Parkfields nursing home Ltd

Parkfields nursing home

Inspection report

556-558 Wolverhampton Road East
Parkfields
Wolverhampton
WV4 6AA
Tel: 01902 621721
email: parkfield_home@btconnect.com

Date of inspection visit: 4 and 9 December 2014
Date of publication: 05/05/2015

Ratings

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

Overall summary

Parkfields Nursing Home provides care and treatment for up to 49 older people that may have a physical disability. The home provides nursing care, which means qualified nursing staff are always available.

The service is overseen by a registered manager. 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.

At the last inspection on 2 April 2014 we asked the provider to make improvements. This was due to concerns in respect of how people were respected and involved in their care, provision of food and drink, staffing and assessing and monitoring the quality of service provision. We received an action plan from the provider who told us that all the improvements would be made by 31 July 2014.

We inspected Parkfields Nursing Home on 4 and 9 December 2014. The inspection was unannounced.

Summary of findings

The action to address our concerns about people having a choice of, and sufficient food and drink was completed. People were able to have a choice of foods and access to drinks. Where people needed specialist diets these were available, as were meals that reflected people's cultural preferences.

We saw and heard from people that staff provided care in a kind and compassionate way and promoted people's privacy, dignity and independence. However, this approach was not consistent and some staff did not show people respect, dignity or offer choices.

There were occasions where we found there was an impact on the times care was provided, for example with meals and medication, this due to how staff were deployed. Most people thought there was enough staff although some mentioned having to wait for assistance. We found that the systems to ensure enough staff were deployed to allow a consistent response to people's care needed improvement.

We found that a number of weaknesses in the home's quality monitoring systems. For example, audits had not always identified areas where the service needed to improve and there were concerns we had previously identified the home had not fully addressed.

People were supported by external healthcare professionals, when required, such as district nurses and doctors, although some people had not seen a dentist recently. We had concerns that not everyone's health care needs were met as planned as we saw some people with fragile skin were not always repositioning in accordance with their risk assessments. This presented a potential risk to their health.

Most people told us they felt safe at the home, although we heard one person told us they were not. We reported these concerns to the local safeguarding authority. Systems for ensuring allegations of abuse were reported to the appropriate statutory agencies, to ensure they were fully investigated were not robust. An allegation of abuse that involved harm to a person was not reported to Wolverhampton City Council by the registered manager.

We found that people were not always protected against the risks associated with safe management of medicines. For example, we found medicines were not always available to treat people's diagnosed health conditions, there were gaps in some people's medicine administration records and medicines were not stored safely.

Staff were aware of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLs), which help to support the rights of people who lack the capacity to make their own decisions or whose activities have been restricted in some way in order to keep them safe. We saw that applications for a DoLs for had been made where this was appropriate.

We saw that a number of people had the opportunity to participate in recreation and occupation, with some commenting positively about this. The views of some visitors indicated that people did not always receive stimulation and we saw for example that some people, who stayed in their rooms, received limited support in this area.

The home had a complaints procedure, which showed that one complaint had been received since January 2014. Some people and relatives told us they were not aware of how to complain. The registered manager did not have a clear knowledge of the escalation route if a complainant was dissatisfied with the provider's response to their complaints.

Not everyone felt they were asked their views about the service. We found there was limited evidence of people completing surveys or questionnaires about their views of the service, although some people were aware of meetings that took place in the home.

There was a continuing breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations in respect of assessing and monitoring the quality of service provision. We also found further breaches in respect of safeguarding service users from abuse, management of medicines and the care and welfare of service users. This meant that the law about how people should be cared for was not met. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service is not safe

Systems for reporting allegations of abuse to the local safeguarding team were not effective.

People were not protected from the risk of poor management of their medicines.

Staff were not always appropriately deployed to allow consistent responses to people's changing needs.

Is the service effective?

Requires Improvement

The service is not effective

Staff were aware of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and applications had been made following the input of visiting professionals.

We found that people's health and well-being was usually supported by external healthcare professionals.

We were not always assured that steps were always taken to protect people who had fragile skin which may be at risk of breakdown.

Is the service caring?

Requires Improvement

The service is not always caring

The way care was provided was inconsistent. Some staff provided care that considered the person foremost and others provided care that did not consider the person's dignity, and was task and not person focussed.

Is the service responsive?

