Westmorland Healthcare Limited

Westmorland Court Nursing and Residential Home

Inspection report

High Knott Road
Arnside,
Carnforth
Lancashire
LA5 0AW
Tel: 01524 761291
Website:

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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?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

This unannounced inspection of Westmorland Court Nursing and Residential Care Home [Westmorland Court] took place on 29 September 2015. We last inspected this service May 2014. At that inspection we found the service was meeting all the five essential standards that we assessed.

The home provides care for up to 48 people. It is set in National Trust owned land and the home is a short walk from the centre of the village of Arnside with access to the local shops and amenities. There is parking available for visitors and a garden area for people living there to use.

Summary of findings

The home provides accommodation on two floors that are both accessible by a passenger lift and bedrooms are for single occupancy. At the time of our visit there were 34 people living in the home.

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

At this inspection 29 September 2015 we found there were breaches of regulation that could have a negative impact upon people using the service. We found that assessments of people's care, treatment and support needs were not always in place, up to date or in sufficient detail to support person centred care. Care plans did not reflect individual choice and did not always include all a person's needs and all the risks that needed to be managed. The management of medicines and the procedures in use in the home did not reflect current national guidance for the safe management of medicines. This could put people at risk of receiving unsafe care and treatments.

The registered provider had installed CCTV in communal lounges. They had not done everything reasonably practicable to make sure they had consulted with people fully and in an open way and taking into account people's views on this and their ability to give consent to this surveillance. Systems and processes were not always in place to identify and assess risks to people's privacy, safety and welfare in the running of the home. People were not being consistently consulted on the running of the home.

The registered provider had not always acted in accordance with the requirements of the Mental Capacity Act 2005 to ensure that all those using the service, and those who could lawfully act on their behalf, had given consent.

The registered provider had not ensured that CQC had been notified of incidents and accidents in the home that they were required to inform CQC of under the regulations. They had not made sure that suspected or alleged abuse had been acted upon quickly and in line with local safeguarding arrangements to keep people safe and allow for an enquiry into the events. The registered provider did not have effective quality monitoring systems in place to monitor and evaluate service provision.

The Care Quality Commission (Registration) Regulations 2009 require that the registered provider notifies the Commission without delay of allegations of abuse and accidents or incidents that had involved injury to people who used this service. This is so that CQC can monitor services responses to help make sure appropriate action is taken and also to carry out our regulatory responsibilities. The sample of people's records that we looked at showed examples of incidents and accidents that had occurred that should have been reported to CQC. Our systems showed that we had not received these notifications. The failure to notify us of matters of concern as outlined in the registration regulations is a breach of the provider's condition of registration and this matter is being dealt with outside of the inspection process.

You can see what action we told the provider to take at the back of the full version of the report.

We spoke with people who lived at Westmorland Court and they told us that staff were "kind" and "helpful" and helped them to do things for themselves. We saw that the staff on duty approached people in a respectful way. We spent time with people on both floors and saw that the staff offered people assistance and took the time to speak with people.

We found that there was sufficient staff on duty to provide support to people to meet individual personal care needs. Staff had received training for their work and were supported by the registered manager and the deputy manager. The home had effective systems when new staff were recruited and all staff had appropriate security checks before starting work. The staff we spoke with were aware of their responsibilities to protect people from harm or abuse.

There was a complaints procedure although not all those we spoke with who lived there were aware of how to make a complaint. All the staff we spoke with told us that they had regular meetings, formal supervision and felt they were supported in their work.

Summary of findings

All of the care plans we looked at contained a nutritional assessment and a regular check was being done on people's weight for changes. People told us the food in the home was "good" and that they had a choice of food and drinks.

We found that there were some organised activities going on in the home and planned for future dates and musical events. The home is visited by the churches in the area and the people have the opportunity to take part or have their spiritual needs are met by their own ministers if they wanted.

Training records indicated that care and nursing staff had received training on safeguarding people at risk of abuse. The staff we spoke with were aware of the need to report incidents to their manager or the nurse in charge for action to be taken.

We have made recommendations that advice and information be sought about supporting people to express their views and involving them, their families and representatives in decisions within the home. We also recommended that the registered provider took advice on using surveillance to monitor aspects of the service and the key issues they need to consider when using it.

We recommended the registered provider sought guidance and advice upon how to make sure there was an easily accessible system for raising a complaint and verbal complaints available in the home. We recommended that the registered manager finds out more about training for nursing staff, based upon best practice, in relation to end of life and palliative care.

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?
The service was not safe.

The registered manager had not referred possible abuse to the appropriate safeguarding agencies in line with agreed local guidance.

The management of medicines and the procedures in use did not reflect current national guidance for the safe management of medicines and had not been properly reviewed.

There were sufficient numbers of care and nursing staff on duty to meet the assessed needs of people living in the home at the time of the inspection.

Requires improvement

Is the service effective?
The service was not effective.

the registered provider had not done everything reasonably practicable to make sure they had taken into account people's capacity and ability to consent to the use of CCTV cameras in their home

People had a choice of meals, drinks and snacks.

We could see that training had been provided for staff to help them understand and support people living in the home

Requires improvement

Is the service caring?
This service was caring.

We saw that the staff treated people in a polite and respectful way.

We saw that staff maintained people's personal dignity when assisting them. Staff also offered explanation and reassurance about what they were doing.

People had been able to bring some personal items into the home with them to help them feel more comfortable with familiar items.

Good

Is the service responsive?
The service was not responsive.

The assessments of people's care, treatment and support needs were not always in place, up to date or in sufficient detail to support person centred care and reflect individual choice.

There was a system in place to receive and handle complaints or concerns raised. However this was not easily accessible to all the people living in the home.

Support was provided so people could follow their own interests and faiths and to maintain relationships with friends and relatives.

Requires improvement

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

Notifications of accidents and incidents required by the regulations that should have been submitted to the Care Quality Commission (CQC) had not been notified.

There were not effective systems in place to make sure the registered provider and manager consistently sought and acted upon feedback from people using the service.

The registered provider did not have effective systems and processes in place to enable them to identify and assess risks there may be to people's privacy and welfare in the running of the home.

Westmorland Court Nursing and Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection team consisted of an adult social care inspector, a pharmacist inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. We spoke with four nursing staff, ten people who lived there, three relatives and five care workers and domestic staff on duty. We spoke with the deputy manager and the office manager.

As part of the inspection we looked at the medicines and records for ten people relating to the use and management of medicines. We looked at how medicines were being stored. We looked at individual care records, which included looking at six people's care plans and risk assessments in detail to help us see how their care was being planned with them and delivered by the staff. We also looked at the staff rotas for the previous two months, staff training and supervision and recruitment records. We also looked at records relating to the maintenance and the management of the service and regarding how quality was being monitored within the home.

Before our inspection we reviewed the information we held about the service. We looked at the information we held about notifications sent to us about accidents and incidents affecting the service and the people living there. We looked at the information we held on safeguarding referrals made to the local authority, concerns raised with us and applications the manager had made under Deprivation of Liberty Safeguards (DoLS).

We did not have a Provider Information Return (PIR) when we visited. 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. The registered manager had not received the request for a Provider Information Return (PIR) before our inspection.

Requires improvement

Is the service safe?

Our findings

People living at Westmorland Court told us about living there. One person told us "I feel I am safe and I trust the staff, if I had a problem I would ask". We were also told "There are always plenty of staff; I am comfortable in my room. My medication is given on time and if I require them the staff come quickly when I ring the call bell". Another person living there told us "I am happy here, I do not want to leave". A relative told us "I cannot praise them highly enough from the top to the cleaner for the care they are giving my [relative]. My [relative] is safe here and there are always plenty of staff around when I come".

We were also told "I feel safe in this home but I do not necessarily trust the staff, there are sufficient but there are some who annoy you, they answer my call bell quickly and I have a nice room and I can stay in my room if I wish. Another person said "I don't feel safe in the home things have gone missing from my room, anyone can walk in but we have a new lock system now and there was none before, so it's better". This had not been reported to CQC and we discussed this with the deputy manager during the visit for them to address now. The registered provider informed us that they had not received any reports of items going missing from people's bedrooms and that all bedroom doors were lockable should people want to lock their doors.

During this inspection we looked at the way medicines were managed and handled in the home. Medicines were generally well organised with a clear system for ordering, recording and administering medicines. Medicines including controlled drugs and medicines that required refrigeration were safely kept within suitable rooms. People we spoke with told us they received their medicines on time.

