Avens Care Homes Limited

Prestbury Court Residential Home

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection on 25 and 27 March 2015. We had decided to bring forward a planned inspection because of concerns raised with the Care Quality Commission (CQC) about staffing levels and the provision of care at the home.

Prestbury Court residential home is registered to provide accommodation for up to 48 people. The service is intended for older people, who may have needs due to dementia or other mental health needs. The provider had recently had a new extension built which has added five further bedrooms with en-suite facilities at the home. At the time of our inspection there were 30 people living at Prestbury Court with one person staying for a short period of respite support.

There was a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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.

We last inspected the home in June 2014 and found no breaches in the regulations we looked at.

At this inspection where people did not have the capacity to consent or make decisions, the provider had not acted in accordance the Mental Capacity Act (2005) and Deprivation of Liberty safeguards. There were no mental capacity assessments for people who lacked capacity. There was no records of 'best interest' decision making to show how people, relatives and other professionals were consulted and involved in decision making about people's care and treatment.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). Applications had been made to deprive people of their liberty using the least restrictive options and the registered manager was undertaking assessments of other people at the home to consider whether any further applications were required.

People were at risk of being socially isolated. Activities were provided at the home but there were long periods of time when meaningful activities were not happening and people isolated in their rooms were not able to access the activities at the home.

People received most of their prescribed medicines on time and in a safe way. However, some improvements were needed in management of topical creams and ointments.

Staff recruitment processes were not robust. The provider had not always undertaken assessments and checks to ensure staff were of good character before they were working unsupervised at the home.

Staff had not received an effectively managed induction process to ensure they had the skills needed to meet people's needs. Improvements in staff training were needed to ensure staff were supported to acquire and maintain skills and knowledge to meet people's needs effectively and safely. Records showed only a third of the staff had received training in manual handling, safeguarding vulnerable adults and Mental Capacity Act (2005) and Deprivation of Liberty safeguards. Staff had received formal supervision and appraisals and had the opportunity to attend monthly staff meetings, so they had the opportunity to express their views and concerns.

Staff were aware of the signs of abuse and knew how to report concerns internally and were confident these would be investigated. Only a third of the staff had been trained in safeguarding vulnerable adults and some were not able to tell us about external agencies they could report concerns of abuse to.

Staffing levels at the home had been reduced due to residential occupancy levels. Staff had found it difficult to adjust to the new staffing levels. The registered manager agreed to look into concerns raised by staff about senior staff not being allocated care duties each morning. This had meant staff had found it difficult to complete care tasks promptly and people were having a late breakfast.

Staff working at the home knew people's needs and preferences well and people and relatives said staff were caring and kind. On the whole there were friendly and respectful interactions between staff and people. People were supported to have suitable and sufficient food and drink.

Quality assurance and audit processes were in place to help monitor the quality of the service provided. The provider had an audit sent to them each month undertaken by the registered manager which was the means they used to keep them informed of how the service was operating and a registered manager from another one of the provider's homes to support the registered manger. However The audit had not recognised or dealt with the identified shortfalls found at this inspection because the systems used to populate the audit were not systematic and thorough.

Improvements were required to ensure systems and processes were in place to protect people's rights, to ensure they were supported by staff who had received appropriate training and to make care more personalised and accurate to people's individual needs. The provider annually sought the views of people using the service and their relatives and friends by being asked to complete a quality assurance questionnaire for their views on the service.

Summary of findings

The premises were well managed to keep people safe. The maintenance at the home was overseen directly by the providers. There were emergency procedures and evacuation plans in place to protect people in the event of a fire or emergency.

We found six breaches of Regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the back 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?

Requires improvement

Some aspects of the service were not safe.

Recruitment procedures at the service were not robust and did not ensure staff were of good character and had the required recruitment checks in place.

Staff were aware of the signs of abuse and would report concerns internally and were confident these would be investigated. However not all staff had received training and were not aware of outside agencies they could report concerns of abuse to.

Medicines were managed safely. However improvements were needed in the management of prescribed topical creams and ointments.

People were supported by having enough staff on duty to meet their needs. Although the changes of staffing levels and the allocation of duties were adding additional pressures on some staff.

Individual evacuation plans were in place to protect people. The premises were well managed to keep people safe.

Is the service effective?

Requires improvement

Some aspects of the service were not effective.

Staff did not have all the knowledge and skills they needed to support people's care and treatment needs. Staff had not received effective inductions and had not had the opportunity to develop their training needs.

People's rights were not protected. This was because staff did not understand and were not acting in accordance with the principles of the Mental Capacity Act 2005 and Deprivation of Liberty safeguards.

Staff had received regular supervision and appraisals and had the opportunity to discuss their ideas and concerns.

People were supported to eat and drink and had adequate nutrition to meet their needs.

People living at the home had access to healthcare services. The district nurse team visited the home regularly to provide nursing support.

Is the service caring?

Requires improvement

The service was generally caring.

People were treated with kindness and compassion and their privacy and dignity were respected. The majority of staff were caring, friendly and spoke pleasantly to people. However some aspects of people's care was not kept confidential and did not promote their confidentiality.

Summary of findings

Staff knew people well, visitors were encouraged and welcomed.

Is the service responsive?

Requires improvement

Some aspects of the service were not responsive.

People were not consistently receiving support that was responsive to their needs. People's care needs were not always regularly reviewed, assessed and recorded. People could not be assured their care needs would be recognised promptly and might not receive care when they needed it.

People were at risk of social isolation. People who stayed in their bedrooms were not being actively supported to take part in social activities.

The complaints procedure had been removed at the time of the inspection. However people were aware of the complaints procedure and complaints received were addressed appropriately.

Is the service well-led?

Inadequate

Some aspects of the service were not well led.

The quality assurance systems were not effective. The provider had a monthly audit carried out by the registered manager as their main means of information about the safe running of the service. Although the systems were in place to provide quality checks, these had not picked up on all areas of concern.

The registered manager understood their responsibilities, and had support from the provider and provider's representative.

Quality assurance questionnaires were sent out annually to ask people and their relatives their views on the service. However there were no other methods used to regularly find out their views to help develop the service.

There were no effective systems to monitor and review people's care records were completed, accurate, regularly reviewed and reflective of people's needs.

Prestbury Court Residential Home

Detailed findings

Background to this inspection

We carried out this comprehensive inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

We reviewed information we had about the service such as previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern. We contacted commissioners of the service and three external health professionals to obtain feedback about the care provided. We had requested a Provider Information Return (PIR) from the provider. 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. Because we had made the decision to bring forward this inspection due to concerns raised with us about the service the PIR was submitted after the inspection. We have reviewed this information and included some details within this report.

The inspection was carried out by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of caring for someone who uses this type of care service; they had experience of services for older people with dementia.

We met most of the people who lived at the home and received feedback from ten people using the service and four relatives. A number of people living at the service were unable to communicate their experience of living at the home in detail as they were living with dementia. We used the Short Observational Framework for Inspection (SOFI). 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 nine staff, which included care and support staff, the registered manager and a registered manager from one of the provider's other homes. We looked in detail at the care provided to five people, which included looking at their care records. We looked at four staff records and at staff training and supervision records. We also looked at a range of quality monitoring information.

Requires improvement

Is the service safe?

Our findings

People who were able to tell us said they felt safe at the home. Comments included, "They (staff) all do their best, I am quite happy here" and "It takes a while sometimes for them to get to me, but they do and then everything is alright". Visitors said they had no concerns about the safety of people they visited. Comments included, "I am very impressed with the care here" and "I feel it is pretty good, the girls are all good".

The arrangements for recruiting staff did not adequately protect people using the service. The registered manager had not ensured all new staff had a current disclosure and barring service (DBS) check to help ensure staff were safe to work with vulnerable adults. This meant people were exposed to risk because those staff were working unsupervised at the home, but had not yet had their recruitment checks fully completed.

Where staff did have a DBS check which highlighted criminal activity there was no evidence to show the registered manager had considered the risk to people at the home before employing the new staff member. Each folder contained two appropriate references and an employment history without any breaks in employment. Two folders did not contain a current photograph of the employee; however there were photographs of all staff in the main entrance to identify them to visitors and people living at the home.

The provider had a recruitment procedure and policy in place. However this had not been followed. This is a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulations 19 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Staff had an awareness of the signs of abuse and said they would report any concerns internally. The home's training matrix showed 31% of staff were up to date with safeguarding vulnerable adults training. Staff said they felt confident any concerns reported internally would be investigated. However one staff member said, "I would contact the owners but don't know their details". Three staff did not know about outside agencies they could report any concerns to if they witnessed abuse. We discussed this with the registered manager who confirmed the provider's information and outside agencies were recorded on the complaints procedure.

The provider had not ensured systems and processes were in place to protect people from abuse. This a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulations 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People received their medicines safely and on time with the exception of prescribed topical creams. Staff received training in the safe administration of medicines. Medicine administration records (MAR) confirmed oral medicines had been administered as prescribed. However, the arrangements for the application of creams did not ensure people would receive them as prescribed. For example, medication records and the cream charts did not include clear guidance for staff about the application and frequency for creams to be applied. Staff gave us a mixed response about which creams people required. Two staff were able to tell us which creams were used by one person and two staff could not. Records of creams applied were not always completed. This meant we could not be sure if prescribed creams had been applied as prescribed or whether staff had forgotten to record their use.

Medicines were locked away in accordance with the legislation and medicines which required refrigeration were stored at the recommended temperature. The pharmacist supplying medicines to the home had undertaken a medication review the week before our visit. Following our inspection the registered manager sent us a copy of their audit, which did not identify any other concerns.

The registered manager said they had reduced the staffing levels because there were 17 residential vacancies at the home. Records of rotas for four weeks from 9 March 2015 to 5 April 2015, confirmed staffing levels identified by the registered manager. These were during the day a deputy manager, supported by a senior care worker and four care staff and three care staff on duty at night. One person living at the home said, "The biggest problem is they say 'I'll be there in a minute' and they're gone half an hour at least'. A visitor said they had noticed it was taking longer for their wife to be got up in the mornings.

Requires improvement

Is the service safe?

Staff said at times they were "stretched", with the staffing levels as they were and this meant some people were not getting their breakfast until 11am, when they were up and dressed. Staff were busy during our inspection, but not rushed and people's needs appeared to be being addressed. One staff member commented, "The manager wants breakfasts completed by 10.30am, which is impossible, there are so many residents to get up. There are six staff are on duty but there are only four staff getting people up, as senior staff take on other duties. It is hard work". Another staff member said, "Staffing levels are fine if everyone here helps. It can be difficult at weekends if staff are off". We discussed this with the registered manager who said they would look into how duties were allocated each morning as senior staff should be undertaking care provision and not doing other tasks at that time. They confirmed they did not use agency staff as they had bank staff available to cover staff shortages.

Staff did not always respond to call bells promptly during our visits. We discussed this observation with the registered manager who said staff had pagers to highlight when call bells were ringing. At the end of the inspection the registered manager said they had ordered more pagers as they had identified only two pagers had been operational during our visit. They said they would start monitoring the staff response to call bells but felt they were normally responded to promptly. The provider's representative, to reassure us pressed an emergency alert on the call bell system to demonstrate that all staff responded quickly to emergency calls, which they did on that occasion.

Communal areas of the home and people's rooms were clean with no unpleasant odours. Staff had access to appropriate cleaning materials and equipment. Staff had access to personal protective equipment (PPE's) such as gloves and aprons. People were supported to eat their meals by staff wearing aprons and blue gloves. However staff did not change their gloves through the mealtime period even after they assisted people to their seats and collected things from the kitchen. This meant they had not used safe food handling techniques to protect people from the risk of cross infection.

Staff said they had access to the cleaning products they needed to do their job effectively. A Control of Substances Hazardous to Health (COSHH) register was available to safely guide staff regarding the chemicals they were using.

