Coate Water Care Company (Church View Nursing Home) Limited

# Chapel House Care Centre

## Inspection report

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Date of inspection visit:
09 March 2016
11 March 2016

Date of publication:
13 May 2016

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

We inspected Chapel House Care Centre on the 9 and 11 March 2016. Chapel House Care Centre is a residential and nursing home for up to 42 older people. Many of these people were living with dementia. 16 people were living at the home at the time of our inspection, and a further person moved in to the home during the days of the inspection. This was an unannounced inspection.

We last inspected in June 2015 and found that the provider was not always meeting the regulations. We found that people did not always receive safe care and treatment, because staff had not always received the skills and support they needed to care for people safely. At our June 2015 inspection, we found the provider had taken some action and people were receiving safe care and treatment, however not all staff had access to the training and support they needed to ensure they met people's needs effectively. At our June 2015 we also recommended that the provider seek guidance from a reputable source regarding staffing levels in the home, and dementia training for staff. We found at this inspection these recommendations had not been acted upon.

There was a registered manager in post on the day of our inspection. They registered manager had been in post for approximately three months and had just been registered with the CQC. 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.

The provider did not have effective systems to monitor the quality of service people received. Audits did not always identify shortfalls in the quality of the service, and when they did, appropriate action was not always taken. People and their relative's views had been sought, however action had not been taken in response to their views. Relatives told us they did not always feel their views had been listened to.

People did not always receive their medicines as prescribed. Staff did not always keep an accurate record of the support they had provided people with their care, treatment and medicines. Where people required their medicines to be administered covertly, staff did not always have appropriate guidance to support people.

People we spoke with were positive about the home, feeling safe and looked after. People enjoyed the food they received in the home and had access to food and drink. People had access to one to one activities and external entertainment, however were often left for period of time without engagement or support from staff.

Staff were not always deployed effectively to ensure people living with dementia were protected from risks. If accidents occurred, staff may not always be able to respond efficiently. Not all staff had the skills they needed to meet people's needs, because staff did not have access to training and support. Staff spoke positively about the new manager and the support they had started to provide.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe. People did not always receive their medicines as prescribed. Staff did not always accurately record the support they had given people around their medicines. Where people required their medicines to be administered covertly there were not always effective systems in place to manage this safely.

Staff were not always deployed within the service to ensure the safety of people and protect them from risk. People went for long periods of time without engagement or support from staff.

Staff knew the risks associated with people's care and had guidance to manage them. People felt safe, and staff understood their responsibilities to protect people from abuse.

### Is the service effective?

**Requires Improvement**

The service was not always effective. People were supported by staff who did not always have access to the training, support they needed to meet people's needs.

People received support to meet their nutritional needs and had access to plenty of food and drink. People were supported to make choices, however not all staff had received training in relation to the Mental Capacity Act 2005.

People were supported to attend healthcare appointments. Staff followed the guidance of external healthcare professionals.

### Is the service caring?

**Good**

The service was caring. People were at the centre of their care, and were supported to spend their days as they choose. Staff respected people and treated them as equals.

Staff knew people well and understood what was important to them such as their likes and dislikes.

### Is the service responsive?

**Requires Improvement**

The service was no always responsive. People's care and risk

assessments were not always current or accurate. Staff did not always keep a record of the care and support they had provided people.

People and their relatives had previously raised concerns about activities. An activity co-ordinator had been employed, and they had clear ideas of how to ensure people were engaged. People enjoyed one to one activities and external entertainment.

The registered manager responded to complaints, and people felt confident they could raise concerns to staff or the registered manager.

## Is the service well-led?

**Inadequate**

The service was not well-led. Audits carried out by the provider did not always identify shortfall or concerns in the quality of the service. Where shortfalls had been identified by the service or by external parties' action was not taken to improve the service.

People and their relative's views had been sought; however no action had been taken in response to these views. Relatives felt their views were not always acknowledged and were concerned about the approachability of the management.

Agency staff did not always receive information which would enable them to meet people's needs. The provider had not acted on requirements made following the last inspection, and the service had a history of not meeting the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A registered manager had been recently registered with the CQC. They had ideas on how they wished to improve the service, to help realise the potential for people receiving care.

# Chapel House Care Centre

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.
This inspection took place on the 9 and 11 March 2016 and was unannounced. The inspection team consisted of one inspector.

