next few weeks. She also informed us of her intention to hold a relatives forum so that concerns, suggestions and opinions could be sought

This was a breach of breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because there were ineffective systems in place to assess, monitor and improve the service that people receive and to protect them from harm.

Previously, the CQC had not been notified consistently about matters relating to people who lived at the home. Prior to the manager starting in March 2015, the registered provider had failed again to notify the CQC of such occurrences. The registered providers' quality audit had failed to identify that CQC had not been notified despite the action plan stating that this would be rectified and 'the area manager will audit this on her monthly audits'. For example, we had not been notified about a number of deaths at the home in the period following the last inspection.

At the previous inspection we brought it to the attention of the registered provider that the statement of purpose and service user guide required updating and did not give accurate information. We saw that, whilst it had partly been updated it still gave incorrect information such as where to direct their unresolved complaints. It continued to advise a person to contact the CQC who do not investigate or resolve individual complaints. This meant that a person was not informed what to do should they remain unhappy with the response from the registered provider.

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 Treatment of disease, disorder or injury	Regulation 20A HSCA (RA) Regulations 2014 Requirement as to display of performance assessments How the regulation was not being met: The registered provider did not display the performance rating. 20A(1) (3) (7)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: Care and treatment should be provided in accordance with the Mental Capacity Act 2005 and associated code of practice. 11(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People were not protected from the risk of avoidable harm. 12(1)(2)(b)(e)

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 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: people failed to receive care and treatment was based upon an assessment of need and personal preferences. 9 (1)(a)(b)(c) (3)

The enforcement action we took:
We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: Care was not always provided in a way that supported independence. People were not always treated with dignity and respect. 10(1) (2)(b)

The enforcement action we took:
We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: audit systems in place failed to identify concerns with the quality and safety of the service.17(1) (2)(a)(b)

The enforcement action we took:
We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Enforcement actions

How the regulation was not being met: people were not protected from the risks associated with medicines. 12(1) (2)(f) (g)

The enforcement action we took: