Blossom Care Home Limited

Blossom Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection of Blossom Care Home took place on 17 and 19 February 2016 and was unannounced. The previous inspection, which had taken place on 17 December 2014, had found the service was in breach of specific regulations, in relation to supporting staff, assessing and monitoring the quality of service provision, record keeping and respecting and involving people who use services. We issued requirement notices and the registered provider developed action plans to demonstrate how they would address these breaches.

This inspection found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to providing person centred care, safe care and treatment, safeguarding service users from abuse and improper treatment, staffing and good governance.

The home provides accommodation for up to 20 people who require personal care. There were 12 people living at the home at the time of the inspection.

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

Staff had received safeguarding training and understood the signs to look for, which may indicate potential abuse. However, safeguarding reporting procedures were not robust and had not been followed.

Risk assessments and care plans were not sufficient to ensure that everyone's needs could be met safely.

Staff had been safely recruited but sufficient numbers of staff were not deployed to ensure that people's needs could be met.

The home was clean and fresh and good practice was followed in order to reduce the risk of the infection.

Staff did not receive appropriate support and supervision to enable them to perform their roles effectively.

People were given menu choices and their diet and nutritional needs were met. People had access to additional health care when required.

Staff were caring at times. However, there were also some negative interactions and periods of missed opportunities to engage with people. End of life wishes were considered.

Different ways of communicating with people had been explored and good use was made of communication cards.

People told us they were bored and there was a lack of meaningful activities.

People were able to make their own choices, in terms of meals and when to rise in a morning.

The registered provider had demonstrated they could be flexible and responsive, by the way that some people residing at the home were accommodated, to ensure their needs were met.

Management oversight at the home was weak. There was a lack of auditing and lack of staff supervision. In some areas the registered manager had not made improvements following the last inspection.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 always safe.

People told us they felt safe.

Safeguarding reporting procedures were not always followed.

Safe recruitment practices had been followed to ensure staff were suitable to work in the home.

Is the service effective?

Requires Improvement

The service was not always effective.

People told us they felt staff were well trained.

Staff did not receive regular supervision to enable them to carry out their duties effectively.

People received support in relation to their diet and nutrition needs.

Is the service caring?

Requires Improvement

The service was not always caring.

At times we observed positive, caring interactions with staff and people.

Staff failed to recognise the significance of a person being excluded due to their hearing aid batteries needing replacing.

Staff missed opportunities to engage with people.

Is the service responsive?

Inadequate

The service was not responsive.

There was a lack of meaningful activities available for people to participate in.

Some care plans lacked detail and staff were sometimes

unaware of people's needs, as documented in their care plan.

The service had been responsive to some people's needs and made adaptations to enable some people's individual needs to be met.

Is the service well-led?

Inadequate

The service was not well led.

Processes for auditing the quality of service provision were weak.

There was a lack of management oversight.

Policies and documentation were not up to date.

Blossom 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 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.

The inspection took place on 17 and 19 February 2016 and was unannounced on both days. The inspection was carried out by two adult social care inspectors on the first day and an adult social care inspector on the second day. Prior to the inspection we reviewed the information we held about the home and we gathered information from the local authority and from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

The registered provider had been asked 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. This information was also used to assist with the planning of our inspection and to inform our judgements about the service.

We used a number of different methods to help us understand the experiences of people who lived in the home, including observations and speaking with people. We spoke with five people who lived at the home, one relative, three care staff, a member of domestic staff, the registered manager and registered provider.

We looked at six people's care records, three staff files and training data, as well as records relating to the management of the service. We looked around the building and saw people's bedrooms, bathrooms and other communal areas.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. One person said, "Oh yes love, I feel safe here." Another person we asked said, "Feel safe? Of course I do."

However, a family member told us, "There are not enough staff. For example when two staff are helping one person upstairs there is nobody downstairs for people. What if someone falls? That's not right."

The registered manager and staff had received training in relation to safeguarding people. Staff demonstrated a clear understanding of the signs they would look for, which might indicate someone was being abused or was at risk of harm.