At the time of the inspection there were 16 people being supported by the service, another person came to the service on our second day of the inspection. We reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law. We also spoke with healthcare professionals and local authority commissioners about the service.

We spoke with six people who were using the service and with two people's relatives. We also spoke with three care staff, an activity co-ordinator, two domestic staff, an administrator, an agency cook, an agency nurse, the registered manager and an operations manager on behalf of the provider. We reviewed five people's care files, care staff training and recruitment records and records relating to the general management of the service.

Requires Improvement

# Is the service safe?

## Our findings

People did not always receive their medicines as prescribed. There was evidence that some staff were not always acting in accordance with the proper and safe management of medicines. For example, staff had not always given four people their medicines in accordance with their prescription, however staff had recorded they had administered these medicines.

One person was at risk of receiving more medicine than they were prescribed. When we counted this person's medicines we found less doses of their medicine than we expected from reading the person's medicine administration records. We discussed this concern with an agency nurse on duty and the operations manager for the service, however there was no reason given regarding this concern.

Nursing staff did not always keep an accurate record of when they assisted people with their medicines. For example, staff had not always signed to say when they had administered people's medicines. There was a risk people may not always receive their medicines as prescribed as an accurate record had not always been maintained.

People's medicines were not always stored in accordance with manufacturer's guidelines. Where staff had recorded one medicine's room temperature throughout February and March 2016, the temperature was always above the recommended maximum temperature given by manufacturers, and sometimes had been recorded at a significantly higher temperature. When we checked the medicines room, we found the temperature to be above the recommended maximum temperature. Additionally temperatures had not always been recorded in January and February on a daily basis. Nursing staff had not raised this concern to the registered manager.

Three people's medicine records showed they required their medicines to be given covertly, as they no longer had the capacity to understand the consequences of not receiving their prescribed medicines. A list of each person's medicines were written and held with their medicine administration records. These lists contained each person's prescribed medicines which included 'as required' medicines such as pain relief, which does not need to be administered every day. There was no guidance on which medicines people needed to be provided covertly, or how these medicines needed to be given. For example, one person should receive their medicines covertly; however the agency nurse did not have the guidance to do this. We discussed this concern with the registered manager, who took immediate action to deal with this concern.

We discussed all of these concerns with the registered manager, operations director and an agency nurse. The operations director and registered manager told us they would address the concerns. The registered manager had started to identify and implement actions for some concerns regarding medicine room temperature and this is discussed in "Is the service well led" later in this report.

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

At our last inspection in June 2015, we recommended that the provider seek advice and guidance from a reputable source regarding staff to enable the provider to ensure there were enough deployed to meet people's needs. At this current inspection we found further concerns regarding how staff were deployed within the service. Two of the service's three floors were being used to accommodate people. The people living on one floor were living with dementia. They had complex needs and required assistance from two members of staff to meet some of their daily care needs. On this floor two care staff support up to eight people, and an agency nurse was briefly available to provide support. We observed four people who went an hour without assistance or support from care staff during the morning. One person was stood by the side of their chair for 40 minutes without any support. While two people walked with purpose around the floor. One person entered another person's room which caused the person to become agitated and shout out. The person left the room shortly. There were no staff around to assist or reassure people. In the event of a person falling or suffering an injury, staff may be unaware and would not be able to respond to incidents effectively. One relative told us, "There are staff on, but they're not up there (on the floor). There are a lot of dependent people. Staff don't have the time to spend with people, they are really pushed".

On the other floor staff had time to respond to people's needs and ensure they had the assistance they needed. People living on this floor told us if they called for assistance it often came quickly.

Staff had mixed views on staffing within the service. One staff member told us, "sometimes it's okay. If we have a problem, we don't always have someone on hand to help". Another staff member said, "It can be a bit difficult. I think there should be another [care staff member] upstairs". One staff member felt there were enough staff on, however felt there was not enough time to talk with people and provide stimulation. They told us, "I personally feel, there is not enough time to spend with residents".

We discussed these concerns with the registered manager and operations director who told us they would look into staffing arrangements to ensure people were protected from unnecessary risks.

These issues were a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from the risks associated with their care. Staff had clear guidance regarding assisting people with their mobility needs, and concerns relating to pressure area care. For example, one person's risk assessments provided clear guidance on how staff should assist them to move safely, including the equipment they needed to ensure the person was safe and comfortable. Where people required assistance to reduce the risk of developing a pressure sore, staff had clear guidance to follow and understood the importance of following these guidelines.

Maintenance workers carried out tests around the premise to ensure systems worked. For example PAT tests had been carried out on electronic equipment. Areas of the home which were not safe for people or visitors were safely secured to reduce the risk. Fire safety checks had been carried out and fire safety inspections, legionella's inspections were also carried out. The service had not had a fire drill for over six months, and were going to be ensuring a drill was carried out shortly after our inspection.

Records relating to the recruitment of new care support workers showed most relevant checks had been completed before staff worked unsupervised at the home. These included disclosure and barring checks (criminal record checks) to ensure support workers were of good character. The service had ensured references were sought for staff member's to ensure they were of good character.

People told us they felt safe in the home. Comments included: "I'm safe. I would find it very difficult for

someone to threaten me here", "I'm safe and happy here". One relative told us, "I do feel they're safe here".

People were protected from the risk of abuse. Care staff had knowledge of types of abuse, signs of possible abuse which included neglect, and understood their responsibility to report any concerns promptly. Staff told us they would document concerns and report them to the registered manager, or the provider. One staff member said, "I would go straight to the manager. I wouldn't give it a second thought". Another staff member added that, if they were unhappy with the manager's or provider's response they would speak to local authority safeguarding or the CQC. They said, "I would go to the local authority, contact the adult helpdesk, I couldn't let it rest".

The registered manager and operations director raised and responded to any safeguarding concerns in accordance with local authority safeguarding procedures. Since our last inspection the provider had ensured all concerns were reported to local authority safeguarding and CQC.

Requires Improvement

# Is the service effective?

## Our findings

At our last inspection in June 2015, we found that staff did not always have the skills they needed to ensure people received safe care and treatment. We asked the provider to take action. At this inspection we found the provider had taken action to ensure people received safe care and treatment. However there was still room for improvement as not all staff had the training they needed to meet the needs of people, particularly those living with dementia.

People were not always supported by staff who had access to the training they needed to meet people's needs. Staff told us they did not always feel they had access to the training they needed. The registered manager told us they had identified staff had not received the training they needed prior to their arrival at the service in November 2015. The service's training records showed only a limited number of staff had received and completed training around dementia care, fire safety, food hygiene and safeguarding. Additionally not all staff received training around the Mental Capacity Act 2005 (MCA 2005) of the Deprivation of Liberty Safeguards (DoLS).

Staff told us they did not feel that all staff had the training they needed to provide person centred care for people with dementia. One staff member said, "They often shout across rooms. It's little things which can upset people. They don't know how to approach people (with dementia)". Another person said, "I've not really had any training on dementia."

The provider and registered manager had not carried out competency assessments of staff to identify the training and support they needed. Some staff recently employed by the provider had worked in other adult social care establishments; however no assessments had been done to establish if the provider or registered manager was happy with staff skills. We discussed these concerns with the registered manager. They had arranged for all staff to initially complete a distance learning course in relation to dementia and safeguarding to help improve staff knowledge. The registered manager also told us staff files and supervision meetings would be organised to encompass staff training needs analysis.

People were not always supported by staff who access to effective supervision (one to one meetings with their line managers). Staff told us they had not always received supervision or an appraisal from their line manager. Comments included "Not had one yet" and "I had one with the last manager." There were limited records of supervision meetings on staff care files. We discussed this concern with the registered manager and operations director who informed us they had were aware not all staff had received supervisions or appraisals. They explained the lack of consistency with the management team had caused this concern.

These issues were a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's ability to make choices were respected. Most staff had undertaken training on the Mental Capacity Act (MCA) 2005. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires

that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. While not all staff had received training, they all spoke positively how they promote choice and people's individuality. One staff member told us, "They're human beings, they have a right to have a choice. One person can't talk, however they can tell you what they want, if they don't want something through their eyes and facial expressions". Another staff member said, "I always provide a choice. Just because someone has dementia doesn't mean they can't choose what they want to eat or drink. We can't force people".

The provider and registered manager ensured where someone lacked capacity to make a specific decision, a best interest assessment was carried out. For one person a best interest decision had been made as the person no longer had the capacity to understand the risks to their health if they were to leave the service unsupervised. The provider made a Deprivation of Liberty Safeguard (DoLS) application for this person. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People told us they enjoyed their food. Comments included: "The food is good, not exciting, however it's more important it's good", "The food is very good. As good as any restaurant" and "Always plenty to eat and drink, it's good".

On both days of our inspection the home's chef was unavailable. An agency chef cooked one day, whilst the activity co-ordinator cooked on the other. On both days people enjoyed their meals. Where people needed assistance with their food this was provided in a patient way. Most of the people living at the service chose to go to the dining room for lunch and there was a pleasant atmosphere. Food was generally well presented and care staff knew people's dietary needs and preferences. One person required a soft diet, and their food on one day was not presented in a way for the person to taste individual flavours on their plate. We raised this concern with the registered manager who ensured immediate action was taken.

Where people had specific dietary needs, staff were aware of this. For example, one person needed a gluten free diet. The agency chef was aware of this. They spoke positively of the food stocks they had to cater for this person's needs. Staff supported this person to have the diet they needed to ensure their wellbeing was maintained. Where people were losing weight staff took action to ensure they were protected from the risk of malnutrition. This included supporting people with their dietary needs and encouraging calorie rich foods.

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist and an optician and could attend appointments when required. People's care records showed relevant health and social care professionals were involved with people's care. For example, records of appointments with healthcare professionals were also scanned onto the services computerised care planning system to ensure information was stored safely and securely.

Good

# Is the service caring?

## Our findings

People and their relatives had positive views on the caring nature of care staff. Comments included: "They've [staff] looked after me well. It's marvellous"; "It's lovely here, the staff are lovely" and "I think the staff are really good, very caring".

Care staff interacted with people in a kind and compassionate manner. Care staff adapted their approach and related with people according to their communication needs. For example, one person was not able to communicate verbally. A staff member slowly talked to the person at eye level. They looked at the person's body language to ensure the person was comfortable before they left them.

Care staff spoke to people as an equal. They gave them information about their care in a manner which reflected their understanding. For example, one staff member took time to talk and encourage one person to eat their meal. They sat close to the person, so the person could see their face. The staff member was patient and took time to support the person. The person enjoyed their conversation with the staff member and was encouraged and supported to make a choice of pudding, which they told us they enjoyed.

Care staff knew the people they cared for, including their likes and dislikes. When we discussed people and their needs, most staff spoke confidently about them. For example, one care staff member was able to tell us about one person, including how they liked to spend their days and the emotional support they needed regarding their health needs. Staff told us what was important to the person and how they supported them to be comfortable in the home.

We observed one staff member who took time to talk with a person about their time in the home. The person was being supported to consider where they wanted to live. The staff member asked them how they felt and they both enjoyed a friendly upbeat conversation. The person told us, "I'm enjoying it here, although I'm looking forward to being a bit more independent".

People were cared for by care staff who were attentive to their needs. For example, care staff knew when people's needs had changed and ensured the support they needed was provided. One person's appetite had reduced. Staff told us how they communicated with the person's family and healthcare professionals to ensure the person was monitored and supported with their diet and food intake.

People were able to personalise their bedrooms. One person had items in their bed room which were important to them, such as pictures of people important to them. Staff respected the importance of people's rooms. They ensured rooms were kept clean and knocked on bedroom doors before entering. Staff used a monitoring system at night, which informed them when people who walked with purpose and were at risk of falling were leaving their room. Staff told us this enabled them to protect people from harm and helped staff ensure people were safe without disturbing their privacy.

People were treated with dignity and respect. We observed care staff assisting people throughout the day. One staff member assisted someone with their clothing in a dignified way. They encouraged the person to

wear their shoes as they liked to walk to ensure the person was comfortable and protected from the risk of any incident or accident within the home.

People were supported to make advanced decisions around their care and treatment. For example, one person was asked for their views of where they would wish to be treated in the event of their health deteriorating. The person, with support from their family had decided they wished to go to hospital and have any treatment which will keep them alive. Another person had made a decision with their family that they did not wish to be resuscitated in the event of cardiac arrest, and this had been clearly recorded on a Do Not Attempt Resuscitation form.

Requires Improvement

# Is the service responsive?

## Our findings

People's care needs were documented in their care plans; however, there was not always clear current guidance for care staff to follow to meet people's needs. This put people at risk of not receiving the care and support they need. For example, one person's care plan did not provide clear information on the support they needed regarding their medicine management and best interest assessments. For another person, their falls risk assessment stated they were at low risk of falls and had not had any falls or accidents since living at the service. We identified the person had three falls in 2016. While the person's risk assessment had been reviewed these accidents were not used to reassess the person's risk of falling and the support they may require.

People's care plans did not always contain information that was important to them, or their life histories. For example, one person told us about their life history, including where they lived and worked. None of this information was recorded on their care plan. This meant that information which care staff and activity co-ordinators needed to engage with people were not always recorded. The home's activity co-ordinator had also identified this issue and was in the process of speaking with people and their family to ensure their care plans were personalised and contained information important to them.

Care staff did not always keep a record of the support they had provided people within the home. For example, daily records had not always been maintained or updated on the provider's electronic care plan system. Additionally a number of people were on food and fluid charts. These records had not always been completed consistently prior to the inspection, and also gave no guidance to staff on how much people needed to drink. There was no evidence that care staff, nurses or management were reviewing these records. We discussed this concern with the registered manager. They were planning to remove monitoring charts where necessary, and ensure staff understood the purpose of why they were monitoring people's intake to ensure their needs were being met.

These issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living with dementia did not always receive personalised care, as care staff did not always have the training to meet their needs. We observed that staff did not always take the time or have the time to engage with people, providing them with personalised care or stimulation.

People and their relatives told us a range of activities had not always been provided to people living at the service and that staff did not always have time to spend with them. One relative told us, "The activities are just starting. There has been nothing for 16 – 18 months". Care staff also told us that they didn't have the time to spend with people and provide them with stimulation which met their needs. People were left for long periods of time without engagement. We observed four people in one lounge, who were sat waiting for lunch. There was no engagement for these people, three people were withdrawn, whilst one person told us, "There's not much going on". One person's relative entered the room and sparked a conversation with people, which people enjoyed.

The home had appointed a new activity co-ordinator. The activity co-ordinator had clear goals they wished to achieve by promoting dementia friendly activities for groups and for individuals. They were in the process of identifying what interest's people had which could be met through one to one and group activities. The activity co-ordinator provided activities to people which included decorating their finger nails. One person was clearly happy with their finger nails. They told us, "They're great". People enjoyed an exercise session provided by an external entertainer. This included mobility exercises with balls. Many people from the home enjoyed this activity and were smiling and engaged throughout.  One relative told us, "I'm pleased they've reinstated activities, I've seen a marked improvement".

People's relatives told us they were informed of any changes to their relative's needs or any incidents. One relative told us, "They let me know if anything has happened". Another relative said, "they let us know if anything is happening, anything that may concern us". People's care records showed often showed where staff had contacted people's family to ensure their needs were being met.

Where people's health needs had changed, care staff took action. For example, care staff had identified where people had been unwell and ensured that they sort advice from senior staff or external healthcare professionals. Where people refused assistance staff tried to encourage and reassure them to ensure their needs were being met, and they were left comfortable. One domestic worker told us how they cleaned people's rooms, to ensure their rooms were clean and fresh after someone had had an accident. They spoke of the importance of ensuring people were treated with dignity and respect.

The provider had a complaints policy. People and their relatives told us they knew who to contact if they had concerns around the service. Three people we spoke with told us they would tell care staff or the nurse if they were unhappy with their care. Since the last inspection two complaints had been made to the service. These complaints were stored on people's individual care records and had been responded to in accordance with the provider's policy.

Inadequate

# Is the service well-led?

## Our findings

The home had recently appointed a manager, who had been registered with the CQC to become the registered manager of the Chapel House Care Centre in March 2016. Prior to this the home had been without a registered manager since November 2014. Since November 2014 there had been no consistent management structure in place to manage the service.

Since the service was registered with CQC in June 2014, the service has had four inspections and has never fully met the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider does not have effective systems to identify concerns, such as staffing, staff training and supervision and records to self-regulate and ensure people receive safe, effective care and treatment. Following the last inspection recommendations had been made regarding staffing and staff training, however these recommendations had not been acted upon. While staff had the skills to ensure people receive safe care and treatment they did not always have the skills to meet the needs of people living with dementia. The provider had not taken effective action to ensure the service met the regulations. The registered manager and operations director felt the lack of consistency regarding the day to day management of the service meant actions had been challenging to implement.

