Leyton Health Care (No 1) Limited

Langtree Park

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
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?	Requires Improvement

Overall summary

We inspected the service on 26 February and 3 March 2015. The visit was unannounced. Our last inspection took place on 13 May 2014 and, at that time; we found the service was not meeting the regulations relating to care and welfare of people who used the service, safeguarding people who use services from abuse and records. We asked them to make improvements. The provider sent us an action plan telling us what they were going to do to ensure they were meeting the regulations. On this visit we checked and found improvements had not been made in all of the required areas.

Langtree Park Nursing Home provides accommodation and nursing care for up to 60 older people some of whom may be living with dementia and other mental illnesses. The accommodation for people is arranged over two floors. There is a passenger lift operating between the floors. There were 31 people living at the home on the days of our inspection.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During our visit we saw people looked well cared for. We observed staff speaking in a caring and respectful manner to people who lived in the home. Staff demonstrated that they knew people's individual characters, likes and dislikes.

We saw people's safety was being compromised in a number of ways. We observed areas of the home were left unsupervised at times. This was in the communal living and dining areas of the home. Staff told us due to the dependency of people living at the home they were unable to ensure communal areas were supervised at all times. We spoke staff and relatives of people living at the home who told us they were concerned about the staffing levels in place at the home. They said they were worried about people's safety.

We found the service was not meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

The service was not meeting the requirements of the Mental Capacity Act 2005. We saw decision specific mental capacity assessments had been carried out for people living at the home however, these were not related to any decisions about the care and treatment people were receiving.

We spoke with staff who told us about the action they would take if they suspected someone was at risk of abuse. We found this was not consistent with the guidance within the safeguarding policy and procedure in place at the home.

We found there were issues with regarding the management of medicines within the home. This was in relation to the administration, storage and lack of guidance in place for staff to follow when administering 'as required' medicines to people.

The home provided care for people living with dementia. There was little evidence of national guidance or best practice on which the home based the care they provided for people living with dementia. This meant the provider could not assure themselves they were meeting the required standards regarding dementia care.

We found there were issues with regard to the standards of record keeping within the home. This related to the storage, accuracy and the lack of guidance in place for staff to follow on how to meet people's needs.

People told us the food at the home was good and that they had enough to eat and drink. We observed lunch being served to people and saw that people were given sufficient amounts of food to meet their nutritional needs. We were concerned however, that people did not have access to drinks at all times due to the removal of the kitchen area on the first floor. The area manager and the registered manager responded to this and on the second day of our inspection we saw work was in progress to install a beverage area.

We saw the home had a range of activities in place for people to participate in. Staff were very enthusiastic and people's relatives told us the activities had a positive impact on the lives of their relatives. This meant people's social needs were being met.

We looked at four staff personnel files and saw the recruitment process in place ensured that staff were suitable and safe to work in the home. Staff we spoke with told us they received supervision every three months and had annual appraisals carried out by the manager. We saw minutes from staff meetings which showed they had taken place on a regular basis and were well attended by staff.

We saw areas of the quality assurance system the provider had in place had not been completed. For example, we saw care plan audits did not show evidence of the care plans being audited. This meant the home was not monitoring the effectiveness of the care people were receiving.

We found there were issues relating to staff not receiving annual refresher training in areas such as dementia care, Mental Capacity Act 2005 and DoLS, safeguarding, health and safety, fire safety, challenging behaviour, first aid and basic life support. This meant people living at the home could not be assured that staff caring for them had up to date skills they required for their role.

We found a number of breaches 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?
The service was not always safe.

Appropriate arrangements were not in place regarding the storage and administration of medicines.

Deployment of staff and lack of leadership within the home meant there were risks to people's safety at times.

There was a lack of guidance within records to ensure risks to people were managed safely.

Inadequate

Is the service effective?
The service was not always effective.

The home provided care for people living with dementia however; we found there was no guidance in place or best practice being followed with regard to this.

We found the service was not meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS) or the Mental Capacity Act 2005.

Staff had not received updates on training they required to fulfil their roles.

People's nutritional needs were met.

Requires Improvement

Is the service caring?
The service was not always caring.

Staff engaged with people in a warm manner which was observed throughout the inspection.

People said their privacy and dignity was respected. We observed staff knocking on doors and asking permission before entering rooms. People who requested support from staff were given support in a discreet manner.

Requires Improvement

Is the service responsive?
The service was not always responsive.

Care records lacked personalisation. There was limited reference made to people's preferences.

There was a programme of activities in place for people. People living at the home and their relatives told us they thought the activities provided had a positive impact on their relative's quality of life.

Requires Improvement

Is the service well-led?
The service was not always well led.