However, we found not all safeguarding incidents had been reported in line with safeguarding procedures. The records we viewed showed that, during August 2015, there had been an allegation that some money was missing from a person's wallet in their room. We could find no evidence this had been investigated or that the incident had been reported in line with safeguarding procedures. We asked the registered manager about this, who recalled the person was reimbursed the money they alleged had been taken and the person confirmed this when we spoke with them. However, although the registered manager told us the incident had been investigated, there was no record of this.

It is important to have robust safeguarding reporting procedures so that people are protected from abuse and improper treatment. The above example demonstrated a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 13 (3) because systems and processes were not established and operated effectively in line with safeguarding reporting procedures.

We asked the registered manager how they managed risk in the home. We were told that risk assessments took place and these helped to minimise risks. The registered manager explained there were 12 people living at the home at the time of the inspection and three senior members of staff. The senior members of staff were each responsible for ensuring four people's care plans and risk assessments were up to date.

We saw one person's care plan had assessments of risk in relation to falls and security. The falls risk assessment took into account the person's mobility needs, any medical information and history of falls. The use of a hoist was required in order to assist the person to move. The plan detailed the type of hoist to use, the type of sling, the method of sling application and which colour sling to use. This helped to ensure staff used the correct equipment and helped the person to move safely.

However, we found that risk assessments were inconsistent and, in some cases, had not been completed. One person had no risk assessments in their care plan. Four people had risk assessments relating to risks associated with evacuating the building in an emergency, but other people did not. One person's care plan contained only one risk assessment and this was in relation to whether their bedroom door should be locked or unlocked. Another person's care plan contained information relating to their dietary needs, stating they had diabetes. This person had lost weight and had been referred to their general practitioner during

February 2016. There was no nutritional risk assessment in place for this person, although a different person who lived at the home had a nutritional risk assessment in place. One person's care plan stated, 'Staff are advised to go in pairs because [name] is at risk of falls.' However, no falls risk assessment was in place for this person. We highlighted this to the registered manager and registered provider. These examples demonstrated a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 12 (2)(a)(b) because the risks to some people had not been assessed.

We looked at whether the premises were safe. The fire equipment testing certificate was valid and dated February 2016. We saw regular servicing of lifting and hoisting equipment and the lift had been regularly serviced. Portable appliance testing had taken place and the certificate for this was valid until May 2016. However, other checks such as the nurse call bell system and lift alarm system had not been regularly checked.

Each care plan contained a section which related to accidents and incidents. We could see that accidents and incidents were recorded and action was taken. However, there was no overview or analysis. By analysing accidents and incidents the registered manager could identify potential triggers or trends and therefore put measures in place to reduce potential incidents. We discussed this with the registered manager who was receptive to this. The registered manager agreed to take this forward.

There was one senior carer and a carer to support 12 people throughout the day, as well as a cook, a cleaner and the registered manager. There were no dedicated activities staff. One of the staff members we spoke with said, "Nine times out of ten there are enough of us. Occasionally we need another." A member of staff we spoke with told us staff were not allocated breaks but they, "Grab five minutes," when they can, in their 12 hour shift.

The registered manager told us there were four people living at the home at the time of the inspection who required two members of staff to assist them to move. We observed periods of time when no staff were available in the lounge or dining area because, if someone who required the assistance of two staff was being assisted, this meant that no other care staff were available to assist people. We observed, on one occasion, care staff asked the cleaner to stay at the end of their shift in order to, 'watch the floor'. This was because the two care staff were assisting a person who required the assistance of two staff and this meant that no other staff were available to ensure people's safety. This was for a period of in excess of ten minutes.

We observed, between 13.30 and 13.45 there were no staff available in the lounge because one of the carers was washing up in the kitchen and the senior carer was using the computer in the office. One of the people in the lounge was saying, 'Auntie, Auntie' for assistance. This person's care plan stated this would indicate they required assistance with continence needs. At 13.45 staff assisted the person to go to the toilet.

At 16.30 a member of staff asked the registered manager to explain to a person they would need to wait ten minutes for assistance to go to the toilet because the two care staff were helping another person.

Given that we had observed periods of time where two care staff were required to assist a person which left no other care staff available, we asked a member of care staff if there was a buzzer or call bell available in the lounge, so that people could summons help if required. We were told there was no call bell in the lounge area. We raised our concerns about this and about staffing levels in general with the registered manager. The registered manager agreed to further consider this.

