Rushcliffe Care Limited

Parkmanor Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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**

Summary of findings

Overall summary

We inspected the service on 25 April 2016 and the visit was unannounced.

At the last inspection on 21 and 26 November 2014 we asked the provider to take action to make improvements. We asked them to improve their practices in relation to obtaining people's consent to their care. We also asked the provider to improve their practices in relation to their arrangements for monitoring the quality of the service. Following that inspection the provider sent us an action plan detailing what improvements they were going to make.

During this inspection we found that some improvements had been made. However, we were still concerned that people's consent had not been obtained in line with the Mental Capacity Act (MCA) 2005. We were also concerned that people's capacity to make specific decisions had not always been assessed. We still had concerns that checks by the provider on the quality of the service provided had failed to identify concerns found at this visit and therefore necessary action had not been taken.

Parkmanor Care Home is a registered care service providing care for up to 40 older people. At the time of our inspection 38 people were using the service, a significant number of whom had dementia. The service is offered over two floors accessible via the stairs or passenger lift. There are two lounges and two dining areas for people to use and all bedrooms are single occupancy. There is also access to a garden area for people to use should they wish to.

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

The provider had not always consistently managed or assessed risks that people were vulnerable to. For example, where people were at risk of skin damage this risk had not been carefully considered and documented. Staff members had recorded accidents and incidents but the registered manager had not analysed ways to prevent them from reoccurring.

The provider did not always have safe systems and processes for managing people's medicines. For example, the storage and recording of people's medicines was not always robust. Staff supported people to take their medicines in a safe way.

The provider had carried out regular checks on the equipment people used and the premises.

There were not always plans available to staff to support people to keep them safe during emergencies. For example, where people needed individual support to evacuate the home, the plans were not thorough.

People did not have concerns about their safety and staff knew how to protect them from abuse and avoidable harm.

People and their relatives had mixed views about the amount of staff available but we found there were enough staff to meet people's basic care needs. The provider's recruitment process was robust and included checking prospective staff before they started to work at the home. This helped the provider to make safer recruitment decisions.

Staff understood the requirements of the MCA 2005 and could describe how to obtain people's consent before they offered care and support. Where people may have lacked the capacity to make their own decisions, the provider had not always followed the requirements of the MCA. For example, how the provider had assessed people's capacity to make decisions was not always clear.

People were supported by staff that had received regular training. However, the regular checking of staff's knowledge and skills had not always been recorded. Staff did not always receive regular support from their supervisor.

People were not always aware what food choices were available to them but food and drink was available to them throughout the day. However, daily records to monitor people's nutrition lacked details of what people had actually eaten and drunk.

People had access to healthcare professionals to maintain good health.

People had mixed views about the caring approach of staff. Staff did not always show compassion and kindness to people although we saw some staff being warm and friendly towards them.

People were supported to maintain relationships with people that were important to them. People's dignity and privacy was not always being maintained because staff were not always aware of people's preferences.

Staff knew about people's communication needs which meant they were able to respond to them effectively.

People's personal information was mainly being kept secure.

Where people could, they had not always been involved in and contributed to the planning and reviewing of their care and support. Where this had not been possible, people's representatives or their relatives had not always been included. People's support plans were not always individual to them and lacked detail that staff could refer to about how they wanted to be supported.

The provider had adapted parts of the home for people with dementia. However, these were not always maintained. For example, some rooms were cluttered and may have confused people.

People's preferences, backgrounds and things that were important to them were not always known by the staff team as these had not always been recorded in people's care plans. People were not offered a full range of activities and interests to meet their preferences and interests.

People did not have access to independent advocacy services information available to them to help them to speak up if they had required this support. Feedback about the quality of the service had been sought but the results had not always been shared with people or their relatives. People and their relatives knew how to

make a complaint.

The provider had carried out quality checks of the service but these had not been effective in identifying the concerns that we found during our visit. Records of people's care were not always in place or were incomplete.

The registered manager largely understood the requirements of their role but not all statutory notifications had been submitted to CQC. People and staff did not always have opportunities to give feedback to them.

Staff enjoyed working at the home and were able to describe the vision of the service such as offering dignified care. Staff had been made aware of their responsibilities.

We found breaches of the Health and Social care Act (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The provider had not always managed risks to people.