Requires Improvement

The service was not always responsive

People's involvement in planning their care was inconsistent, some feeling they were always involved, and others feeling their views were never sought.

Some people had access to stimulation they enjoyed, but there was limited stimulation for people that were more isolated due to their dependency.

People did not always know how to raise complaints or to who.

Is the service well-led?

Requires Improvement

The service is not well-led

The service's systems to assess the quality of the service provided in the home were not always effective.

Summary of findings

The systems used had not ensured that people were always protected against the risk of receiving inappropriate or unsafe care and support.

Systems were not in place to ensure that breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations were addressed.

Parkfields nursing 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.

This inspection took place on 4 December 2014 and was unannounced. One inspector returned to complete the inspection on the 9 December 2014.

The inspection team consisted of four inspectors, one pharmacy inspector and included an expert-by-experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. We had received information from local statutory bodies (for example the local safeguarding authority) who provided information about safeguarding allegations and concerns they had received about the service. We considered this information when we planned the inspection of the service.

We saw how staff interacted with the people who used the service on a number of occasions during the inspection. We also used the Short Observational Framework for Inspection (SOFI) over lunch time in the dementia care unit. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 15 people who used the service and four relatives. We also spoke with the registered manager, the deputy manager, three nurses and seven care staff. We also spoke with the maintenance person and administrator.

We looked at 11 people's care records to see if these records were accurate, up to date and supported what we were told and saw during the inspection. We looked at three staff recruitment files and records relating to the management of the service, including quality audits and complaint records. Our pharmacist inspector looked at the management of medicines, including the medicine administration records for nine people.

Inadequate

Is the service safe?

Our findings

At our inspection in April 2014, we found there was insufficient staff available. This had impacted on people's care which was not always provided at times that reflected their needs or expressed preferences. The provider sent us an action plan outlining how they would make improvements. They told us that they had employed more care staff and reviewed the staffing to ensure people's needs were met in a timely manner that reflected their preferences.

People told us," If I ask for anything, they [the staff] are usually quite quick" and, "When you ring your call bell they do their best. Their response varies; sometimes it's half an hour before they come". Another person told us "They [staff] don't chat, too busy". A member of staff told us, "We have no time, have to be on the floor all the time".

We saw on the first day of our inspection that staff were very busy. Staff told us a person needed additional help due to their health, there was an absent member of staff and another person had a planned appointment and needed staff to accompany them. These factors impacted on the staff ability to get people up for breakfast at their preferred time and administer medicines when needed. Staff were not as busy on the second day of our inspection, and we saw breakfast and medicines administration was not delayed. We spoke with the registered manager about how they deployed staff to ensure they were able to respond to unplanned changes in people's needs or emergencies. They told us after we raised our concerns that they planned to employ additional staff in the mornings. They said this would ensure they could be more flexible when they responded to people's needs, this to be reviewed after a trial period. This showed that our concerns from our inspection in April 2014 had not been addressed, and systems to ensure there was consistently sufficient staff available could be more robust.

One person told us, "If I didn't feel safe I wouldn't be here". Another person said, "I've never had any trouble with anybody, never felt unsafe". A relative told us, "[The person] is very safe here". A second relative said," I feel they are quite safe. I know how to raise concerns". Some people told us they were not safe. One person said that, "The staff hurt you; they're very nasty to you. Some are very nice but others are very nasty and hurt you". Another person we spoke with also said some staff were not very nice, although others, "Are not like that at all". One person told us, "I lost my silver watch. I went to the matron but never saw it again". The registered manager confirmed that this watch had not been found, and beyond a quick search they referred to no further action had been taken to establish what had happened to this watch. A relative told us, "When [X] came here, a gold ring, engagement ring, glasses and false teeth went missing. They have never been found. I didn't make an official complaint, I should have done". We reported this to the registered manager who was unaware of this person's possessions being missing. This was a concern as some of the missing items included were those the person may have used on a daily basis, for example false teeth. We reported all the allegations we heard to the local safeguarding authority.

The registered manager said they had received one concern since the last inspection. We saw the record of this concern from April 2014 was an allegation that two members of staff were rough and caused a person an injury. The registered manager said they investigated this allegation as requested by the person's relative. They said they decided to give staff further training and closer supervision. This action was recorded in the concerns book with no more records of the investigation outcomes. We asked the registered manager why they had not reported this allegation to the local safeguarding authority as alleged abuse. The registered manager said, "I know I should have reported it", but we saw they had failed to do so. The registered manager reported this allegation to the local safeguarding authority after we raised our concerns with them. We were informed of a number of recent safeguarding alerts by the local social services prior to our inspection. Some of these were identified by visiting health care professionals' observations of care practices within the service. These areas of potential abuse had not been recognised or reported by the registered manager.