Requires Improvement

Summary of findings

There was a lack of leadership observed on both of the two units within the home.

There was no effective accident, incident and complaint analysis carried out.

The provider had a quality assurance system in place however; we saw some audits had not been completed.

Langtree Park

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 26 February and 3 March 2015 and was unannounced. The inspection team consisted of two adult social care inspectors, a specialist advisor with a background in dementia care 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.

At the time of our inspection there were 31 people living at the home. During our visit we spoke with seven people who lived at the home, six visiting relatives, nine members of staff, one visiting healthcare professional, the registered manager and the area manager.

We spent time looking at documents and records which related to people's care and treatment and the management of the service. We looked at five people's care records. We also spent time observing care in the lounge and dining room areas to help us understand the experience of people living at the home. We looked at all areas of the home including the kitchen, people's bedrooms and communal bathrooms.

Before our inspection, we reviewed all the information we held about the home, including previous inspection reports. We also spoke with the local safeguarding team.

Before the inspection, we asked the provider to complete 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. On this occasion the provider had not received their PIR.

Inadequate

Is the service safe?

Our findings

Our last inspection took place in May 2014 and we found the service was not meeting the regulations related to safeguarding people who use services from abuse. We asked them to make improvements. The provider sent us an action plan telling us what they were going to do to make sure they were meeting the regulations. On this visit we checked and found some improvements had been made.

During this inspection we spent time on both floors of the home. We saw the environment was well maintained and we saw documentation which showed that regular checks were carried out on the fire alarm system, emergency lighting, fire extinguishers, nurse call system and water temperature within the home. We looked at records which showed that if repairs were required to the environment, these were recorded and when completed they were signed to show the action had been carried out. The manager told us a member of maintenance staff was available five days a week and if urgent repairs were required, there was an on call system available to ensure repairs were carried out promptly. This meant people were cared for in a suitably maintained environment.

We looked at the safeguarding policies and procedures in place at the home. We found the home had the West Yorkshire multi agency policy and procedure in place for staff to follow. The home also had a copy of the provider's policy in place and we saw this had been reviewed in November 2014.

We spoke with members of care staff who demonstrated an awareness of safeguarding and whistleblowing. They were able to articulate key issues to consider in relation to potential abuse by either staff or family members. They were uncertain of further investigation procedures; however they were clear in their understanding of how to report concerns. They indicated that they would confront any colleagues who may be abusing a resident. This was not in line with the policy in place at the home.

We looked at the training records for staff and saw 21 out of 69 staff were out of date with training on safeguarding. This meant staff may not be aware of how to raise concerns about abuse and their role in the protection of vulnerable adults.

We looked at the arrangements in place for the ordering and disposal of medicines and found these to be safe. However, when we looked at the way the home stored and administered people's medicines we found there were issues. We saw one of the medicine trolleys was left in the dining room for long periods of time during our inspection. It was locked but it was not secured to the wall. We also saw there was no way of ensuring the medicines in this trolley were being stored at the correct temperature. We saw a second medicines trolley was being stored securely in a locked room. However, we saw staff were not consistently recording the temperature of the room on a daily basis. For example, from 11 February 2015 there were 11 days of temperature recording which had not been documented. This showed medicines were at risk of not being stored at the required temperature.

We saw there were a number of policies in place relating to the management of medicines. These were dated 2013 and did not have dates to show they had been reviewed. One policy titled 'Drug administration & storage' did not have an issue date. We spoke with the area manager who told us the provider would be updating all of their policies in April 2015.

We saw the medication administration records (MAR) in use were printed by the dispensing pharmacy and included details of the person concerned such as their GP and their date of birth. We looked at the MAR's of people who were prescribed medication which required covert administration and found the MAR's did not contain adequate guidance for staff to follow.

We observed two medication rounds taking place. On the first floor unit we saw medicines prescribed for administration at 9am were being administered at 10.20am and onwards. One person's relative informed us that their relative had not received their morning medication. They told us they knew this because of the way their relative was behaving, they told us, "I think X (the person) should have had their medication earlier on, they'll be due for their afternoon ones soon." They also requested pain relieving medication from the nurse as they had observed their relative to be in pain. The person had to wait to receive this medication due to it requiring covert administration (in food). There was no area on the first floor of the home to ensure that people who required their medicines to be

covertly administered in their food could have this prepared promptly. We saw the person waited 15 minutes whilst a staff member went down to the main kitchen and prepared them a sandwich.