The above examples demonstrated a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 18 (1) because sufficient numbers of suitably qualified, competent, skilled and

experienced persons were not deployed to meet people's care and treatment needs.

We looked at three staff files and found safe recruitment practices had been followed to ensure staff were suitable to work with vulnerable people. For example, the registered manager ensured that references had been obtained and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

The registered manager had a staff disciplinary policy and we saw that appropriate action had been taken when this was necessary.

We looked at whether medicines were managed and administered safely. Storage temperature checks were recorded daily and medicines were securely stored. We looked at the medication administration records (MAR). The records we sampled reconciled and the balance of remaining medicine was correct. We saw there was a system in place for accurately ordering and returning medicine.

We observed the staff member prepare people's medicines in disposable cups and hand the medicine to the person. The staff member waited until the person had taken their medicine. The person was not rushed in any way.

A member of staff advised that, on occasions, if a person was not going to be at home during the day, and they had capacity to manage and take their own medicine, they had been given their medicine to take at a later time. However, when this happened, the staff member had signed the MAR to show the medicine had been administered. We advised the member of staff they should only sign to show medicine has been administered at the point that it is administered.

We found the home to be clean and fresh. We saw there was colour coding system in place of cleaning equipment to help effective cleaning and reduce the risk of the spread of infection. We observed staff wearing appropriate personal protective equipment (PPE). Anti-bacterial hand gel was available at the entrance to the home and a sign was placed, requesting visitors to use this. Effective hand washing signs were displayed adjacent to sinks. This showed that steps had been taken to help prevent and control the risk of infection.

The service had been awarded a five star rating from the local authority for food hygiene at their most recent inspection of food hygiene in July 2015, which equates to, 'Very Good.'

Requires Improvement

Is the service effective?

Our findings

One person told us, "Yes, staff seem to know what they're doing. They use all the equipment, you know, the sling and hoist."

Speaking about the food, a person living at the home told us, "The food is fantastic." You get a choice of food." This person told us, "There's nothing I'd want to change here."

We looked at staff training records and found the records were difficult to navigate. Therefore it was difficult to establish which staff had received specific training. We looked in individual staff files, another file which contained certificates for multiple members of staff, attendance sheets for more recent training courses and the training matrix. We were able to determine, from looking at all the different available information, staff had received training in essential areas such as safeguarding, moving and handling, fire safety and first aid for example. However, staff had not received training in relation to the Mental Capacity Act 2005. We discussed with the registered manager that the way in which training records were organised would make it difficult to determine which staff needed their training refreshing. The registered manager was already aware of this and was currently looking to update the files to make the system more efficient.

We saw two of the three senior carers, responsible for administering medicines, had last received training for this in December 2015. However, one senior carer had last received training in March 2014. The registered manager was able to show us that all three senior carers and the registered manager had been booked onto medication training on 4 March 2016.

Although the staff we spoke with told us they felt they received the training and support they needed in order to carry out their duties effectively, we found that staff did not receive regular supervision. We looked at three staff files. One file showed the staff member had last received supervision during February 2013. Another member of staff had last had supervision during January 2015. In another staff file we found the date of the last supervision was January 2013. The registered manager told us that regular staff meetings were held and that, if there were any concerns regarding a member of staff, then individual supervisions would be held. Additionally, we could find no evidence of staff appraisals and the registered manager acknowledged these had not taken place. This demonstrated a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 18(2)(a) because staff did not receive appropriate support, supervision and appraisal to enable them to carry out the duties they are employed to perform.

Communication cards using pictures were used in order to assist people to communicate their needs to staff. We saw staff using these cards when assisting a person whose first language was not English. The registered manager told us some interpreting cards had also been devised to translate English words into the person's first language, in order to help assist the person and staff to communicate with each other. This demonstrated that steps had been taken to assist people to communicate their needs.

The Mental Capacity Act 2005 (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.

The registered manager had attended training provided by the local authority in relation to the MCA and Deprivation of Liberty Safeguards (DoLS). The registered manager was able to demonstrate their understanding of this by outlining to us the principles of the MCA and DoLS and they were aware of the implications this had on people living at the home, for example that people must be assumed to have capacity and that people could not be deprived of their liberty without appropriate authorisation.