Two staff said they would approach the local safeguarding authority if concerns they identified were not addressed. Most of the staff we spoke with however said they would only raise these concerns with the registered manager, and were not aware of whom to escalate concerns to, despite having had training in safeguarding adults. As the registered manager had not reported or recognised allegations of abuse brought to their attention there was the potential that allegations would not be reported to the local safeguarding authority.

Inadequate

Is the service safe?

These issues demonstrated a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people if they were given their medicines when they needed them. One person told us "Medication is ok, yes". Another person said, "Depends on how busy they [the nurses] are, usually about the usual time". We saw nurses gave some people their medicines without checking to see if they had taken it, or offering support to help them take it. We spoke with some people who confirmed they were using their own inhalers and we found that they had not used these as prescribed. Nurses told us there was no monitoring of inhalers people self-administered. People were not using their preventative inhalers properly so were breathless. This meant they had used reliever inhalers which is not in accordance with British Thorasic Society guidance.

We found people's medical conditions were not always treated appropriately by the use of their medicines. For example in order to ensure good pain control certain analgesics must be administered every 12 hours but we found the service was not ensuring that this requirement was being adhered to. We checked the times medicines were given with staff and the medicines administration records (MARs) and found people had not always received their medicines as prescribed by their doctor. We saw some poor practices during a medicines administration round, which included the administration of some controlled drugs. This included administration records signed before the medicines had been given.

Where people needed to have their medicines administered by disguising them in food or drink, the provider had not ensured that the necessary safeguards were in place to ensure these medicines were administered safely. For example a person was taking antibiotics which needed to be administered on an empty stomach (to ensure effective). There were no systems in place that ensured they were administered correctly. In addition where people needed to have their medicines administered directly into their stomach through a tube, the provider had not ensured that the necessary safeguards were in place to ensure that these medicines were administered safely; for example in a way that ensured there was no potential for drug interactions, side effects or even medical conditions not being treated effectively. We spoke with a nurse who was unclear as to how to administer medicine safely through the tube, so that the medicines were given safely. We checked records for people who had pain relief skin patches applied to their bodies. These records had not demonstrated that the skin patches were being applied safely which meant people that used these medicines may be subjected to unnecessary side effects.

We found the medicine refrigerator temperatures were not being measured correctly. Readings taken on the day of the inspection showed the refrigerator temperature was below an acceptable minimum temperature. This meant that medicines would not remain effective. The temperature of the medicine fridge was identified not to be at a safe temperature by visiting pharmacists in November 2014 which showed there had been no action been taken to ensure the safety of the medicines stored prior to our inspection. We looked at the disposal records for medicines that were no longer required by people using the service. These records did not show that unwanted medicines were disposed of safely.

These issues demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment checks for staff that were recently employed. We found that checks had been carried out prior to the employment of these staff. These included Disclosure and Barring Service checks (DBS). DBS checks enable employers to check the criminal records of employees and potential employees so they can ensure they are suitable to work at the service. Staff we spoke with confirmed they did not commence work until their DBS checks were completed. We found some gaps in staff files which did not explain the absence of references from last employers and gaps in their work history. We did speak to staff and the registered manager who were able to explain these gaps. The registered manager said they would improve how they recorded staff recruitment checks.

Requires Improvement

Is the service effective?

Our findings

During our inspection in April 2014, we were concerned that people did not have a choice of suitable and nutritious food and drink. We asked the provider to send us an action plan outlining how they would make improvements. They told us they would ensure people had a choice for each meal and would get people's feedback on what people thought about food and drink. They also said they would monitor people's food and fluid intake.