We spoke with the relative of another person who told us, "We have issues sometimes with X's (the person) tablets. They have to have them at set times and a lot of times we have to go up to staff and chase them. Staff haven't been staying with X when they take their tablets and they've found a couple on the floor". This showed people did not receive their medicines in a safe and timely manner. This breached Regulation 13 (Management of medicines) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with people and asked if they felt safe living at the home. Most people told us they felt safe however, one person told us they didn't think there were enough staff on duty to meet the needs of people living at the home. They told us, "I think they work hard these girls. There's not enough though, I was asking from 8 o'clock to get someone to take me to the toilet, I waited a long time."

We also spoke with people's relatives. One relative we spoke with told us they had concerns for their relative's safety. They said, "My relative broke their arm in a fall at the home and then fell again the next day. Both falls were unseen that worries me sometimes." Another person's relative told us they were concerned about the staffing levels at the home. They said, "There's not enough that's my opinion. The carers are good but they seem to be running about a lot and my relative never seems to have the same carer." Another visiting relative said, "Staff are really good with my relative, my big bugbear is the lack of staff." A visiting relative told us, "Visitors are like unpaid carers sometimes, especially in the afternoons when they (staff) start going on their breaks - nothing will change until something happens to someone." One person's relative told us, "Something's going to happen one day. Carers do the very best they can but they don't seem to have an input into what is done." They were referring to a recent decision by management to remove the kitchen from the first floor. They said, "They've ripped the kitchen out and there's nowhere to keep the trolleys safe – if staff are pulled away when a person needs them the trolleys can be left unattended. All they have is a bathroom if someone wants a drink, you have pots lying around". They told us about an incident they had witnessed where "There had been so much aggression from residents – my relative included. The nurse dragged the only carer out of the lounge to help – I was left with a hot drinks trolley and the residents on my own". Another visiting relative told us, "They could do with some more staff, if two go down on breaks there's only two on the floor and if someone then goes down for the tea there's only one left." This meant staff were not available to respond to people's needs, to offer direct supervision or to maintain people's safety.

We spoke with staff who also told us they were concerned about the current staffing levels at the home. They told us how hard they found it to ensure people's needs were met and to keep people safe. One staff member told us, "There's not enough, depends of course what people's needs are, but some are quite demanding." Another staff member told us, "Most of the time no, there's not enough, there should be two here at all times, there's usually only one." Other comments made by staff included, "It's heavy going at times always busy here", "Non-stop." "Never get a chance to look at care plans you just pick it up as you go along." "Two nurses would be good, could do something, one is not enough." One staff member told us, "Sometimes you feel you can't give the care they need. I like to sit with them and have a natter, you can't." Another said "I feel now that I'm not doing the job as it should be done – to make their life better, there's no time to chat, or have 1 to 1's with people."

We spent time observing care practices in the first floor lounge. During that time an activity co-ordinator was playing a guitar and singing to people, two visitors were sitting with their relatives. There were two staff members who were busy assisting people with personal care. The nurse was in the office. We saw one person wanted to go to the toilet but carers were busy assisting another person. The person was spoken to by a staff member and agreed to wait. The staff member then took another person to the toilet, telling the Activity Co-ordinator they were leaving the room. The person tried to get up again and we saw they were unable to walk unaided. One of the staff members saw this and rushed into stop the person from falling. Following this within minutes another person attempted to walk around the lounge unaided. Staff appeared stressed and at no point did the nurse come to offer assistance. We saw staff were very busy and worked very hard to meet needs and supervise people's safety. However, we concluded there were not at all times, enough staff to

Inadequate

Is the service safe?

ensure people's needs were met safely and that people were properly supervised to ensure their safety. This was a breach of Regulation 22 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment records for three staff. We found recruitment practices were robust and each staff member had undergone pre-employment checks before they started work at the home. Each record showed detail of the person's application, interview and references which had been sought. We spoke with one staff member who confirmed this recruitment process had been followed. This showed that staff were being properly checked to make sure they were suitable and safe to work with vulnerable adults.

We looked at the number of accidents and incidents which had occurred since our last inspection in May 2014. We saw that a number of incidents had occurred recently which involved one person living at the home. On a number of the incident report forms we saw there was no 'manager evaluation' recorded and the documents did not show evidence of whether they had been reported to safeguarding. The manager confirmed they had reported all of the incidents to safeguarding and supplied evidence of this after the inspection. We found no evidence to show analysis of accidents or incidents including safeguarding incidents which occurred at the home had been carried out since our last inspection in May 2014. It is good practice to carry out analysis of incidents that may result in harm to people. It means changes to their care and treatment can be made where needed, and may prevent the risk of reoccurrence.

Is the service effective?