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 hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The registered manager had considered that one person at the home lacked capacity and was being deprived of their liberty. The registered manager had therefore applied to the local authority in order to seek authorisation to deprive the person of their liberty, in accordance with the MCA and associated Deprivation of Liberty Safeguards.

The registered manager was clear that restraint was not used at the home and the staff we spoke with also confirmed this. A member of staff was able to explain to us how they would talk to people if they came across behaviour they found challenging or if people were resistant to receiving care and support.

We observed a lunch time experience. People were offered a choice of two different meals at each meal time; one of which was vegetarian. The cook engaged well with people and we observed the cook asking people what they would like to eat and people's choices were accommodated. However, we saw a senior carer pour everyone a glass of orange juice without offering a choice of any other drink.

Food was served through a hatch from the kitchen area to the dining area and was taken directly to people. Condiments were available and tables were laid with table mats and cutlery, with serviettes. People chose where they wanted to sit. The salad was colourful and food looked fresh and the food smelled appetising.

Due to the level of need, people required minimal assistance with eating their meals. However, staff were attentive to peoples' needs at the mealtime and asked if people were okay. This oversight of the mealtime experience helped to ensure people's nutritional needs were met.

We observed people being invited to the dining tables at tea-time. Some people chose to stay in their rooms or in their chairs in the lounge area. Staff brought food to people and offered a choice of hot or cold food and a choice of drinks. People appeared to enjoy their food.

We saw, throughout the home, that good signage was in place in order to help people to navigate.

People had access to health care and we saw that referrals were made to other agencies or professionals such as general practitioners, district nurse and podiatrist. This showed people living at the home received additional support when required to meet their care and treatment needs.

Requires Improvement

Is the service caring?

Our findings

One person told us, "They're very good the staff. They keep asking me if I want anything." Another person said, "The staff are okay" and another person told us they were happy living at the home.

We observed some positive, caring interactions between staff and people at the home, but this was not consistently so. People appeared at ease in the presence of staff.

On one occasion we observed a member of staff assisting someone to stand and leave the table. This was done in a caring manner. The person was given reassurance throughout and the member of staff moved at the person's pace, saying to the person, "It's okay, don't rush [name]. You're okay."

We also saw some positive, genuine interactions between staff and a person who was 'pretending' to sit in someone else's wheelchair. The interactions were relaxed and showed the person was at ease with staff and other people, laughing and joking.

However, at times we observed staff sitting at the dining tables chatting with each other at a time that could have been used to engage people, either in conversation or in meaningful activities. Throughout the day we observed missed opportunities to engage with people.

At 3.30pm on the first day of the inspection, we observed two members of care staff sitting at a table together, in the dining room. People sat passively watching television or looking around the room, as they had been for much of the day, and the staff did not attempt to strike up conversation or engage with people. Staff sat together and could be heard saying, "It's the quiet before the storm."

We saw staff talking with people and, although this was done in a respectful manner, this tended to be, 'in passing' rather than engaging people in any meaningful conversations.

One person had difficulty in hearing us. They told us, "It's such a lonely place when you can't hear at all. It would make so much difference to me. It would mean everything if I could hear." We used written communication with the person in order to determine what the reason for this was. The batteries in the person's hearing aid required replacing and they had needed replacing for over a week. A member of staff confirmed the hearing aids simply required a battery that could be bought in a local store. The person was excluded from conversations with others and from interactions because staff had not acted upon the need, despite being aware of it. We requested that someone obtain a battery for the hearing aid on the day of the inspection and this was arranged.

We observed one person come into the lounge area and say to a member of staff, "I want to know why I haven't had my cream." The member of staff said, "Sit down and I'll sort you out in a bit." Although the person did display repetitive behaviour and this was documented in their care plan which may have meant they had already been assisted with their cream, the response from the member of staff did not demonstrate a patient and caring manner.

People were able to maintain their privacy if they so wished. Assessments were completed and people chose whether they wanted a key to their room and whether they wanted their room to be secured. This meant that people were able to lock their room according to their own wishes.