People told us, "In the morning I get a choice of breakfast. They ask you at breakfast time what you want for lunch, you get three choices including vegetarian", "I'm satisfied with the food, I like it" and, "I get a choice of breakfast in the morning. They come and ask me what I want for dinner. They put milk in my mash potato especially for me". Other people said," I would rather have my meals here than some of the other places I've been. If I don't want what's on the menu they will do something different" and, "Plenty of drinks, want one just ask for one". We saw there were plenty of jugs of squash around the home and staff supported people with drinking, where needed. Relatives we spoke with told us, "[The person] likes the food; [the person] is able to choose what they want" and, "I've seen the food, it looks fine". We saw that staff came round and asked people about their choice for lunch, and people were offered a variety of foods. This showed some people were able to make choices about the food they had. We looked at records of people's fluid intake. These showed people's fluid intake matched assessments undertaken of the amount people needed every day.

We spoke with the cook and they were aware of the people's dietary requirements, for example those people that required fortified foods (containing for example butter and cream).They told us that a Speech Therapist had advised them about those people that needed a pureed diet. They said Caribbean meals were available and a person we spoke with confirmed they had some of these meals and was happy with them.

On the first day of our inspection we saw that breakfast was delayed for some people. We saw lunch was not offered at a later time to compensate for the late breakfast. Some people had less than three hours between these two meals and may not have been hungry at lunchtime although we spoke with one person who said they always had breakfast at 7.30am. We saw afternoon tea was served at 4.30pm. This showed that although people had supper there would have been up to 16 hours between main meals. We saw breakfast was available earlier on the second day of our inspection however and people we spoke with did not express any concerns about the times of meals.

This showed the provider had addressed the specific concerns that we raised at our inspection in April 2014.

We were informed by local health commissioners about how the service had managed some people's pressure ulcers recently. They had identified that some people's pressure ulcers had been avoidable, and the way care was provided by the service had contributed to these. The registered manager told us about actions they had taken to improve in this area based on the recommendations from health care professionals. We were told these improvements included the provision of appropriate equipment, training for nurses in management of pressure ulcers, improved documentation and on-going liaison with external tissue viability specialists. The registered manager told us there was no-one using the service with a pressure ulcer at the time of our inspection. They said there was one person who had fragile skin and a broken area of skin caused by moisture. This person's records showed us that there were regular checks on the condition of their skin and staff told us how they would identify if the person's skin was at risk of breakdown. We saw records of this person's regular repositioning to relieve the pressure on their skin. We saw equipment was in place to protect their skin. We spoke with a nurse who said there was a person who had a pressure ulcer that the registered manager had not identified. We spoke with this person and they told us that they were able to relieve the pressure and reposition independently, but staff did remind them to do this at frequent intervals. They told us any pain was controlled and we saw that they had access to appropriate equipment, for example an air mattress.

The nurses we spoke with told us that people identified at high risk of skin breakdown would be repositioned two hourly. We saw one person identified at high risk of skin breakdown by the registered manager was not moved into a different position for over two hours. The person's repositioning charts stated they should be moved two hourly. We checked this repositioning chart and found this showed no record of staff repositioning the person since the previous day. We looked at another person's care records the registered manager identified at high risk of

Is the service effective?

skin breakdown. Their care records also stated they were at high risk of skin breakdown. There was no care plan in place in respect of how the health of their skin would be promoted to inform staff. We saw records that showed the person was repositioned frequently. We saw pressure relieving equipment was in place. However, we saw this person sitting in a day room for three hours without having any change of position. Without intervention to change position, this could have caused the person's skin to breakdown.

These issues demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people we spoke with told us that the service was supportive of their healthcare needs. One person told us, "I have my own doctor. If I'm poorly I get the staff to call him. They have always come the same day. The optician comes regularly every three months. The chiropodist is due on the 12th December. Dentists have never been mentioned". Another person told us, "I saw the doctor ages ago, I didn't have to wait long to see him. I had my glasses checked a while ago, not seen a dentist. They do my feet quite often". We spoke with one person who told us they were having on-going dental work. However, people's care files did not have records of their regular dental checks. We spoke with relatives and they told us people were referred to health professionals when needed. One told us, "I pointed out my sister's foot problem, they called the doctor. [The person] is having an eye assessment next week".

People told us they were not restricted. One person said, "I can do anything I want. I get up and go to bed when I want" another that, "I can do what I want, they don't restrict me. I can't think of anything that I have been asked to give my consent". A relative told us, "[The person] can do what she likes here; they don't restrict [the person] in any way". We saw some people had bed rails fitted to prevent them falling from bed. We spoke with two people who used them and they said they had consented to the use of these bedrails. Where people were unable to consent to these bedrails we saw that consent forms had been completed and on occasion the signature of the person's representatives obtained. There was no record to show that the relative was able to legally consent for the person however, or evidence that a best interests decision had been made with the appropriate persons.