The provider did not always have safe systems and processes for managing people's medicines.

There were enough staff to meet people's basic care needs and the provider's recruitment processes were robust.

People felt safe and staff knew how to protect people from abuse and avoidable harm.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's consent to their care had not always been recorded and the requirements of the MCA were not always being followed.

People received support from staff who had received training but who had not always received regular guidance.

People were not always aware of their food options and their nutritional needs had not always been recorded thoroughly.

People had access to healthcare services to maintain their health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were being supported by staff that did not always consider their privacy or show kindness and compassion to them.

People's preferences were not always known by staff although staff knew their communication needs.

People were not always involved in planning their care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's support and their plans did not always focus on them as individuals.

The provider had not documented if people had contributed to their care needs. Their reviews of their care had not shown how people or their representatives had been consulted with.

People and their relatives knew how to make a complaint if they had wanted to and could give feedback to the provider.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider's quality checks and people's records were not comprehensively completed.

Staff had been made aware of their roles and responsibilities and enjoyed working at the home.

People and staff did not always have ways to offer feedback to the provider.

The registered manager was largely aware of their responsibilities.

Parkmanor Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 25 April 2016 and was unannounced. The inspection team included an inspector, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has had personal experience of either using services or caring for someone in this type of care service.

Before the inspection visit, we reviewed information that we held about the service. This included information that we had received about the service as well as statutory notifications that the provider had sent to us. A statutory notification contains important information about certain events that they must notify us of as required in law. We also contacted the local authority to ask them for their feedback about the service.

We spoke with six people who used the service and four relatives of other people living at the home. We also spoke with the registered manager, two registered nurses and three care staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at the care records of five people who used the service and other documentation to see how the service was managed. This included health and safety management, checks on the quality of the service that the registered manager had undertaken and policies and procedures. We also viewed three staff files to check how the provider had recruited and the support in place for staff.

Requires Improvement

Is the service safe?

Our findings

Risks to people had not consistently been managed to protect them from harm. We saw that whilst some risk assessments had been completed and regularly reviewed so that staff had up to date information about the people they had supported, others had not. For two people we saw that their care records had documented that they were at risk of malnutrition but their weight was not being routinely documented. This meant that there was a risk that people were not being monitored appropriately to keep them protected from not having enough to eat and drink. For another person we saw that they had been identified as being at a high risk of skin damage. Their care plan stated that they had needed assistance from staff to reposition every four hours. The records we saw showed that for seven days there were only two entries to show that this had been completed. Another person was also at risk of skin damage. They had required assistance to change position every three hours. We saw that on four days in the last seven, the time between turns was up to seven and a half hours and on others occasions between four to five hours. This meant that for those people there was a risk that they might not have been getting the assistance they required to protect them from skin damage. The registered manager told us that they could not be assured that the support these people had needed to reposition had occurred. They said that they would investigate why the records had not been completed.

People's care needs had not always been fully assessed when they had moved into the home. For one person they showed behaviours that could challenge others and cause themselves and others harm. There were no plans in place for how to safely support the person and others when this had occurred. There were no behavioural management plans in place to ensure people remained safe and care staff had no information to offer this person consistent care and support. For another person there were insufficient care plans and risk assessments available for staff to follow. There was a short term care plan available but this had not indicated what the person's immediate risks or care needs were. We went to see the person in their bedroom and found that they had a catheter in place. Their personal care records showed that their urine output had not been recorded for two days. We also found that the person's fluid intake had not been recorded completely. This would have allowed the registered nurses to make decisions about any actions needed if they had concerns. We were concerned about the look of the person's urine and informed the registered manager who told us that they would personally go and attend to the person. This meant that there were risks to the person's well-being that had not been assessed or appropriately monitored.

Where a person was identified as being at a high risk of falling, we found that there was no risk assessment or care plan to support the person to reduce the risk. The registered manager told us that they would make sure that a care plan was written and shared with staff.

Although the registered manager gave us assurances at our visit that the concerns raised would be addressed, the risks to people may have been significant. The registered manager did not provide us with information after our visit to give us assurances that the appropriate checks were always occurring.