Consideration was given to end of life wishes. One person had a do not attempt cardiopulmonary resuscitation (DNACPR) order in place. We saw this was recorded clearly in the person's care plan. We asked a member of staff about this and they were aware which person had a DNACPR order in place and staff understood the implications of this. This showed that people's end of life wishes were considered and shared with staff appropriately to enable people's end of life wishes to be met.

Inadequate

Is the service responsive?

Our findings

One person told us, "I get bored. I get the paper but, other than that, nothing." A relative we spoke with also told us they felt their family member was, "Bored."

We asked a person whether they had choice and control and they told us, "Yes. So, I could have a beer if I wanted one but I don't want one. I have what I want."

One person told us, "I like to get up early in a morning. I'm an early bird. Staff help me to get up early." This person told us, "You get a choice for dinner and tea. I choose what I want. I like to read my paper."

Care plans were held electronically. A member of staff we spoke with told us they could look at people's care plans regularly and whenever they wanted. Staff had their own password to access the computer. We looked at six people's care plans. The content of care plans was variable.

One person's care plan documented the person was prone to pressure sores and the person should be prompted to change position regularly. The plan stated, '[name]'s skin is checked daily by staff and creams applied if needed. If any sores appear, district nurse will be informed straight away.' We asked to see records to show the person's skin was checked daily. However, these could not be provided. The registered manager asked a member of care staff, who confirmed the skin was checked but this was not recorded. It would be difficult for staff to know whether the person's skin had been checked if this was not recorded and this could therefore place the person at risk of pressure sores. This demonstrated care had not been provided in line with the person's care plan.

We looked at another person's records. This person also required assistance to change their position regularly. We saw records were kept in the person's room and these indicated that staff had assisted the person to change position six times each day, in accordance with their care plan.

One of the plans we sampled contained a personal history and information relating to the person's interests. However, this information was not provided in other plans we sampled. It would be difficult to plan and provide meaningful activities for people if staff did not know what interests the person had. When we highlighted this, the registered manager acknowledged the plans required further information.

The registered manager told us care plans were reviewed monthly and people were asked for their views before plans were updated. We could see that plans had been reviewed monthly but we could not find evidence to show that people had been involved in reviews. The registered manager told us this was done informally and this was why there was no record of people being involved.

We saw one person was repeating the phrase 'Auntie' throughout our inspection. The person's care plan stated if the person used the phrase, 'Auntie' this meant the person needed to go to the toilet. We asked a member of care staff if they were aware of this and they were not. The staff member thought that, when the person used the phrase, 'Auntie' that it was a sign of respect. This meant that staff were not always aware of

people's needs, as documented in their care plans.

Two people did not have a care plan or relevant risks assessments in place. When we raised this with the registered manager we were told these people were initially residing at the home temporarily. However, one person had been living at the home for more than three weeks and the other person had been residing at the home for ten days. The registered manager had received a short term plan and discharge notes from the hospital but had no information relating to risk, mental capacity, mobility or dietary needs for example. Notes from one person's arrival stated, 'Mobility is poor. Walks with a zimmer. Needs two carers to assist. Has difficulty chewing. Legs are ulcerated.' No risk assessments had been completed in relation to these needs. We raised our concerns with the registered manager and registered provider, who advised they, "Did not expect [the person] to stay long." However, not developing a care plan and not having risk assessments in place means the person is at risk of not receiving appropriate care and treatment and the registered manager agree to address this.

The above examples demonstrated a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 9 (1), (3)(a) because care and treatment did not always meet people's needs and care plans were not reviewed in collaboration with the person.

The previous inspection found there was a lack of activities or meaningful occupation for people. A Healthwatch visit also reported this during their visit of September 2015. At this inspection, we observed people sat passively looking around the room or at the television for long periods of time. People told us they were bored and there was a lack of planned activities. We raised this with the registered manager, who told us some staff had attended a good practice event during November 2015 in relation to activities and this had resulted in some board games being purchased. We were told newspapers were delivered daily and the hairdresser came once a week. We observed staff trying to engage people with these games prior to lunch-time. Not everyone wanted to join in and some people quickly lost interest. We found a lack of activities and social stimulation.