Our findings

We looked at staff training matrix which showed some staff had completed a range of training which included infection control, fire safety, moving and handling, first aid and food safety. However, some staff still needed to complete mandatory training or refresh this training. For example, 55 out of 69 staff had not yet completed training in first aid. A further 14 staff which included nurses, were also out of date with the training. We saw from the matrix, 51 staff were out of date with fire safety training, 14 staff were out of date with dementia care training with no evidence to show whether 19 members of staff had ever completed dementia care training. We spoke with the manager as we saw 'N/A' was recorded on the training matrix against a number of staff for each of the areas of training. The manager told us they did not know how this had happened but 'N/A' meant 'not appropriate'. The home had a training plan in place to make sure staff's training needs were met. However, there were no dates planned for any of the training deficits we found. This meant people living at the home could not be assured that staff caring for them had up to date skills they required for their role. We discussed our concerns with the manager who told us they would contact the training provider immediately and ensure the deficits in training were addressed.

Staff said they felt well supported by the manager of the home and found them approachable. They said they received one to one supervision and also attended regular staff meetings which the manager attended. One staff member said they had received one to one supervision recently in January and February 2015 and prior to this they had met with the manager at six weekly intervals. We saw evidence which showed most of the staff working at the home had received regular supervisions. However, feedback from some staff suggested they were unclear as to who provided supervision. For example, the registered nurse thought a senior carer provided supervision, although two staff members indicated the manager saw them 'every few months.' We saw that all staff had received an annual appraisal in 2014 and were due again in May and June 2015. This showed that staff on the whole were receiving regular management supervision to monitor their performance and development needs.

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 that one person living at the home was subject to an authorised Deprivation of Liberty safeguard (DoLS). We saw there were 13 people living on the first floor unit of the home who were unable to leave the unit unless they were escorted by staff. These people were at risk of being deprived of their liberty. The manager said they had not identified people who were possibly at risk of being deprived of their liberty therefore; applications had not been made to the local authority.

We met with a person and saw they had recently been admitted to the first floor of the home. Throughout the conversation the person expressed several times they wanted to leave the home and did not want to be there. We looked in the person's care records and saw no action had been taken by the home in response to this. We also saw that staff made attempts to distract the person however; they did not report the person's requests to leave to the manager. We looked at the staff training matrix and saw 56 out of 69 staff were out of date with training in Mental Capacity Act and DoLS training. This showed that staff were unaware of their responsibilities under this legislation.

The MCA (Mental Capacity Act 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. We looked in the care records of four people and saw there were documents in place for the purpose of assessing their mental capacity. The documents stated the assessments were to be carried out in relation to specific decisions. In one care record, we saw a mental capacity assessment had been carried out which stated the person had the mental capacity to make simple decisions. We found the assessment did not specify which decision it related to. We saw a consent document in place for this person which had been signed by their relative. There was no evidence to show why the person had not signed to give their own consent. In another care record we saw the person had a mental capacity assessment carried out in relation to their ability to make decisions regarding their finances. The outcome of the assessment stated they were not able to make any informed decisions as they had

Is the service effective?

Alzheimer's. None of the capacity assessments had been carried out in relation to the person concerned making decisions about the care and treatment they received at the home.

We were told by the manager that one person was receiving their medicines covertly. They told us the person's GP had given permission for medicines to be given covertly and we saw a letter in the person's care records from the GP which confirmed this. However the procedure required under the Mental Capacity Act 2005 and reiterated in the National Institute for Health and Care Excellence (NICE) document 'Managing medicines in care homes guideline (March 2014) had not been followed. This was a breach of Regulation 18 (Consent to care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home provided care for people living with dementia. We observed the care given to people with dementia and saw that staff lacked the skills they required to support people living with dementia. We looked at the training records of staff that worked at the home and saw that some of the staff had 'N/A' against their name which meant they did not require dementia training. We saw activity staff had been included in this.

We were concerned about the lack of leadership on the first floor unit for people living with dementia. We saw the staff on duty were working with little leadership or direction. There was no identified 'Lead nurse' or 'Dementia champion' for the unit. This role is essential in promoting good practice, monitoring care, and ensuring that all care is evidence based. The current registered nurses working on the unit had no agreement amongst themselves as to who should take a lead in relation to care on the unit. Our discussions with staff on the day indicated that they did not regularly access care records to read people's care plans, and were reliant on nursing staff to tell them what to do.

We looked in the care records of four people. We saw the care plans in place did not provide staff with clear guidance on how to meet the needs of people who were living with dementia. "Due to X (the person) having Alzheimer's they are unable to be independent in everyday life", "Try to learn the signs for when I am in pain or something is wrong." We also saw comments which were not appropriate for example, "Be firm and stern."