The provider did not always have safe systems and processes in place for managing people's medicines. We saw that people's medicines had not always been stored according to national guidance. There were

medicines that had required specialist storage and we found that these were not being stored correctly. The registered manager told us that they would look at purchasing extra storage cupboards so that these medicines were stored appropriately. We did see that the provider had regularly monitored the temperature of the medicine room to make sure that it was appropriate for the medicines they were storing.

Staff were not always recording the administration of people's medicines and treatment. For example, where people were supported to apply prescribed creams, the administration had not been documented. We also saw that the site of one person's insulin injections had not been recorded twice in the last two weeks that we checked. The rotation of the site is important to reduce the risk of hardening of fatty tissue that will interfere with the absorption of the insulin. We further saw that the charts for the monitoring of people's blood glucose were not always complete. These would have helped the registered nurses to make accurate assessments of the effectiveness of people's treatment plans. For another person the site of pain relief patches was not recorded and for another they had gaps in their record. Recording of this is important so that the site is checked and any issues or adverse effects are acted upon. This meant that there were risks that staff who had administered medicines or who had offered people treatment did not always have up to date information available to them. We spoke with a registered nurse about this who told us they would take action to update their recording processes.

Where people required medicines infrequently, for example on a three weekly basis, this was not always recorded on their medicine record. This meant that there was a risk that a dose could be given late or missed. Instructions for staff to follow when people had been prescribed as and when needed medicines were in place for some people but not all. We further found that where two people were receiving medicines in their food, this had been agreed with their GP. However, their support plans did not specify that covert medicines were a last resort and consent should be attempted in the first instance. We also saw that where a person had a diagnosis of arthritis their records did not include information about how their pain levels would have been monitored. After our visit the provider told us that systems and processes in relation to our concerns about people's medicines had been reviewed.

We did see some safe practice when people were supported with their medicines. For example, staff supported people to sit up in bed before offering their medicines to prevent them from the risk of choking. We saw staff talking to people about their medicines and the administration was unhurried. The provider had made available to staff a medicines policy that staff could describe. For example, one registered nurse told us how they would report a medicines error to the registered manager.

People felt safe living at the home. One person told us, "I am well looked after and happy". Relatives said that they thought their family members were safe. Their comments included, "He is well cared for" and, "My mother is safe here".

The provider had a system to record all accidents and incidents. We saw that the records were thorough and detailed the incident, any injuries sustained and any follow-on action that had been required such as seeking medical assistance. However, accidents and incidents had not been analysed to look for similarities between these with a view of taking action to try to prevent reoccurrences. This meant that the provider had not reviewed their systems, processes and practices that may have contributed to accidents and incidents.

People received care from staff members who knew their responsibilities to protect them from avoidable harm and abuse. The provider had made information available to staff about how to respond to abuse. There was also a safeguarding policy in place. This had detailed the responsibilities of staff should they have had concerns about the safety of people they supported. Staff were able to describe the key points of this including reporting concerns to the registered manager. Records confirmed that staff had received training

in protecting people from abuse. This meant that staff had been guided in how to protect people.

The provider did not have a full range of plans in place of how to support people in an emergency. We saw a general emergency plan that was available to staff that had documented the action for staff to take when, for example, there was a loss of power or a fire. We saw that staff had regularly practiced evacuating the building so that if a fire had occurred, staff knew what to do. However, individual plans to support people to evacuate the home if needed, were not comprehensive. Although the provider had assessed people's level of need, there was no detail about the actual assistance and the amount of staff that would be required to support people. This meant that there was a risk that people may not have received the support that they needed if an emergency had occurred.

People lived in a home that had been regularly checked by the provider. For example, we saw that the fire panel and firefighting equipment had been recently inspected. Other checks on the environment had occurred such as making sure that the water supply was safe and the safety of people's equipment that they had used had been regularly checked. When we looked around the home we saw that mobility aids were mainly clean and in good working condition. However, we saw that some wheelchairs were missing footplates and if used could have posed a risk of injury and should have been removed from use. We fed this back to the registered manager who told us that they would look at them and remove them if necessary.

We found that some equipment and furniture required repair and attention. For example, a dining room table was not sturdy. We also saw that in one person's bedroom there was a bed table which had foam attached around the edges that was stained with food. In another person's bedroom we saw that a table had its side worn and splinters were showing. This meant that there risks to people's health and well-being.