One person was writing letters. They told us they liked to write letters and read magazines and they were singing along to the radio. We saw this person's care plan identified that the person liked to write letters. The registered manager told us they had attempted to download some films which would be of interest to an individual whose first language was not English.

We saw five people's bedrooms. These were personalised and we saw that some people had photographs of their family and items of sentimental value. One person told us they had chosen the particular type of television they wanted in their room and this was obtained for the person.

The registered provider and registered manager had arranged for some alterations so that bedrooms could be adjoined. This enabled some people, who had been together for many years, to maintain their relationship whilst living in the home. The rooms had been planned in such a way that the couple could live together in the home, whilst maintaining their own private space when they so wished. This demonstrated the registered provider and registered manager had been flexible and responsive to the needs of the couple.

The registered manager told us people were given choice, such as whether they would like a bath or shower or what they would like to eat. The staff we spoke with told us they tried to offer people choice. A member of staff gave examples such as, "What to wear and what to drink." During the inspection we observed a person ask for, "A cuppa." The member of staff responded by saying, "Yes, no problem. Do you want a milky one? How many sugars?" The member of staff made the drink to the person's liking.

We saw there was a complaints policy and we asked to see records of complaints. We were provided with a complaints record, which listed three complaints; one from June 2014, one from January 2015 and one from December 2015. However, it was difficult to determine whether these had been resolved or responded to in line with policy because records were minimal.

We asked a carer how information was shared between staff on different shifts. We were told there was a verbal handover as well as written handovers at each shift change. We asked to see the information that was shared on the written handover sheets. The information provided on the handover sheets was brief and one person was not listed on the sheet, despite residing at the home for over a week. We discussed with the registered provider the fact that one person's information was missing from the handover sheet and we were told the person may be on another sheet. We were then handed some more sheets that were not in any order and had not been filed away. This pile of papers also had some diet and fluid intake forms mixed in with them. The papers were not organised and it was difficult to determine what information had been shared, when and with whom.

Some people's names and records were missing from the daily handover sheets. The handover documentation was ad-hoc and chaotic and this meant that information relating to people's care needs was not always shared appropriately between different staff.

Inadequate

Is the service well-led?

Our findings

The home had a registered manager in post, who had been registered with the Care Quality Commission to manage the home since September 2015. The staff and people we asked told us the registered manager was visible in the home.

A member of staff told us that teamwork was good at the home and that staff, "All get on together like a big family." Another staff member said they felt people received, "Good, safe care from staff who work well together."

We asked the registered manager how staff were made aware of their roles and responsibilities and expectations. The registered manager told us they preferred an informal approach and they tried to create a team atmosphere. The registered manager felt there was a supportive staff team and highlighted to us that staff turnover was low. Some members of staff had worked at the home in excess of 10 and, in one case, 20 years.

The registered manager and registered provider had a supervision policy in place. The policy stated, 'Supervision should be held every two months and should last approximately 50 minutes so the supervisor and supervisee have 10 minutes to reflect on their interaction before they continue their day.' The staff we spoke with told us they felt supported by the registered manager. However, the registered manager had not taken steps to ensure staff received regular supervision in line with policy. The register manager told us they observed staff practice and fed this back to staff. However, this was not recorded so we could not see evidence of this. This demonstrated a lack of management oversight and meant there was a risk that staff competency was not maintained.

We saw evidence of five staff meetings held throughout 2015. Discussions included subject areas such as activities not being provided, staff being reminded to complete daily entries and respecting resident choices. Staff meetings are an important part of the registered manager's responsibility in monitoring the service and coming to an informed view regarding the standard of care and treatment for people living at the home.

The registered manager was aware the last quality surveys, requesting people's views in relation to the quality of service, were sent to people in October 2014 and no questionnaires had been sent since this date. Furthermore, no resident meetings were held in order for views to be heard. The registered manager told us they sat with people on a one to one basis and asked for their views, for example whether they felt safe and whether they liked the food. However, the registered manager kept no records of this and we could see no evidence these discussions took place and no evidence that improvements had been made based on any feedback received. This demonstrated a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, regulation 17 (2)(e) because the registered manager and registered provider did not seek, record and act on feedback from relevant persons for the purpose of continually evaluating and improving the service.