We spoke with staff about their understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. DoLS are safeguards used to protect people where their liberty may be restricted to promote their safety. Staff were able to describe what restrictions may look like, for example they said for one person it could be the locked front door. We did not see the person expressing a wish to leave the home during the inspection however, and staff said that they would offer them the opportunity to go out, at which point they usually decided not to. Staff we spoke with told us that people should have their rights and choices promoted, although our observations showed some staff did not uphold people's rights, for example asking for their consent when providing care. Staff told us there were two people currently under a DoLS and the registered manager confirmed that a formal application for these had been submitted to the local social services. We were made aware before this inspection that a professional visitor had identified there was a person who was potentially restricted and it was following this that the registered manager submitted a DoLS application.

Requires Improvement

Is the service caring?

Our findings

At our inspection in April 2014, we were concerned about staff not ensuring the dignity, privacy and independence of people. We asked the provider to send us an action plan outlining how they would make improvements. They told us they would make improvements to ensure that this concern was addressed, for example staff would have training on dignity in care

One person told us that, "They [staff] are very kind and caring". Another person told us, "Yes, they do provide good care". A third person told us, "All the staff are nice, I've never been shouted at". A relative told us that "Her care seems alright, they are quite kind. They have a laugh and a joke with them. Quite caring, I think so. I have never seen anything different". However, one person told us, "The staff are not nice to you in every way. I wished I'd never come here, I hate it here, I hate it". We saw when talking to this person that their finger nails were long and dirty. We shared their concerns with the local safeguarding authority. We also saw some people's hair was untidy showing time had not been taken to help them with their presentation and promote their dignity. One relative told us, "The care is better now after I spoke to [staff]; it was mainly her nails and hair". Another relative told us, "Her nails are a bit long and her hair doesn't look brushed to me".

We saw the staff providing people with care and support. We saw some occasions where people were supported and assisted in a caring manner, for example, we saw people helped to move from wheelchair to a static chair on more than one occasion. Staff explained what they were doing and talked the person through the process step by step. We saw staff used privacy screens so the other people could not see them transferred. We saw other occasions where staff did not talk to people when they provided care with no discussion, no choice provided and no time spent checking the person was content, for example, we saw staff helped someone to eat without talking to them. We saw that they wiped the person's mouth and removed their clothes protector without any discussion, or asking for their permission to complete these tasks. This contrasted with other occasions where we saw people were helped with their meals in a way that promoted their dignity when staff explained what the meal was, fed people at their pace and took time to give them drinks with their consent. We saw some staff talk kindly to people when helping them eat for example saying, "Tell me when you have had enough, you are doing very well today". This showed that the approach of staff in promoting people's dignity and choice was inconsistent.

We saw occasions where staff spoke over people as opposed to addressing them directly. We heard one staff member refer to people that needed assistance with their meal as, "Feeders" as opposed to a more dignified form of reference that described the individual as needing assistance with their meals. We saw that staff began setting up activities after lunch before people had finished eating. We also saw occasions where nurses gave medicines without any discussion and no offer of choices as to whether they wanted the medicine. We discussed these issues with the registered manager who told us they thought staff required further training on, "Customer care".

One person told us, "The food is quite rushed in the day". We saw the main meal served in the dining room was very noisy with loud background noise coming from the kitchen. We heard staff talking loudly and a lot of noise from kitchen implements. We heard staff shouting across the room to other staff while people were eating. We did not see much discussion or signs that indicated people were happy. We saw that all meals and drinks were served in 10 minutes and the meal presented as a task with little thought given to how it could be a more enjoyable and dignified experience that promoted people's enjoyment of their meal.

People we spoke with told us that they were able to be independent when they wished. One person told us, "I use my frame and go to the toilet on my own. Sometimes I struggle and I use the call bell, they come straight away". Another person said, "I have my own freedom, go to the shop, go downstairs". We saw where people were able they could move freely around the service.

We spoke with staff and they were able to tell us of ways in which they would promote people's dignity and privacy. Some staff told us that they had received training in dignity in care. Staff were able to give examples of good care and were aware of how to ensure people's cultural values were promoted. For instance, they were aware of the importance of ensuring some people wore head coverings, as we saw had happened.