One person told us that they felt the number of staff available to support them was sufficient. They said, "I call them with my buzzer and they come". Relatives felt that there were not always enough staff to meet the needs of their family members. One relative told us, "Staffing here is sometimes short". Another said, "There are not enough staff to feed and care for people. Most are left in bed and several are not getting staff attention". We saw that people's basic care needs were being met. We also saw that people's dependency levels had sometimes been assessed that had identified people's level of need. However, we could not see that where people had recently moved into the home, this had been incorporated into the provider's analysis of staffing levels. This meant that the provider could not be confident that the current staffing levels were sufficient to meet people's individual needs. The registered manager told us that where people had recently moved into the home their care needs required assessment.

The provider had thorough recruitment processes in place. We looked at four staff files and we saw that as part of the recruitment process the provider had undertaken a criminal records check. Two references had also been obtained alongside right to work checks. We also saw that registered nurses had confirmation of their professional registration in their files. This meant that the suitability of prospective staff had been checked which helped the provider to make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

At our inspection on 21 and 26 November 2014 we found that where people did not have the capacity to consent, the provider had not acted in accordance with legal requirements. This was a breach of Regulation 18 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. At this inspection visit we found that the provider had not taken all of the necessary action to meet the requirements of the regulation. We were concerned that it had not been documented how people's consent had been gained for the care that had been planned. We were also concerned that people's capacity to make specific decisions had not always been considered.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether staff were working within the principles of the MCA and we found that this was not consistent.

People or their representatives had not signed their care plans to show their consent to their care. We saw that the registered nurses had signed these. Furthermore, where consent forms for the taking of photographs were in place these had not always been signed. The registered manager told us that people's care plans had been discussed with their next of kin. We discussed with the registered manager that only people legally authorised can make decisions on people's behalf. Where these were not in place, best interest decisions would have needed to have been made. In the documentation that we viewed, best interest decisions had not always been considered. This meant that people's human rights were not consistently being upheld.

We saw that where one person's capacity to make decisions had been considered, several decisions had been assessed together. It had not been documented how the person had been supported to make these decisions and who had been part of any following best interest meeting. We saw that for this person the assessment had concluded that the person had and had not got the capacity to make decisions. The assessment also stated that further assessment had been required but there was no indication of what this was. The registered manager told us that the documentation should have been more detailed and clearer. For three other people their capacity had not been considered and we saw that these people may have lacked the capacity to make decisions. This meant that the provider had not fully considered people's capacity and might not have been offering care that was in their best interests.

Although the registered manager gave us assurances that they would look at people's consent to their care and to assess capacity where we found it to be missing, the risks to people were significant. These matters were a breach of Regulation 11 Need for consent of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We saw that staff members asked people for their consent before they carried out personal care tasks. They did this in a careful way and gave people time to respond where this was needed. Staff that we spoke with understood the requirements of the MCA. They could explain about protecting people's rights by offering choices and working with other people to ascertain what might be in a person's best interests. We saw that staff had received training in the MCA. We also saw that the provider had made available to staff guidance on how to assess people's capacity by having posters on display within the home.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospital are called the Deprivation of Liberty Safeguards (DoLS). We saw that the registered manager had made the appropriate applications to the 'supervisory body' (the local authority) where they were seeking to deprive someone of their liberty. Staff understood when a DoLS application might be needed. For example, they were able to describe that an application might be needed if a person had been constantly supervised. This meant that the provider was taking the appropriate action when they had sought to deprive a person of their liberty.

One person told us that they thought staff had the right skills and knowledge. They said, "They seem to know their stuff". Staff told us that they had sufficient training. One commented on recent dementia training that they had undertaken and said, "It was really useful, it made me think a lot about how I do and how I approach things". One registered nurse told us that the provider was putting together a programme of training to support the registered nurses to remain up to date with their registration. We saw that staff had received an induction when they had started to work for the provider. This had included training in the areas of, for example, assisting people to move position, food safety and infection control. We found that the training for staff was mainly up to date although annual competency checks for staff had not always taken place. We saw that there were plans to check staff members' competence in areas such as assisting people out of their beds, to eat and drink and with their personal care. Records showed that only eight out of 31 care staff had been assessed in the last 12 months. The registered manager told us that they were confident that these checks had occurred and that they would re-look at their records.