We asked to see the policies and procedures for the home and were given a file which contained these. We found the policies were not dated and contained information which related to out of date regulations and legislation. We also found documentation in the reception area, such as a guidance document about compliance with essential standards was also out of date. We found an information booklet in a person's room was out of date and related to a home with a different name. We made the registered provider aware of this, who agreed to address this.

We asked to look at emergency plans that were in place for the home. We were given a file which contained emergency plans. However, the file was scant and contained very little information. For example, although the index indicated there were plans in place in the event of fire, flood, power cut, gas leak, equipment breaking down, none of these plans were available to view. This demonstrated a lack of management oversight.

Auditing systems and recording in the home was weak and incomplete. The registered manager told us they had begun to audit medication, although acknowledged this practice had only begun during the month of the inspection. Although mattress cleaning took place on a regular basis there were no mattress audits, which would include inspecting the integrity and quality of mattresses. We asked the registered manager about this and they confirmed that no such audit took place.

Records showed internal safety checks such as emergency lights, fire extinguishers and safe water temperature checks had been tested monthly until December 2015. Although records showed that lifting and hoisting equipment and the lift had been regularly serviced, the lift alarm had been regularly checked throughout 2013 but there were no records of checks being carried out since March 2014. Records showed the last checks of the nurse call system had taken place during May 2013. We asked the registered manager whether there were any further up to date records, but were told this was not the case. This meant the registered manager had not ensured safety checks had been carried out and this could mean the premises and some equipment were not safe. The registered manager advised they were in the process of recruiting a new maintenance person. We advised the registered manager ensured checks took place in the interim period.

It is important that registered managers and registered providers have systems in place for regular audits so they can monitor and improve the safety and quality of service and mitigate risks relating to health, safety and welfare of people. The above examples demonstrated that systems and processes, such as regular audits, were not in place. This further demonstrated a breach of the Health and Social Care Act 2008 (Regulated Activities) 2014, regulation 17 (2)(a)(b)(f).

There was a 'home cleaning schedule – daily record'. However, it was difficult to determine whether all the cleaning and checks that should have been completed had been completed because there were two different record sheets. Some of the areas which required cleaning were included on both record sheets. The registered manager explained one of the sheets had been devised for night staff to complete but the record did not indicate this and, in any case, was not fully completed. This made it difficult to determine whether all areas were being cleaned as they should be. We highlighted this to the registered manager who agreed to give this further consideration.

There was a lack of information regarding people's care needs, such as care plans and risk assessments for example. The registered manager had not identified the risks associated with this. Registered managers have a duty to maintain complete and contemporaneous records in respect of service users. We found records to be incomplete and, in some cases, lacking altogether for example in areas such as care plans, risk assessments and hand-over records. This demonstrated a breach of the Health and Social Care Act 2008

(Regulated Activities) 2014, regulation 17 (2)(c).

During the inspection, we found the registered manager to be receptive in relation to areas where we raised concern. However, concerns were highlighted at the last inspection in relation to lack of staff supervision, lack of auditing and incomplete records. The registered provider had sent action plans to us to show how these areas would be addressed but we found, at this inspection, the areas had not been addressed.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care did not always meet people's needs or reflect their preferences. Assessment of the needs and preferences of service users was not carried out collaboratively with relevant persons.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to the health and safety of service users were not always assessed. The registered provider did not do all that was reasonably practicable to mitigate risks because they did not assess risk adequately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not established and operated effectively in line with safeguarding procedures.

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	Regulation 17 HSCA RA Regulations 2014 Good governance The quality and safety of services were not assessed and monitored. The health, safety and welfare of services users were not assessed and monitored, in order for risks to be mitigated. Contemporaneous records in respect of each service user's care and treatment were not completed. Feedback from relevant persons was not sought, recorded and acted upon. The registered manager and registered provider did not evaluate and improve their practice.

The enforcement action we took:

Warning notice to be complied with by 29 April 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed to meet people's care needs. Staff did not receive appropriate on-going or periodic supervision in their role to make sure competence was maintained.

The enforcement action we took:

Warning notice to be complied with by 29 April 2016.