The environment was safe and secure for people who used the service and staff. There were arrangements in place to manage the premises and equipment. However on the first day of our visit we identified one call bell which was not working, which we made known to the registered manager. By the second day of our visit an outside agency had been called in to check the call bell system at the home and they had made repairs and had recorded all bells were working, A full time maintenance person undertook regular checks, which included, checking water temperatures, window restrictors, emergency lighting and wheelchairs. Staff were able to record repairs and faulty equipment in a maintenance log and these were dealt with and signed off by the maintenance person. Fire checks and drills were carried out weekly in accordance with fire regulations and regular testing of electrical equipment was carried out. There was evidence of regular servicing and testing of moving and handling equipment. Following extension work at the home the provider was undertaking landscaping to improve the outside areas; this was being managed safely. Maintenance at the home was under the direct supervision of the provider who, after consultation with the registered manager prioritised larger maintenance projects.

A fire plan was in place in the corridor which contained individual personal evacuation plans which took account of people's mobility and communication needs. This meant, in the event of a fire, emergency services staff would be aware of the safest way to move people quickly and evacuate people safely.

Accidents and incidents were reported in accordance with the organisation's policies and procedures. Staff had recorded accidents promptly and the actions they had taken at the time.

Requires improvement

Is the service effective?

Our findings

Staff might not always have the necessary skills required because there was not an effective system in place to ensure training needs were assessed. Inductions were poorly delivered, documented and it was not clear how effective it had been for some staff.

Staff files contained an induction tick sheet to identify new staff had been familiarised with the home. There were no induction records to show staff had undertaken induction that met with nationally recognised induction standards. Staff said they were allocated two or three shifts to shadow more experienced staff members when they came to work at the home. Comments included, "I did three shadow shifts with a different person each time, some days were better than others. I have learnt a lot more since then".

The registered manager had not put into place for new staff a robust system to ensure they had undertaken the mandatory training required by the provider. The registered manager said she undertook competency checks and carried out supervisions with new staff. However these were not documented. The registered manager had recorded on the February 2015 audit to the provider, "That written competency forms had not always been completed although verbal discussions were held". Following our inspection the registered manager sent us an action plan which said inductions at the home would be reviewed to ensure they reflected the common induction standards and they would ensure all staff received appropriate support/induction during their probationary period which would include competency evaluations and supervisions.

Staff training was not monitored to ensure staff received training relevant to their roles. The home's training matrix recorded 32 staff working at the home and of these only ten had undertaken manual handling training, safeguarding of vulnerable adults and Mental Capacity Act 2005 and Deprivation of liberties safeguarding. Four staff had attended food hygiene and three staff had completed infection control training. However, it did show all staff, with the exception of one had undertaken fire induction training and 24 staff had completed a dementia workbook. The registered manager said they did not feel the training matrix reflected all of the training which had been undertaken at the home. This meant we could not clearly identify what training had been undertaken at the home.

Staff said there was very little training at the home. In an action plan sent to us by the registered manager following our inspection, they said they would update the training matrix to include all training undertaken and source training to cover any gaps in staff knowledge.

The provider was not ensuring staff were receiving appropriate training and professional development. This is a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulations 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Staff had received supervision which involved individual staff, meeting with a more senior member of staff or the registered manager throughout the year, to discuss their work and explore any issues that may have arisen to improve their practice. The registered manager said it gave staff a chance to highlight their concerns. Staff gave us a mixed response about supervisions at the home. The majority of staff said they felt well supported and would be happy to discuss any issues. However, three staff said they did not have regular supervisions and felt when they had supervisions they were not able to make their views known. One staff member commented, "It depends on who does the supervision how good it is" another said "I did not feel my last supervision achieved very much". The registered manager said they were in the process of arranging annual appraisals, where they would review staff performance.

The provider was not meeting the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and associated Codes of practice. Staff demonstrated a limited understanding of the principles of the MCA and DoLS. Following the inspection the registered manager sent us an action plan which said they had recognised prior to our inspection the need for staff to undertake MCA training and had scheduled MCA training to take place.

People who lacked mental capacity to take particular decisions were not protected. The MCA sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected. People who were assumed not to have capacity had not had their mental capacity assessed and best interest decisions had not been made when they were required. For example, best interest decisions had not been made to put pressure mats next to people's beds to alert staff they were out of bed and the use of bedrails which might not be the

Is the service effective?

least restrictive option. In some instances staff had assumed people did not have capacity and had requested their next of kin sign documents on their behalf which is not in line with the MCA 2005 Act.