We saw the signage in place around the home was adequate for people living with dementia. Information to tell people which bedroom was theirs was personalised and we saw one person was being supported to make their own personalised sign by a member of activity staff. We spoke with staff including registered nurses and none of them were able to tell us about a model of care in use at the home, the National dementia strategy or NICE guidance (National Institute for Health and Care Excellence) with respect to caring for people with dementia. The manager and the area manager were also unable to provide any examples of how the home implemented guidance available. Due to the lack of implementation of best practice guidance the provider could not assure themselves they were meeting the required standards regarding dementia care.

Staff told us people were supported with accessing health care services such as GPs, dentists and opticians. We saw evidence to support this in the care records we looked at. This showed people living at the home received additional support when required for meeting their care and treatment needs.

Without exception all of the people and relatives we spoke with told us they thought the food at the home was good. One visiting relative said, "The food is lovely. I have a bit of stuff here when I stop to help her eat sometimes". A person living at the home told us "The home has a good cook, he makes lovely cakes".

We observed lunch being served on both units within the home and found people had mixed experiences of the mealtime. On the first floor unit, people experienced a delay in the food being brought up to the unit. We saw people became agitated as they were sat waiting for their lunch to arrive from 12.15pm until just after 1pm. Staff told us they did not know why the delay had occurred. When the meal arrived we saw two staff served lunch to people and this was done in an unhurried way.

We observed lunch being served in the ground floor dining area. We saw tables were laid well with clean table clothes, cutlery and napkins. We saw some people preferred to sit in easy chairs at individual occasional tables in the lounge area.

There were three staff members serving lunch to 11 people in the dining and lounge area and there were four people who they also were supporting to eat in their rooms.

Is the service effective?

Drinks were offered to people and we observed each person being asked what they wanted. We saw that staff appeared to know what each resident would ask for. We saw that as each meal and drink was served one staff member took responsibility for recording this on the 'Diet and Fluids' charts. We saw staff taking meals on trays with a drink to people in their rooms.

The food looked appetising and was well presented. It comprised chicken pie, swede, peas and potatoes. Two people we spoke with said their meal was "brilliant" and "lovely and hot." One person was assisted to walk in just after lunch had started to be served had and another person who had been out of the home was brought in. Staff worked around the arrival of both people quietly and without fuss.

All of the interaction between staff and people was related to the task of seating and serving them. We observed this was all conducted in a kindly, patient manner. People were asked if they wanted assistance with their meals and were this was required it was given in a kindly, patient and non-patronising manner. We saw one staff member cutting up one person's meal ensuring that the size of the pieces was as the person wanted it. We also saw a staff member encouraging one person to eat.

Lunch time on the first floor of the home presented a different experience for people. We observed people being encouraged to drink during lunch we saw that drinks were not readily available for people in the lounge areas at other times. Staff often appeared too busy to ensure they checked if people were thirsty. People living with dementia may also struggle at times to communicate their thirst to staff.

We spoke with visiting relatives who told us they were concerned about access to hot and cold drinks for people. One visiting relative said, "They have a regular drinks trolley but could do with more drinks available". Another relative told us, "Having no kitchen, staff have to rush up and down. There are dirty pots upstairs. There's no kettle, no way to make residents a cup of tea. No place to keep milk."

We spoke with the manager and the area manager regarding these issues. The kitchen on the first floor unit had been ripped out and replaced with a sensory room. This had left the unit without an area to store and prepare drinks for people. On the second day of our visit we saw work was in progress to install a beverage area with a fridge where items could be stored.

Requires Improvement

Is the service caring?

Our findings

All interactions between staff and residents we observed were kindly, gently and patient. They were not over familiar nor patronising and were felt to be appropriate and sensitive. People and relatives we spoke with told us that staff treated residents with dignity. There were quiet areas in the home were people and relatives could sit if they wanted quiet or privacy. One person said "I like to keep private and they respect that."

We saw that staff knocked on people's bedroom doors before entering rooms; they asked if they wanted help before taking any action and ensured that dress was adjusted properly after person care or assistance had been given. For example, we saw two staff members use a hoist to transfer a person to an easy chair. They constantly explained what they were doing and reassured the person. We saw that after they had seated them they ensured the person's clothing was pulled down and that they were comfortable. This showed that staff took time to support people with their personal care in a way which promoted their dignity.

We heard a person who was shouting from their room and they sounded distressed. We saw a staff member go to the person and sit on the bed with them, holding their hands and reassuring them. The staff member spoke to the person in a warm and gentle manner.