Staff told us that they had not met regularly with the registered manager or their supervisor. One staff member described how they had not had an individual meeting with the registered manager in the last 12 months, whilst another told us that one had occurred within the same timeframe. Other staff told us that they had received an annual review of their performance but they did not meet at other times individually with their supervisor. Where these meetings had occurred, we saw that staff had received guidance and support in relation to health and safety and the standards of care being provided. The provider's policy stated that individual meetings with staff members would occur six times a year. Records showed that this had not consistency taken place. This meant that there was a risk that staff may not have been providing effective care to people as this had not been regularly checked by the provider. The registered manager was confident that staff members had received this support and told us that they would review their records.

One person commented on the food offered to them and said, "There is little food choice and dry chicken is not right". We saw that there was a menu displayed but it was typed in small writing that people who had dementia type conditions or visual impairments would not always be able to understand. We saw that there was not a visual choice available to people at lunchtime. We asked four people about the lunch that was being offered on the day of our visit and they told us that they hadn't been told what it was. This meant that people were not clear about food options. One friend of a person raised a concern with us. They said, "Several residents are not hydrated". However, we found that people had access to drinks throughout the day including those who chose to spend time in their own rooms. Staff had available to them a list of people's dietary requirements which had been displayed in the kitchen so that they could meet people's

nutritional needs.

Where people's food and fluid intake required monitoring, we found that the recording of this was not always thorough. For example, the description of food eaten was not always descriptive. We also saw that the amount of fluid people had required daily had not been recorded on their charts. The recording of this is important so that staff would have known if additional fluids were required. The registered manager told us that they were looking at a new system so that all staff had this information readily available to them.

People had received support from healthcare professionals in a timely manner where this had been required. People's care records had documented that people had seen their GP where staff members had concerns about their well-being. We also saw that specialist support and guidance had been sought from, for example, psychiatry services and speech and language therapists. In this way people were being supported to monitor their health by staff who had requested additional support where this had been needed.

Requires Improvement

Is the service caring?

Our findings

People and relatives had mixed views on if staff had offered kind and compassionate care. One person told us, "I can say that some carers are good and some bad". Another person said, "Carers are very caring. There is no bullying from the carers and I am treated with respect and dignity". A relative commented on the approach of staff members. They told us, "Care staff, some are not very good and not trained in dementia care". Another relative said, "Staff are polite, helpful and approachable".

Staff did not always show compassion and kindness in their support offered to people. We observed people being supported during a mealtime. Staff members had assisted people into an appropriate and comfortable position where this had been required. They took time to describe the meal being offered, enquired with people if the temperature was suitable and if they were enjoying the food. One person was reluctant to eat their main meal so a staff member bought two different desserts which the person enjoyed. The person indicated by raising their hand to say they had had enough. This was respected by the staff member. We saw a different approach from other staff members. For example, we saw that a person was struggling to cut their food up. A staff member saw this and did not assist the person. On another occasion we saw a staff member supporting a person to a dining room table. The person's legs were pushed by the staff member so that they would fit under the table. We saw that this was done in an uncaring way as the staff member did not explain what they were doing. We fed this back to the registered manager who told us that they would speak to the staff involved.

People were not always being treated with dignity and respect. We saw that a number of communal areas had neither blinds or curtains at the windows. People's care plans did not state that this was their preference. This meant that people's privacy needs were not always being met. We read feedback that the provider had received from relatives and saw this concern had been raised over nine months ago. We also saw that there was clutter in the lounges including an unused commode being stored in one of them. We observed staff knocking on people's bedroom doors before they had entered. However, where people were being cared for in bed, these doors were left open throughout our visit. We saw that some people had dislodged their bed clothes when moving in their bed. As these rooms were off main corridors which are used by other people and visitors, this practice did not ensure that people's privacy and dignity was being maintained. We spoke with the registered manager about this who told us that they would revise people's care plans regarding people's preferences to have their door open or closed. Where people could not make this decision, we were told that a best interests decision would be made.

Where people could have been involved, we did not see that they had been part of making decisions about their care. It also was not always recorded in people's care records how significant others may have been part of this process. Where people may have required additional support to make decisions, we found that advocacy information had not been made available to them. An advocate is a trained professional that can help people to speak up. We spoke with the registered manager about these concerns and they told us that they would look into how they could support people and their representatives to be involved in decisions about their care.