The registered manager said they had been working with the local authority DoLS team regarding making Deprivation of liberties safeguards applications. This is where an application can be made to lawfully deprive a person of their liberties where it is deemed to be in their best interests or for their own safety. The registered manager was aware of the Supreme Court judgement in March 2014 and intended to assess all of the people at the home and make applications the local authority DoLS team as appropriate.

The provider was not gaining consent from the relevant people and were not acting in accordance with The Mental Capacity Act 2005. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulations 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The home referred people promptly to health and social care services. For example, staff had contacted the GP out of hour's service when they were concerned that a person's wound dressing had caused a skin reaction, which meant staff were monitoring the person's skin. Care records showed one person had been offered a dental visit, which they had declined and staff had recorded to "re offer in twelve months' time". However when the person appeared to have tooth ache and was holding their jaw. Staff contacted the dentist and arranged an appointment.

People's dietary needs were met and they had the option of alternative choices available to them. People said they enjoyed the meals at the home. Comments included, "That was very nice, I couldn't eat anymore" and "I have plenty, thank you, sometimes too much". Staff had made referrals to the GP, dietician and speech and language team (SALT) where they had felt people were at risk of poor nutrition or swallowing difficulties. Pureed meals were prepared in a way that was appealing to the person and each portion was presented separately on the plate. People's meals were not always adequately spaced. On the first day we observed breakfast and lunchtime at the home. Some people did not receive their breakfast until 11.15am and the people who required support with their lunchtime meal started their lunch at midday.

The home used a four week rotating menu, with a single meal choice with an option for alternatives, for example, omelette, salad or sandwiches. There were no picture prompts in use to help people with a memory problem to make a decision about the choices available to them. Staff asked people if they wanted roast lamb as they put the people's meals in front of them. No alternatives were offered except for one person who was offered an omelette or sandwiches when they didn't eat their roast dinner. The dessert trolley had five options to choose from. Staff gave people time to choose what they wanted, and then asked if they would like cream or custard, without rushing them to decide. People were offered extra portions of the main meal and dessert, when one person was reluctant to have or choose a pudding from the trolley, a staff member said "Try a little bit and if you don't like it, I'll get something else."

Staff supported people to eat their meals in an unrushed manner. For example, a staff member sat next to a person at eye level, they observed the person and asked if they had finished before offering the next mouthful.

People's nutritional screening was undertaken using a Malnutrition Universal Screening Tool

(MUST) to identify people who were at risk from dehydration or poor nutrition. These assessments were held in a separate folder and the assessed information was not being used to populate people's care plans. This meant any risks which were identified by the assessment were not being used to guide staff about actions and monitoring which would need to be taken to prevent possible malnutrition or dehydration. We discussed with the registered manager that some of the MUST assessments had not been completed correctly. They said they would arrange for senior staff to undertake training in the use of the MUST assessment tool.

One person's dietary plan dated May 2013 stated that they "Needed varying support due to their mood and cognition". There was no information about the person's dietary preferences. When we asked a staff member how they knew people's food preferences, they said, "That they got to know what people liked (over time), They might also try a couple of things or a variety to see which the person seemed to like the most".

Requires improvement

Is the service caring?

Our findings

Residents were treated with affection and patience by staff, who appeared skilled in speaking appropriately with people, including those with dementia. People were well cared for and well dressed. People's comments included, "The staff are so nice", "Nothing's too much trouble…if I've got to be in a home, it couldn't be any better'. A visitor commented, "The majority of the care staff are very good…but one or two just haven't got it." The provider recorded on the provider information return (PIR) that they provide a friendly, lively, engaging environment. " When asked what could be improved at the home one relative said 'The laundry, it's always getting mixed up even though his clothes are all named." They confirmed this concern had not been raised with the home.

Some ancillary staff were seen engaging in conversation with people at the home in a happy friendly manner. However, some staff were not acknowledging people when they came into their vicinity. For example, a staff member vacuuming in a person's room did not acknowledge the person sat in the room and a senior staff member went through the lounge on two occasions without acknowledging anyone in the room.