People told us staff were "Willing to go that extra mile" to make their lives more pleasant. We saw there were balloons and a "Happy Birthday" banner up in the ground floor lounge and was told this was for a person's birthday two days ago. The relative of another person told us, "They did a little party for my relative in January, made them a cake".

We saw the staff were kind and welcoming to visitors. One relative said "I can come any time I want, they generally bring me a cup of coffee and I can have one anytime I want one". Another relative said "They encourage relatives to come to events, singing etc. and sell buns and have raffles".

We looked at the care records of four people and found little evidence to show the involvement of the person concerned. We saw that where documents required signing by the person this had not been done. There were many instances where this was blank. People we spoke with told us they knew they had records which the home kept about their care but had not been involved in developing care plans.

We spoke with two people's relatives who told us they had been asked to sign documents in care records by staff. One relative told us, "They show us the care plan and we can look at it anytime. My relative has records by the side of their cabinet showing what they've done for them". Another person's relative told us, "My relative was involved in the care plan; the manager is updating it at the moment." This meant that the home were not consistently involving people, or where appropriate their relatives in the planning or reviewing of care.

Requires Improvement

Is the service responsive?

Our findings

People had their needs assessed before they moved into the home. This ensured the home considered how they were able to meet the needs of people they were planning to admit to the home. We saw however, that these assessments had not all been filled out correctly in that some areas had not been completed and did not therefore identify people's needs fully. We also saw that some were not signed or dated so it was not clear if they were current records and still relevant.

We saw one person was recently admitted to the home. We looked at the 'Respite support plan' for this person and found the document had not been completed. The manager told us they had left instruction for this to be completed by the night staff however, when we checked the handover document we saw it did not mention this. We saw the person had a range of needs which with no guidance for staff to follow meant they were at risk of receiving inappropriate care or care which did not meet their needs.

We looked in four people care records and found there were areas where the information recorded did not reflect the persons up to date care needs. For example, we saw one person had a 'Mental health assessment' carried out in August 2014. This identified the person had a range of needs including communication needs and emotional needs. We saw the person had a 'Communication' care plan in place dated March 2014. It stated the person was able to express 'physically' when they were in pain and staff had to 'learn the signs' for when the person was experiencing pain. The care plan did not state what physical signs the person would exhibit when they required pain relief. The person had recently injured their wrist following a fall and had been prescribed pain relieving medication. This care plan had not been updated to reflect the person's recent injury which meant staff did not have clear guidance to follow on how to meet the care needs of the person.

Another person's care records showed they had recently become more challenging towards female staff. However, we saw this information was not reflected on their 'Personal preferences' document dated January 2014 which staff had ticked 'don't mind' against whether the person preferred male or female staff to assist them.

We saw staff were completing 'behavioural analysis' records which were a log of incidents relating to challenging behaviour exhibited by one person. We saw from these records that the person's needs had changed with respect to how many staff they needed to assist them with personal care. We looked in the person's care records and saw none of their assessments or care plans had been updated with regard to the change in their needs. This meant the home had not provided staff with clear guidance on how to meet the person's needs and the records in place were not an up to date and accurate reflection of the care the person required.

We found there were a number of instances were records had not been completed accurately by staff. For example, a 'Personal hygiene' record in place for one person stated 'wet' or 'dry' and made no reference to whether the person had their personal hygiene needs met. There were also periods of two days at a time when there were no recordings made. This meant it was not clear if the person had been assisted with their personal care needs.

We saw a number of examples which showed the reviews staff were carrying out of care plans in place for people were not detailed and were often repetitive. This affected the quality of the review. For example, on one evaluation sheet we saw "No changes" and "Care plan remains the same" recorded. We also saw examples of where staff had continued to complete reviews of assessments on the blank sides of documents instead of starting a new document. This meant the dates of the reviews and the signatures of the completing person were not always legible.

There were examples in care records where we saw conflicting information had been recorded regarding people's support needs. For example, on a 'My activities of daily living assessment' document we saw it stated the person concerned did not need any assistance from staff with their mobility needs. However, on their risk assessment it stated 'Staff always to ask me if I need assistance' and in a care plan titled 'Maintaining a safe environment' it stated 'Sometimes I am dependent on staff to assist me at times.' This meant the care records of the person did not clearly identify their support needs.

Care plans were not always centred on the needs of the individual. For example, on two people's 'My family and friends' documents we saw 'I do not follow any religion as I have Alzheimer's' had been recorded by staff.

Requires Improvement

Is the service responsive?

We saw life history documents had not been completed consistently with people who lived at the home. A life history document enables staff to understand and have insight into a person's background and experiences. We spoke with the manager about this and they told us some people were unable to engage. We saw that two people had regular visits from their relatives and we asked the manager if they had been approached to complete these documents. The manager told us they would make more of an effort to ensure families were approached to complete the documents with staff.