People's communication needs were known by the staff members who had supported them. We saw that staff used different ways to enhance their communication. For example, we saw staff gently touched people to gain their attention and we saw staff ensured that they were at eye level with those people who were seated. This was important so that people could see staff and so that staff could look at people's expressions clearly to understand their response when they could not verbally state their choice or decision.

We saw that conversations between staff and people was mainly warm and compassionate. For example, on one occasion we saw a staff member sitting with a person and spending time talking about their past and reminiscing about things that the person had taken part in. The person was smiling and engaged in the conversation with the staff member. People had also received support to maintain their emotional well-being in a kind way. We saw that when people had become anxious and distressed, staff had responded calmly and sensitively. For example, where a person was upset, we saw staff sat with them until they had gently fallen asleep. However, most conversations with people focused mainly on tasks that needed to be undertaken and not necessarily on things that were important to them as had sometimes been detailed in their care plans.

People's care records were not always being stored correctly. We saw that some people's care records were left unattended in a dining room. Staff told us that they were writing people's daily care notes and had left these unattended as they were undertaking other duties. This meant that there was a risk that people's private and confidential data might have been accessed by unauthorised people. We saw that there were clear data protection and confidentiality policies in place available to staff. These were largely being followed as we saw that people's care records were mainly being kept in a lockable office.

Staff members could describe some things that were important to people. We saw that they talked about people in a person-centred way and were familiar with some of their preferences. For example, when people chose to wake up in the mornings and what foods they had enjoyed. One staff member told us that one person would get very distressed if they had not got their jewellery on. They said, "She likes to twiddle with her bracelets although she doesn't talk very much. It always brings a smile to her face when you put it on". Another staff member told us, "When residents are first admitted we always help them to unpack. That's when we start getting to know them, we speak to relatives and friends about what they like and what their interests are". This meant that staff knew how to develop relationships with people although we did not always see this being incorporated into their practice.

People's families and friends were able to visit without undue restriction. On the day of our visit we saw visitors throughout the day with their family members. They were able to use the communal areas or visited their family members in their rooms. We saw that staff made visitors welcome by offering them a drink.

Requires Improvement

Is the service responsive?

Our findings

People told us that the service was not responsive to their needs. One person said, "It's my home, I understand, but it does not work that way. The response we get is you are in here and this is how we do it". Another person told us, "No way" when asked if they had been offered a bath regularly. Relatives felt that the service was not always responsive to their family members' needs. One told us, "He is supposed to have a bed bath regularly, but gets one once a week. I am told that the pads are changed regularly at four hourly intervals but I have to remind the senior carer every now and then". Another relative said, "Observations are not done as agreed. And she is given a shower once a year (but regular washes)". We saw that people's care records did not always detail when people had been offered assistance with their personal care. This meant that the provider could not be sure that people had received regular assistance that had met their needs.

People's needs had been assessed prior to moving into the home, but this information was not person-centred in terms of focusing on them as individuals. The assessments had detailed the basic care needs of people. The registered manager told us that after 72 hours a full care plan should be in place for people. However, for three people who had recently moved into the home, their care plans were largely empty and there was only very basic information about people's care needs available to staff. We saw that detailed information for these people on nutrition, skin integrity, mobility, their understanding and safety were not completed. We also saw that people's daily care records contained information on tasks that staff members had undertaken. They did not include observations about how people had spent their time, choices they had made or any preferences they had shared with staff. This meant that there was a risk that the service was not being responsive to people's preferences about their care. The registered manager told us that these care plans should have been in place and would work with the registered nurses to make sure that they were. We did see that for one person that a 'This is me' document had been completed by a family member. This included information for staff to offer responsive support to the person including significant life events and that the person had enjoyed sewing, music and watching television.

We saw that some people's bedrooms had pen boards that could be filled in by staff. Some of these had detailed brief but important reminders for staff members. We read that a person had required assistance to put their dentures in place and that it was a person's birthday. This meant that staff had some information available to them to make sure people were receiving care that was individual to them.

When we observed people having their lunch, we observed five people remained in their wheelchairs in one dining area. We asked the registered manager if this was by choice or if people had not been given the opportunity to transfer to a dining room chair. The registered manager told us that they would review people's care plans to make sure that people's preferences were identified and that staff knew about them as they said that this information would be missing.