On the whole information about people was treated in a confidential way. All personal information was kept in the main locked office to make sure it remained confidential. Staff were guided by a notice advising them not to discuss their work on social media to protect people's personal information. However, staff did not always ensure people's confidentiality. On three occasions staff were discussing confidential information in front of other people who lived at the home.

People who could tell us said their privacy was respected; staff were respectful and knocked on people's bedroom doors. Bedroom and bathroom doors were kept closed when care was being provided. However, there were no locks or signage on some bathroom doors to promote privacy. There was no curtain in the shower/wet room, which meant the shower would be visible from the corridor if the door was opened. One staff member said, "We would knock before entering if a door was shut".

People were treated with kindness and compassion by staff who knew each person well and understood their likes, dislikes and any preferences. Staff spoke with people to let them know what was happening. For example, when staff were supporting a person in a wheelchair, they made them aware there would be a bump on entering and leaving the lift and then took them in slowly to reduce the impact. When another person was moved in their wheelchair to the dining table, staff asked if they were near enough to the table before they left them.

Staff actively involved people in making decisions about day to day decisions. For example, what they would like to wear and whether they would like to have a wash, shower or bath each morning. Staff were offering people the choice of two flavours of drink and taking the jug around to help people decide. People who could were free to walk about in the communal areas to maintain their independence.

There were no set visiting times at the home which enable relatives and friends to visit at times that suited them and the people they visit. Visitors were coming and going throughout our inspection. One visitor said, "It is very useful I can pop in at any time to visit (my friend)". They felt they were kept informed by staff off changes and concerns about the people they visited at the home.

There were 45 bedrooms at the home and all had en-suite facilities. People's bedroom doors had photographs and names on to help people identify their rooms. Some people had personalised their bedroom with their possessions, such as pieces of furniture, pictures, photographs and ornaments. This gave these bedrooms a personal and homely feel.

Requires improvement

Is the service responsive?

Our findings

People did not receive personalised care that was responsive to their needs. Before coming to the home the registered manager or a senior member of the team undertook a pre admission assessment to ensure the home could meet people's needs. Visitors said they had chosen the home and the registered manager had visited to assess the needs of their loved one. The information gathered at the pre admission assessments was used to generate care plans.

Care plans did not reflect the care provided. The registered manager said they undertook care plans reviews every six months unless there was a significant change to someone's care. We identified that people's care plans were not being reviewed when changes happened and in one example not completed at all. For example, a person had come to the home in June 2014, their care plans had not been completed to support them with their orientation, behavioural support, general health care, sleep needs, foot, skin and oral care. There was no guidance for the staff to support this person although their behavioural needs challenged the service. This was confirmed in an accident report where a staff member had been injured by this person. The registered manager said the person had changed presentation recently and there were times when thy needed additional support especially around teatime to support and reassure them. Staff said there were special techniques they used to reassure the person when they were not settled. These included, listening to music, taking them to a quieter area of the home or just walking with them. The registered manager confirmed they had not made the mental health team aware of the changes in the person's presentation and asked them for guidance. On the second day of our inspection following our feedback, the registered manager had made a referral to the mental health team and the persons care plans had been completed and updated to reflect their needs.

A second person had fallen in February 2015 which had caused a significant injury. Their care plans had not been reviewed and updated with changes to their care needs since October 2014. A third person had come to the home at the end of 2014 and care plans had been written. However their family member had raised concerns about them being more confused, they had fallen and the GP had made the home aware of a new health need which could put them at risk of feeling weak. However the person's care plans had not been reviewed and updated to reflect these needs. A fourth person had not had their care records reviewed since 28 May 2014. The registered manager said these would be reviewed as a matter of urgency.

Arrangements were not in place to make sure people and their families where appropriate were involved in making decisions and planning their own care. Visitors we spoke with were not aware of care planning. However they said they had been asked about their relatives needs when they came to the home but had not been involved in any reviews. One visitor said they had recently completed an end of life plan with the GP and had spoken to the registered manager about this. However people said they were happy with the care and the information they had been given. People complimented individual members of staff, including kitchen staff and cleaners as being particularly good and helpful.