We reviewed a number of care plans with a visiting professional from the local older adult's community mental health team. We were concerned to find a care plan for one person which had the name of another person written on it.

We were concerned to find a number of folders and charts containing a range of daily care records for example, personal hygiene and observations to be left on the top of a cabinet in the lounge. These records contained intimate information and should not have been left in an area where they could be looked at by a visitor or another person living at the home. This showed that records relating to people's care were not being stored securely. Some of these records were found to be incomplete and inaccurate. For example, according to one person's records they had their bowels open only three times in 26 days, which would be of concern however; there was nothing further in the records to reflect any concern. We spoke with a staff member who suggested it may have been recorded elsewhere.

We judged that all of the above concerns regarding record keeping at the home was evidence of an on-going breach of Regulation 20 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there was a complaints policy and procedure in place. All of the visiting relatives we spoke to told us they were aware of the complaints process. We were told of complaints both formal and minor which had been made by relatives and of varying degrees of response by management. One relative said, "I've never had a need to make a formal complaint, I'd go straight to the manager, but if I've ever had a problem I go to the carers and they sort it out". The home had received three complaints since our last visit in May 2014. We saw evidence which showed two of them had been investigated and resolved to the complainant's satisfaction. However, the third complainant was not happy with the outcome of the investigation into their complaint. We saw the manager had followed the procedure in place for all three of the complaints. This showed the complaints people made were responded to appropriately.

The home had a commitment to gathering the views and opinions of people and relatives regarding the quality and type of service provided. The home had regular relatives' meetings but these were not always well attended. One relative said, "They have relatives' meetings every month, I don't go because I'd rather spend those two hours with my relative." Another relative said, "They have meetings quite regularly, I've been to one." We saw the minutes of the most recent meeting held at the home. It showed three people had attended. The manager remained positive and told us they felt the meetings were very important for the home.

We saw there was a questionnaire for relatives and visitors' in the reception area of the home. Visiting relatives told us they were also aware of these. One relative said, "There are some (questionnaires) on the desk where you come in now, I've filled them in." Another relative said regarding questionnaires, "There's one out there now." This showed the home had mechanisms in place to communicate with people and their relatives to involve them in decision making or commenting on the service.

The home had dedicated activity staff who provided 60 hours per week (including weekends) of activities to people living at the home. We received positive feedback regarding these staff and the activities which they planned and facilitated. We spoke at length with one activity co-ordinator and we observed them at various stages of our inspection offering a range of activities to people. During the morning they were sitting with one person encouraging them to make a sign for their door. In the afternoon they were playing the guitar and singing with people in the upstairs lounge and we saw that people appeared to really enjoy this and were joining in. There was a lot of friendly banter between people and the activity co-coordinator.

We were told that the home had a full program of activities. There was a large notice board showing the activities for morning afternoon and evening sessions for all 7 days. This had bright images, including photographs and was attractive and stimulating. The activity co-ordinator told us,

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Is the service responsive?

"There's 'Keep Fit' every Tuesday with a rugby union trainer. On Thursdays there are always two of us and we have hair-dressing, hand massages, make-up and sometimes we have a mini photo shoot." For those less active they said, "If they are in bed we sit with them 1 to 1 and do crafts or just talk and reminisce. At Christmas we made personalised presents, the same on Valentine's day, if they can't do much we still sit with them and do it for them so they can still give presents. We have karaoke and singing, I play the guitar, we have singers come in twice a month if we can raise enough funds. We raise funds through coffee mornings, raffles and craft sales. At Christmas we make a lot to sell, we put a lot of our own time in then."

They were able to tell us about people's likes and abilities. For example, she said "X (the person) has Parkinson's and the involvement with activities morning and afternoons seems to make a difference. X doesn't really acknowledge anything but we still sit with them and do their nails etc., unless of course they show they doesn't want it". We were told that music was used a lot in the home to "calm situations, diffuse situations or moods."

We were shown a 'Sensory room' on the first floor. This was apparently an initiative proposed by the Manager but the activity co-ordinators had developed it. It provided stimulation to touch, smell, sight and hearing. The activity co-ordinator gave an example of how it benefitted people saying "X (the person) does nothing but walk, pacing the whole time, but in the sensory room they stand still, seems to relax, seems calm." A visiting relative said "The entertainment people are really good, they put some good functions on, they (people) really enjoy it, really respond. They make some nice mementoes and presents". This showed the home was meeting the social needs of people who lived there.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post who was supported by a team of registered nurses and care staff. We spoke with people's relatives who told us that they thought the registered manger was approachable. One relative said, "I don't have much contact with her but she does say hello, seems friendly and she tells me what's going on". Another relative said, "We have no problems, but if we did we'd go and see the manager, she's so obliging".