The provider had made some adjustments to the environment to be responsive to people with dementia type conditions. For example, the corridors had items on the walls for people to touch to promote sensory stimulation. We also saw photographs of some people on their bedroom doors to aid people's orientation. However, we also saw that there were practices that could confuse and distress people with memory

difficulties. For example, although staff had received training in working with people with dementia, bathrooms were often cluttered with equipment. They were not conducive to people with dementia as visual clues were not clear. We heard staff asking people what they had wanted to eat the following day. People had struggled to make a decision. Some people seemed confused about what they were being asked whilst others had not been asked at all. We spoke with the registered manager about this and we explained that people with dementia would find making a choice in this way difficult. The registered manager told us that they would look at their processes to check that they were appropriate.

Where people's needs had been recorded, their needs had been regularly reviewed. However, the records of these did not show how people or their representatives had contributed to this process. We saw that registered nurses had signed people's support plans to record that they had been reviewed. The provider told us that they would review their documentation to make sure that people are consulted with on a regular basis about their care. On the day of our visit we saw that people's needs were considered during the staff handover. Handovers involve staff coming onto their shift being given information from staff finishing theirs. Staff told us that they found handover meetings useful and informative. They said that these meetings helped them to prioritise their work and to consider who required extra observations.

People did not have access to a full range of activities that met their individual interests. The registered manager told us that an activities worker was employed for 16 hours every week. Staff described how they had regular themed days. People and staff members had recently celebrated St George's Day where most of the people and some relatives attended. One relative spoke positively about an activity they had been part of and said, "I am very happy as there is a sing-a-long and I join them". However, on the day of our visit we saw that there was little activity offered to people. We observed that people were left for long periods of time without activity or interaction from staff members. We also saw that staff mainly offered conversations to people during personal care support or when they were assisting with food and drink. Where people were cared for in bed there was little stimulation apart from when care tasks were being undertaken. We found that people's care plans did not always detail people's social and leisure interests which meant that staff might not have known about these. We observed an activity of balloon throwing that had been initiated by staff. We saw that people did not look interested in this activity and many chose not to take part. This meant that people's interests had not been fully considered when delivering care.

People and their relatives knew how to make a complaint should they have needed to. However, we found that some people and relatives that we spoke with were hesitant when speaking to us. One relative told us, "We do not want to upset the carers or the manager after building relationships with them. We do not want to complain...My relative's care is not what they should be getting". We saw that the complaints procedure had been displayed near to the entrance to the home and that there was a comments and compliments book located in a lounge. We found that there was no feedback recorded in the last 12 months in this book. The registered manager showed us that three complaints had been received in the last 12 months and we found that they had responded appropriately to these. This meant that although processes were in place for the provider to receive complaints, people or their relatives might not always have felt able to.

There were arrangements for relatives to give feedback to the service about the care offered. We saw that in the last 12 months relatives had been provided with a questionnaire. We read some positive comments about people's care and there were suggestions for improvements. The registered manager told us that the results of the questionnaires had been displayed in the home at the time. However, they also told us that any actions that they had taken had not been shared with relatives or people using the service. This meant that the provider had not always told people and their relatives how it had listened to and acted upon the feedback it had received. We did see that a 'You said, we did' board was in place with some comments from the provider. For example, the provider had received feedback in the past that people were not sure of how

to complain. The provider had taken action to make the complaints procedure more visible by having it in everyone's bedrooms. We saw examples of this when we visited.

Requires Improvement

Is the service well-led?

Our findings

At our inspection on 21 and 26 November 2014, we found that there were not effective systems in place to regularly monitor the quality of the services provided to identify, assess and manage risks relating to the health, welfare and safety of people. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the provider had not taken all of the necessary action to meet the requirements of the regulation. We were concerned that the provider's quality checking had failed to identify concerns found at this visit and therefore necessary action had not been taken.

We saw that the provider had quality checking processes in place. For example, people's medicines had been audited daily by the registered nurses and these were then passed to the registered manager for a weekly check. However, the records for March and April 2016 were incomplete and we found that they had not highlighted our concerns about the management of people's medicines.