We saw that there was some staff that provided care in a kind and compassionate way and promoted people's

Requires Improvement

Is the service caring?

privacy, dignity and independence. However there was still scope for the provider to ensure that all staff were consistent in their approach to ensure people were always well cared for.

Requires Improvement

Is the service responsive?

Our findings

Some people told us that they were able to share their views and received care in a way they were happy with. One person said the staff, "Communicate very clearly". Another person said, "I have control over my life, I wouldn't have it any other way". A relative we spoke with told us a person had some falls, and the home had been quick to inform them.

People told us about their involvement with planning their care. One person told us, "They review my care regularly". We spoke with visiting relatives and one told us, "There are normally reviews with Wolverhampton Social Services; I had it in the office about three to four months ago [the deputy manager] was there. (The person's) weight was a concern". Another said, "Her family were involved with her care arrangements when she came here". Other people told us they were not involved. One person told us, "They don't involve me in my care, they just look after me". Another person told us, "Involve me in my care? They don't do that, they just give it to me". A third person said, "The care is automatic; they don't talk about my care". Another visitor said, "When she first came in we discussed her care. I didn't sign anything, I don't have a copy". This indicated people, or their representatives were not consistently involved in planning their care. The majority of people we spoke with had said they were satisfied with how their care was provided however.

We found that recording in people's assessments and care plans we checked was inconsistent and while some assessments and records did reflect things that people told us were important to them, others did not. For example we found that there were gaps where significant needs identified in assessments had not led to a care plan that would show how preventative care was to be provided by staff. We asked staff about what they knew about people where there were gaps in records and they were able to tell us some information about the person's individual needs.

People and visitors told us that there were open visiting times, and we saw a number of people's relatives and friends visited during our inspection. One relative told us, "I can come when I like, I come regularly" One person did tell us that they were unable to maintain contact with their relatives however as they staff were unable to bring a telephone to their bedroom. They showed us they had a mobile phone but were unable to use this as they had no charger. Neither the registered manager nor staff were aware of the person's wishes regarding access to a telephone and this had not been recognised when their care was planned, with no reference to this in their care plan. The registered manager told us they would get the person a charger for their phone.

We asked people about opportunities that were available for stimulation and occupation. Some people told us about participation in sessions they enjoyed, although other people felt they received little stimulation. One person told us, "I like to join in with the activities" and, "There are four activities a week, Exercise Man on Monday, Craft work Wednesday, bingo Thursday, Friday is 'Play Your Cards right', 12 of us play usually. No activities at the weekend." Another person told us "This ball game; everyone plays it. I like playing it. I watch telly and put the radio on". We saw staff involving 11 people in throwing a large soft ball around to people for 10 minutes. Other people told us, "If there is any activity, I do it, I like all kinds. I like bingo, can't think of anything else". Another person said, "I just sit here, don't do anything else". A relative told us, "I don't think (the person) is stimulated here. I have never seen one to ones; only the ball game". Another relative said: "I have never seen anyone sit with residents". A third relative said There's no stimulation; I don't think there is any. She just goes into her room and just sleeps". We saw there was limited stimulation for people outside of the set sessions people told us about beyond the television and radio. We saw staff organised sessions in the mornings and afternoons.

We saw that there were a number of people that remained in their rooms and some of these people told us, "I watch TV, happy with this". Another person said they had their TV and radio and that, "No one interferes with you", which met with their expressed wishes. These people said it was their choice to remain in their rooms. We were not always able to ask the views of all the people that remained in their rooms but did see that for some people there was little stimulation, for example music playing in the background. We asked the registered manager how they provided stimulation for people who needed bed rest and they said the activities co-ordinator, visited these people in addition to organising the set activity. However the activities co-ordinator only visited the home for an hour in the afternoon of every weekday. We saw their time was taken organising the set 'activity' sessions during our inspection. We saw other more dependent people sitting, or lying in bed without stimulation for long periods.

Requires Improvement

Is the service responsive?

We saw the home's complaint procedure was displayed on the wall in the reception hall and the dining room. We saw this required updating to reflect the name of the current regulator (CQC as opposed to one of our predecessor organisations) and our complaints remit. The procedure was available in different languages in a folder held in the reception area.