We also spoke with staff and asked if they felt supported by the manager of the home. One staff member said, "It's hard to talk to the manager. You feel as if you are complaining, she's not listening I've got past it". Another staff member told us they felt "Well supported by the manager, she is very approachable, you can go to her if you have any problems, but I don't have any really."

We looked at minutes of staff meetings which we saw were held on a regular basis for all staff groups. This included nurses and senior carers, domestic and laundry, activities and maintenance and night staff. We saw the meetings were well attended but the minutes did not include dates for actions. Staff we spoke with told us they thought the meetings were useful and found it a good way to raise any issues they had. Morale appeared good amongst staff we spoke with. One staff member said, "It's brilliant, the staff are really like a family." Another said, "All the staff are good friends, we get on, it's like a family."

Throughout the inspection we made a number of observations which highlighted the lack of leadership on both of the units within the home. We saw there were nurses on duty however, one observation we made was that a member of care staff seemed to be in charge of organising priorities for the day ahead. Although the staff member appeared more than capable we felt the lead should have come from the nurse.

One the first floor unit we felt the lack of leadership had more of an impact on people's care. For example, despite there being a number of nurses employed at the home there was little evidence of specialism regarding dementia care. We found that care provision appeared to be on a shift to shift basis with no clear operational policy, or clearly defined model or philosophy of care. There were also issues with respect to the lack of guidance for staff in the care plans written by the nursing staff. We spoke with the manager about this and they told us they would address these issues.

We saw the provider had a quality assurance system in place which consisted of audits which required completion on a monthly basis by the manager. This included audits of accidents, falls, bed rail usage, complaints monitoring, pressure sore, medication, infection control, care plans, CQC/safeguarding notifications and the dependency tool. We looked at the previous three months of audits and found these had been completed by the manager. However, when we looked at the way the service audited care plans, we saw this did not ensure people were receiving high quality care. For example, we saw audits of care plans were carried out on a 'check list' type document and where there was space for the person's care plan to be audited, we found this often had a line through it and did not contain any details of the care plans which had been looked at. The manager confirmed there were no other mechanisms in place for checking the effectiveness of people's care plans. Throughout the inspection we had found a number of issues regarding peoples care plan's which we had brought to the manager's attention.

We found there were issues with regard to the lack of action planning when issues were identified through audits which although not completed by the manager, they were signed off by them. For example, in the monthly domestic audit we saw a number of issues identified such as COSHH training needing to be updated by staff, new toilet seats needed, no menus on tables and some staff having no name badges. We saw there were dates planned for these issues to be resolved.

The area manager visited the home regularly to check standards and the quality of care being provided. The manager and staff said they spoke with people living at the home, staff and the manager during these visits. We looked at the records of visits for the last two months. We saw that frequently similar issues were identified each month and it was unclear if effective action had been taken to address them. For example; issues regarding documents not completed in a number of people's care records were raised. We saw there was no action plan in place to show

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Is the service well-led?

who would complete the necessary actions. This meant the system in place for monitoring the quality of the service provided did not consistently ensure aspects of people's care was effective.

Throughout both days of our inspection we brought a number of issues to the attention of the manager and the area manager. We identified a number of breaches regarding the safe management of medicines, people being at risk of unsafe or inappropriate care due to issues relating to care records, arrangements not in place to ensure the service was meeting the requirements of MCA 2005 or Deprivation of Liberty Standards and the service failing to ensure there were enough staff on duty to meet the needs of people using the service. All of these issues demonstrated to us that the provider did not have effective systems in place to assess and monitor the quality of the service provision. This was a breach of Regulation 10 (Assessing and monitoring the quality of service provision) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 17 HSCA (RA) Regulations 2014 Good governance **17.**—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; (d) maintain securely such other records as are necessary to be kept in relation to— (i) persons employed in the carrying on of the regulated activity, and (ii) the management of the regulated activity;

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

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 **12.**—(1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include (f) where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs; (g) the proper and safe management of medicines;

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18.—(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

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 11.—(1) Care and treatment of service users must only be provided with the consent of the relevant person. (2) Paragraph (1) is subject to paragraphs (3) and (4). (3) If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act.

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 17 HSCA (RA) Regulations 2014 Good governance 17.—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— (d)maintain securely such other records as are necessary to be kept in relation to— (i)persons employed in the carrying on of the regulated activity, and (ii)the management of the regulated activity;

The enforcement action we took:
Warning notice