The home had two dining rooms but on the first day of our visit people were only using the smaller dining room linked to the conservatory which was very busy and noisy. The registered manager said the second larger dining room was not being used because it had recently undergone redecoration and staff had not got back into the routine of using it again. Staff said the larger dining room had been used for people who needed support, but now there were less people it was easier to use the one dining room. This meant people were not being given the opportunity to choose where they had their meals. On the second day of our visit one person was using the larger dining room.

People at the home were not protected from the risks of social isolation and loneliness and staff had not recognised the importance of social contact. People said "I join in whatever there is, but there's not much, well you've got to haven't you?"; "I get very bored, (activity person) is very good and I try to join in everything"; "I'm just busy doing nothing here." Some people at the home had family living locally this meant they had frequent visitors and said they were taken out of the home. One person said "I went to Teignmouth on Mother's Day and had lunch out. In here I knit, read, write my diary, read the paper, go outside."

An activities co-ordinator worked at the home for thirty hours a week; however as part of their duties they were expected to help with the breakfast and the lunchtime meal. In the entrance to the home there was a prominently displayed activity board with cards showing the activity of

Requires improvement

Is the service responsive?

the day. On the first visit day of our visit it was manicures. We identified that only two people who had been very active through the morning and whose behaviours were challenging, were kept occupied having a manicure which lasted an hour. At the same time there were 12 other people in the lounge area who were not offered any activities. In the afternoon five people were engaged in making Easter decorations. Records of activities were held in separate folders and had very little information recorded about people's hobbies and social preferences to guide staff. For example, one person's record said "They liked to see people and they got down when they didn't, their eyesight was very poor so they didn't come to join in activities". During the month of February 2015 it was recorded this person had seen the hairdresser and had a manicure. This person said when we asked her about activities, "I've nothing to do, unfortunately I can't read because of my eyesight."

Records showed that people who stayed in their rooms were not receiving meaningful activities. For example out of 11 peoples entries for February 2015 it was recorded that eight people had been on bed rest and had not undertaken any activities. The activity person said they did not have time scheduled with people who remained in their rooms, but they tried to visit them when they could. The registered manager sent us an action plan following the inspection telling us about improvements which were going to be made to the activities provision at the home. These included, an activity plan being put into place to reflect people's needs, to reduce social isolation, the activity person not undertaking care duties, improved quality and content of documentation.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulations 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The home worked in partnership with health and social care professionals. The local district nurse team who oversee the nursing needs of people living at the home said they visited the home most days and had a staff member escort them on their visits. They confirmed they were happy because the home told them about concerns and one said, "They have a difficult job here, they have some complex patients, we have to keep an eye on". A relative said their loved ones had all necessary medical care from outside professionals and the staff informed them of any changing needs.

People and visiting relatives said they would be happy to raise concerns with senior staff and were confident they would be dealt with. Their comments included, "I'd go to (registered manager) or (staff member), or maybe just one of the seniors but I've had no concerns. There was no complaints procedure on display in the home to advise people and visitors how to make a complaint. The registered manager said there had been one on display in the main entrance but people were known to remove notices. On the second day of our visit this had been addressed and a new complaints policy had been put on display. The two complaints received at the home had been responded to and dealt with in line with the provider's policy.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager in post as required by their registration with the Care Quality Commission (CQC). People, visitors and staff spoke on the whole positively about the registered manager. Their comments included, "I get on really well with the manager, she is good at her job"; "Really good with the residents and families"; "Very good always there for you, she really cares" and "Really supportive and approachable"; "'Devoted to the job and very helpful". Two staff members commented that they did not feel the registered manager would challenge all staff about any poor practice raised with them. We discussed this with the registered manager they said they were happy to challenge any poor practice at the home and that staff were not always aware of issues they had tackled.