We asked people if they were able to raise concerns or complaints. One person told us, "There is a complaints procedure book on the table in reception, it's in different languages". Another person said, "I have no complaints, I suppose I would speak to someone, I don't know who". Relatives we spoke with were unclear as to the service's complaints procedure. One relative told us, "The complaints procedure was never explained to me. It might have been in her folder" and another that, "No-one has told me how to raise concerns; no-one has said anything to me". People said they would speak to staff if concerned but were unsure as to the service's complaints procedure. The service's complaints log showed the home had received one complaint in just less than three years. The registered manager confirmed this record was accurate. We saw that the last complaint in April 2014 was investigated, action taken with the outcome that an apology was provided to the complainant. This showed that complaints were not routinely received by the service, this indicative of some people not knowing how to complain.

Requires Improvement

Is the service well-led?

Our findings

At our inspection in April 2014, we were concerned that the registered person was not protecting people against the risks of inappropriate or unsafe care and treatment: This by using an effective system to monitor the quality of the service. The provider sent us an action plan outlining how they would make improvements. They told us that they would introduce systems to ensure the quality of the service improved and was continually monitored.

There was a registered manager in place who oversaw the day to day running of the home. They were supported by a deputy manager and a team of nurses. People had mixed views about who the registered manager was. One person said, "[A nurse] is the manager, I see her around the home. She is quite visible; I think she is well respected". Another person told us they thought the deputy manager was the registered manager. One person said, "I didn't know we've got a manager". There were other people who were not always sure who to raise comments with, or in one instance were not confident in doing so. One person did tell us however, "Yes it is well run, I'm very happy".

The service had some means of involving people in the running of the service, such as meetings, but people's involvement was minimal and their involvement was not encouraged. One person told us, "We have meetings every six months about twenty attend. April was the last meeting. The manager or senior nurse runs it. Minutes are not published. Nothing needed to be done from the last meeting, there were no action points. Haven't seen a survey form". Another person told us, "I have been to a meeting, I enjoy them. Not seen a questionnaire". A relative told us, "They never ask me my views". Other people did not know about the meetings. One person told us, "I don't know about resident's meetings, never noticed a sign on the door. Never been asked to do a survey". Another person said, "I've never heard of resident's meetings, I've never heard of that". A third person said, "No, I haven't been asked about anything". We did see a record from one meeting held in early December 2015 chaired by the deputy manager. Brief actions for improvement were identified by the registered manager, based on five survey forms people completed after our first day of inspection. We had identified these issues and raised them with the registered manager on the first day of our inspection, prior to this survey.

We asked the registered manager how they maintained an overview of the service so that they were aware of key areas where improvement may be needed. The registered manager said that it was, "Not a finished process". We saw there were some audits, for example an analysis of accidents between July 2013 and January 2014 that had identified actions to take, although there was no update of this up to the time of our inspection. We also saw a pressure ulcer risk audit completed in early November 2014. This had again identified actions for improvement. One of these actions was that meetings were to be held with staff to discuss improving documentation so that pressure areas were identified and monitored. A staff meeting had not taken place since this date, the last one in October 2014 (where concerns about documentation not been completed had been raised). In addition we identified that audits had not ensured medicines were managed so that people had their medicines as needed, and safely.

We asked the registered manager to identify those people who were at risk due to their fragile skin and malnutrition and they identified some people at risk. From discussion with staff, our observations and records we found there were people the registered manager had not identified were at risk. For example, we identified from care records one person had lost weight each month from August 2014. There was no formal assessment in this person's notes of the risk of malnutrition; although other assessments of this person's health needs showed that this would have been appropriate. We asked the registered manager and they were not able to show us systems they had in place that would help them identify and monitor people who were at greater risk due to fragile skin and weight loss at the time of our inspection. They showed us blank forms that they were yet to complete in respect of people at risk of poor skin integrity or malnutrition. They told us these would be in people's individual care records, although they were not able to identify all those people.

Some action plans developed by the manager were very brief, for example following a review of five questionnaires from people there were some areas they identified where they felt the service could be better. The actions identified carried little detail, no analysis and did not show that there was a robust response that would ensure people's comments were addressed. The registered manager was unable to show us a detailed development plan for the service, this despite having recent written input from commissioners that identified areas where the service

Requires Improvement

Is the service well-led?

needed to improve. The registered manager was not always able to demonstrate to us how they promoted learning from events and concerns that had been identified by other statutory agencies to improve the service.