We saw that other audits had occurred. The registered manager had looked at accidents and incidents that had been recorded by staff members. We saw that in January 2016 there were 12 incidents involving six people. Eight of these were unwitnessed by staff members. There was no action plan in place to suggest that there had been an analysis of the data by the provider. We found that there was no audit in February and in March 2016 no action plan had been implemented for eights falls that had occurred. The registered manager agreed that action plans were not in place. An analysis is important as it can identify patterns of why certain accidents and incidents occur. A follow-on action plan can identify measures to address any quality or safety issues that are being compromised with a view of improving the service and outcomes for people. They also told us that although they had responded to complaints, they had not undertaken an analysis that had been recorded about why people may have complained. This meant that the provider was not using its checks effectively to consider how they could improve the quality and safety of the services offered to people.

There were a range of concerns that we raised with the provider at our visit. These included the safe management of people's medicines, seeking people's consent in line with the MCA, assessing risks to people and ensuring that people's needs had been considered in a person-centred way. Although the provider gave us assurances that these matters would be promptly addressed, we found that checks on the quality of the service were not effective in identifying these issues. This meant that there may have been risks to people receiving unsafe or inappropriate care because the provider had not effectively monitored and evaluated the service.

People's records were not always in place and some were incomplete. For example, some care plans were largely empty of information and turning charts and medicines records had not always been thoroughly completed by staff members. They did not contain all of the information that staff would have required to provide effective and responsive care. Because the records were not always accurate and complete there was a risk that people would not receive safe, person-centred consensual care.

These matters constituted a breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

There were not always opportunities available for people or staff to give feedback to the service. We saw that the registered manager had made time every week to meet with people or their relatives. They had displayed a poster for a 'surgery' once a week inviting people to give feedback .The registered manager told us that sometimes relatives came to these. We also saw that the registered manager spoke with people and staff and answered their queries on the day of our visit. However, the provider had not always made arrangements that encouraged open communication with them. One person told us, "I am not sure about having residents meetings but the manager comes every morning". The registered manager told us that residents and relatives meetings had ceased since 2013 as people had not always attended these. We saw that staff meetings had only occurred twice in the last 12 months and some staff told us that they could not recall when they were last involved in one. We could also not see that people and staff had been asked for their views on the quality of the service. This meant that there was a risk that the provider was offering care to people that had not been based upon the opinions and feedback of people or staff members.

The registered manager was largely aware of their responsibilities. We saw that the relevant notifications had usually been made to the local authority and CQC. These included where people had been involved in a significant incident or where someone had died. Where people had been deprived of their liberty, statutory notifications had not been submitted to CQC. We spoke with the registered manager about this and they were not aware of this expectation. After our visit the registered manager submitted these notifications to us.

Staff told us that they enjoyed working at the home. Comments included, "It's a lovely community" and, "A great team". Staff described the registered manager as approachable and usually available if they had needed support. They felt supported on a day to day basis. A relative gave us good feedback about the registered manager. They told us, "The manager is brilliant". However, these comments were not always consistent with what we found during our visit.

Staff were able to describe the aims and objectives of the service. They described how they strove to offer dignified care to people and to respect people's wishes. This was in line with the provider's statement of purpose that the registered manager described which set out what people could expect to achieve; for example receiving support from trained staff. This meant that the staff team knew about the goals of the service. However, we saw several instances where the service did not live up to the statement of purpose.

Staff were aware of their responsibilities to raise concerns about people's safety or well-being if they needed to. They described how they could report any concerns to the registered manager or other managers within the organisation. We saw that there was a 'Speak Out' poster displayed close to the entrance of the home. This directed staff to speak to their supervisor if they had concerns. There were also contact details for the local authority's safeguarding team. We saw that the provider had made a range of policies and procedures available to staff members for them to follow. We asked staff members about some of these and they were able to describe them. In these ways staff had been made aware of their responsibilities.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not always fully considered people's consent to their care and followed the requirements of the Mental Capacity Act 2005. Regulation 11(1).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality checks were not effective in assessing, monitoring and improving the quality and safety of the services provided in the carrying out of the regulated activity. Regulation 17(2)(a). The provider did not always maintain an accurate and complete record in respect of each person, including a record of the care and treatment provided to the person. Regulation 17(2)(c).

The enforcement action we took:

Issued a warning notice