People and their relative's views were not consistently sought or acted upon. The last survey of people and their relative's was carried out in June 2015, while there were positive responses, there were also areas where people and their relatives felt the service was either satisfactory or poor. People and their relatives expressed some dissatisfaction with activities within the home and support around their spiritual and cultural needs. There was no response or actions from the provider in response to these comments. Relatives and the registered manager told us there had been no resident or relative meetings since they had been in post or for some period of time. Two relatives felt negatively about the management of the service. One relative told us how they had previously raised concerns regarding staffing within the home to different service managers. They never felt their comments were acknowledged. When asked if they had raised their concerns to the current registered manager, they told us they had not as due to past experiences they did not feel the management was approachable. Another relative told us, "When the last report came out, I was a bit upset. The carers are wonderful, the management is poor". We discussed this concern with the operations director and registered manager who told us they would bring a quality survey of people and their relatives forward as the provider's policies aimed to carry out six monthly quality assurance surveys.

The registered manager carried out audits around management of medicine and people's care records. Medicine audits for January and February had identified issues around missed signatures, room temperatures not being recorded. Action had been taken around ensuring room temperatures were recorded and also asked nursing staff to report concerns around the room temperature. However these actions were ineffective as we found medicine room temperatures were continuously over the manufacturer's guidelines and no action had been taken by nursing staff or the registered manager to rectify this. Medicine audits did not enable the registered manager to identify concerns found at this inspection around people not receiving their medicines as prescribed. Additionally a pharmacy inspection in January identified similar concerns around people being at risk of not receiving their medicines as prescribed,

however no actions had been taken following this inspection.

The operations director carried out a monthly quality monitoring checklist. The last checklist had been completed in January 2016. This audit had identified concerns which were also noted in the service's continuous improvement plan. One action was regarding staff paperwork; however there was no evidence of actions taken to address these concerns. Additionally these audits did not identify concerns we found at this inspection regarding staffing and concerns around dementia care.

The service had a continuous improvement plan which had been implemented in July 2015. This plan contained action plans which included ensuring all staff received effective supervision (one to one meetings with their line manager) and staff training. These actions had not yet completed, with an action deadline date set as 'ongoing'. We discussed the improvement plan with the registered manager and operations director. They told us they were involved in reviewing and amending this plan to ensure if helped with the development of the service moving forward.

The registered manager told us that complaints, incidents and accidents as well as safeguarding concerns were all noted and stored on people's individual care records. The service were unable to identify any possible trends regarding complaints or safeguarding concerns despite having systems which enabled them to identify trends with regards to any incident or accidents. The registered manager showed us they were planning to implement complaints and safeguarding logs which would enable them to identify any possible trends.

Agency staff did not always have the information they required to meet people's daily needs. For example, an agency nurse did not have the information they needed regarding people's covert medicines. This meant that they were unable to assist people with their medicines as required. They gave one person their medicines, unaware that the person's medicines should be administered covertly. An agency chef told us they received conflicting information regarding people's dietary needs of people. A member of care staff ensured they had the correct information; however information displayed in the home's kitchen was incorrect. We raised this concern to the registered manager who told us they would take appropriate action.

These issues were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had taken action to speak with staff through team meetings. Meeting minutes discussed staff competencies and their roles, providing the registered manager an opportunity to discuss concerns with staff. Staff spoke positively about the registered manager and the stability they had brought to the role. Staff were being given opportunities to develop and take on more responsibilities within the role. For example the home's activity co-ordinator had been given clear responsibilities and was enthusiastic regarding the role. Staff were all eager to see the service meet it's potential. One staff member told us, "It's a nice home, it's definitely got potential".

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People did not always receive safe care and treatment. People did not always receive their prescribed medicines. Regulation 12 (f) (g). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The service did not maintain accurate, complete and contemporaneous record in respect of each service user. Regulation 17 (2)(c). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staff were not effectively deployed in the service to protect people from risks. Not all staff had the skills to meet people's needs, as they did not always have access to appropriate support (one to one meetings with their manager) or training. Regulation 18 (1)(2)(a). |