Each month the registered manager submitted an audit they completed to the provider. The provider had a manager of one of their other services that visited the home most weeks to support the registered manager and had recently been heavily involved in the registration with CQC of the new extension. The monthly managers audit, was not always effective because the registered manager had not been supported to recognise the documents required to complete the audit. For example, each month the registered manager recorded they had completed the provider's monthly monitoring form, an analysis of the accidents and incidents at the home. However this registered manager had confused this document with another and therefore there was no effective system to demonstrate there was learning from accidents and incidents at the home

The system used by the registered manager to assess information for the audit was not systematic and meant gaps were not identified. As part of the audit the registered manager reviewed four care folders each month. They said they chose people's folders at random. There was no policy in place for senior staff to know whose responsibility it was to complete people's care folders on admission and to regularly review. This meant there was no system to ensure all care folders were kept up to date, reviewed and reflected people's needs. The registered manager said when they undertook reviews of people's care folders as part of the audit they produced actions for staff to undertake. They were unable to show us any actions they had given staff and said they had no system to check actions identified had been completed.

The registered manager also looked at personnel files as part of their monthly audit. As part of the audit they looked at whether a Disclosure and Barring check had been completed and whether two satisfactory references had been received. The registered manager said they selected randomly three staff files each month but they had not identified where checks had not been completed. This meant they did not have a robust quality system to ensure all staff were recruited safely.

People using the service were not offered any formal opportunity to make their views known. However the registered manager said "Whilst carrying out my daily room checks I visit people's rooms and communal areas, spending time with resident/s, talking with them to ascertain their views on issues such as staff and food. Anything that needs addressing is either addressed on the spot and/or at the staff meetings." They confirmed they did not document these meetings and actions taken. It was recorded on the February 2015 manager audit that meetings for people who use the service had been difficult to arrange because of people's ability; however they could demonstrate that families were kept informed by posters and letters.

The provider did not have effective systems to assess and monitor the quality and safety of the service provided at the home and were not ensuring accurate records were kept in relation to people at the home. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulations 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The provider is required by law to notify the Care Quality Commission (CQC) of significant events such as deaths, and any allegations or instances of abuse. The registered manager was sending notifications to CQC in a timely manner.

There were monthly staff meetings. Staff said they were able to voice their concerns at these meetings. One staff member said, "(the registered manager) always says at the meetings, "If you don't want to say something here come and see me afterwards and some staff do."

Inadequate

Is the service well-led?

The provider sent out annual quality assurance questionnaire to people and their relatives. The responses from the 2014 survey highlighted concerns around the general decoration of the building and people not being able to use the garden fully. The provider had responded to this by undertaking redecoration within the home, new flooring had been laid, and new chairs had been purchased. Garden furniture had been purchased and landscaping the outside areas had been started. The responses to the 2015 survey were still being received when we undertook our inspection.

People were at risk because accurate records about each person were not consistently maintained. Gaps were found in people's food and fluid charts as well as in prescribed cream charts. The charts were all stored in the main office at the home. The registered manager said staff usually completed these charts mid-morning, in the afternoon and at the end of their shifts. This meant records were being completed retrospectively and we could not be assured from these records that people were receiving the care recorded and their care needs were being met.

Care records were not accurate and complete and did not record the care provided.

The provider was not ensuring accurate records were kept in relation to people at the home. This is a breach of Regulation 20 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	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider was not ensuring staff were receiving appropriate training to enable them to carry out their duties. Regulation 18 (2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider was not acting in accordance with The Mental Capacity Act 2005. People rights were not protected by appropriate assessment of capacity being undertaken, appropriate consent was not being gained to provide care and treatment and best interest decisions were not being made in accordance with this act. Regulation 11(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider was not ensuring care and treatment was appropriate to meet people's needs. Assessment and reviews were not being made and care plans did not reflect people's needs. People were not able to participate in making decisions regarding their care or treatment. Regulation 9(1)(a)(b)(c)(3)(a)(b)(c)(d)(f)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider did not have robust recruitment procedures in place to ensure people employed were of good character and had the necessary recruitment checks in place. Regulation 19(2)(a)(3)(a)

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 The provider had not ensured systems and processes were in place to protect people from abuse. Regulation 13 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider was not ensuring people were protected by having systems and processes to effectively ensure the safe management of the service. Because of quality assurance assessment and monitoring to improve the service had not been effective to identify risks. Accurate records were not maintained in relation to people at the home and managing the regulated activity. Regulation 17 (1)(2)(a)(b)(c)