The provider carried out a visit to the home on 2 December 2014 and had also identified some areas that needed improvement, for example the information in people's care plans was not always clear. Commissioners had also raised similar concerns about the quality of care plans at their last visit in November 2014. This meant the findings of other agencies and the provider had not been used effectively by the registered manger to improve the service's record keeping. We spoke with one nurse who was concerned about guidance in how to complete people's care plans. When asked they said they had received no care plan training and spoke of conflicting guidance as to what the expectations of them were when completing people's records. We saw that staff had received training in some areas before the inspection that included developing knowledge around areas other agencies had raised concerns about, for example medication and care for people with fragile skin and pressure ulcers.

We saw that the registered manager had introduced a simplistic staffing tool since our inspection in April 2014 but this did not consider factors such as the impact of the environment, the number of people remaining in their bedrooms (of which we saw there were several) and people who may require additional input due to repositioning for example. When asked, the registered manager was unclear how they calculated people's dependency levels as identified in their staffing calculation. This indicated that systems for calculating staffing tool based on people's dependency had not considered factors that impacted on the number of staff needed, and when, this so there was no detriment to the quality of the service people received. This was important as some people had said they had to wait for assistance on occasion.

We spoke with staff who told us they felt well supported by the registered manager, and records showed they had received supervision on a regular basis. The registered manager when asked was unable to show us how they planned staff supervision however, as records only showed supervision sessions staff had undertaken, and not those that were planned. This showed a lack of forward planning that would help ensure staff continued to receive on-going support on a planned and timely basis.

Despite our previous inspections identifying areas where the service needed to improve, and recommendations made by commissioners, the provider had failed to put effective systems in place to assure the safety and quality of the service provided to people. These issues demonstrated a continuing 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.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 - Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment. (1) The registered person must make suitable arrangements to ensure that service users are safeguarded against the risk of abuse by means of— (a) taking reasonable steps to identify the possibility of abuse and prevent it before it occurs; and (b) Responding appropriately to any allegation of abuse. We were not assured that the provider or registered manager would take appropriate steps to, or ensure that allegations of abuse were reported to the appropriate safeguarding authority. This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 - Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.

This section is primarily information for the provider

Action we have told the provider to take

Medicines were not managed in a way that ensured people were protected.

This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 - Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person - centred care. The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of— The planning and delivery of care and, where appropriate, treatment in such a way as to— (i) Meet the service user's individual needs, (ii) Ensure the welfare and safety of the service user. People's care was not always planned and delivered in a way that ensured they were protected against the risk presented by poor health.This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision 10.(1) The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to— (a) Regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and (b) Identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. (2) For the purposes of paragraph (1), the registered person must— (a) Where appropriate, obtain relevant professional advice; (b) Have regard to— (i) The complaints and comments made, and views (including the descriptions of their experiences of care and treatment) expressed, by service users, and those acting on their behalf, pursuant to sub-paragraph (e) and regulation 19, (ii) Any investigation carried out by the registered person in relation to the conduct of a person employed for the purpose of carrying on the regulated activity, (iii) The information contained in the records referred to in regulation 20, (iv) Appropriate professional and expert advice (including any advice obtained pursuant to sub-paragraph (a),

This section is primarily information for the provider

Enforcement actions

(v) Reports prepared by the Commission from time to time relating to the

registered person's compliance with the provisions of these Regulations, and

(c) Where necessary, make changes to the treatment or care provided in order to reflect information, of which it is reasonable to expect that a registered person should be aware,

Relating to—

(i) The analysis of incidents that resulted in, or had the potential to result in,

harm to a service user , and

(d) Establish mechanisms for ensuring that—

(i) Decisions in relation to the provision of care and treatment for service

users are taken at the appropriate level and by the appropriate person (P), and

(ii) P is subject to an appropriate obligation to answer for a decision made

by P, in relation to the provision of care and treatment for a service user , to the

person responsible for supervising or managing P in relation to that decision; and

(e) Regularly seek the views (including the descriptions of their experiences of care and treatment) of service users, persons acting on their behalf and persons who are employed for the purposes of the carrying on of the regulated activity, to enable the registered person to come to an informed view in relation to the standard of care and treatment provided to service user.

The enforcement action we took:

We have served a warning notice on the provider telling they are failing to comply with Regulation 10 of the Health and Social Care Act 2008 (Regulated activities) 2010. We have told them they are required to become compliant with 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 [Regulated Activities] 2014) by 21 April 2015.