Medicines Administration Records (MAR) were supplied by the community pharmacy and the nursing staff oversaw the management of these. Records were generally complete and changes in medicines were managed effectively. Recent changes to the medicines ordering systems had improved medicines supply and accuracy. However we found a number of errors that placed people at unnecessary risk. One person was prescribed a strong medicine to calm them down when they were anxious but this was not recorded on the current records and there was no information about how to safely administer it. We found another person also prescribed this medicine and they had no information in their care plan or with their medicines records to safely support its administration. A third person was allergic to penicillin but this was not recorded on their MAR.

Medicines such as pain killers that were prescribed 'when required' had no care planning information to support their safe administration and variable doses (e.g. one or two tablets) were not accurately recorded so it was not possible to know what dose had been given to people. Creams and other externally used medicines were not safely recorded and there was no information about how to safely apply them. Nursing staff signed for administering creams but delegated the application of them to care workers. The lead nurse for medicines showed us new records that were to be kept in people's rooms that care workers would sign after applying a cream and this would have more information about how and where to apply them.

Medicines awaiting disposal were not stored according to national guidance so there was a risk of misuse. Homely remedies were kept (a product that can be obtained, without a prescription, for the immediate relief of a minor, self-limiting ailment) but these were not safely used. One of the medicines was out of date and had been given to several people; staff were also using these medicines which was not supported by the homes policy and national guidance.

The medicines policy and current practice did not reflect current national guidance for the safe management of medicines and had not been properly reviewed. National guidance also expects an annual review of staff knowledge, skills and competencies relating to managing and administering medicines but we saw no evidence of this or any recent medicines training.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The management of medicines and the procedures in use did not reflect current national guidance for the safe management of medicines and had not been properly reviewed. This meant people might be at risk of receiving unsafe care and treatments.

We looked at accident and incident records held in the home and found that accidents, incidents and near misses that affected people living in the home had not always been reported to the appropriate agencies for action. For

Requires improvement

Is the service safe?

example we found records of an incident where the behaviour of one person living there had put another person at risk. The incident had not been referred to the local authority safeguarding team or notified to CQC. Referral to the safeguarding team ensures that all evidence of an incident can be assessed and if necessary agreed protection plans can be put in place to protect people at risk.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider did not have robust systems in place to make sure the service notified the correct agencies and followed local safeguarding arrangements to keep people safe.

Training records indicated that care and nursing staff had received training on safeguarding people at risk of abuse. The staff we spoke with were aware of the need to report incidents to their manager or the nurse in charge for action to be taken.

We looked at staff recruitment records of the newest staff to see that checks required by regulation to help keep people safe had been done. This helped to ensure staff working in the home were only employed if they were suitable to work in a care environment. We saw required Disclosure and Barring Service [DBS] checks had been done and references obtained

We looked at the staff rotas for the last six weeks. We found there were sufficient staff on duty to provide nursing and personal care to the people living there. We found that there was not a formal dependency tool in use to help assess how many staff were needed to meet any changes in people's personal care needs. These kinds of formal tools would indicate good practice as they can assist in formally assessing how many staff might be needed to support people as their needs increased or changed.

Requires improvement

Is the service effective?

Our findings

People we spoke with who lived in the home told us the staff supporting them respected the choices they made. One person who lived there told us "The care and support I get here are ideal, the staff are kind and friendly, I do not know if I have a care plan but the doctor comes if I need him". Another person said "I am happy with the care and support I get; they take care of me very well". A relative we asked told us they felt "The staff seem to work well as a team".

We asked people about the food provided for them in the home. People made some positive comments about the food. We were told "I enjoy all my food" and "The food here is very good when the regular cook does it but the agency staff are not so good. If you do not like what's on the menu you can have something different" and also "You can also have snacks day or night". A relative commented that" Since [relative] came out of the hospital they have been eating better than they have done for a long time".

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). The MCA and DoLS provide legal safeguards for people who may be unable to make decisions about their care. We looked at care plans to see how consent was obtained from people and how decisions had been made around treatment choices.

We looked at documents regarding 'do not attempt cardio pulmonary resuscitation' (DNACPR) decisions. No one had an advance directive on file to indicate particular treatment preferences in the event of not being able to make a decision. We saw that GPs had made clinical decisions as to whether or not attempts at resuscitation might be successful. There were no advance directives about care and treatment on file.

We noted that the information held by the service around who held Power of Attorney (PoA) for a person was not always clear in people's care plans and there was not always evidence seen of the authority. Powers of Attorney show who has legal authority to make decisions on a person's behalf when they cannot do so themselves and may be for financial and/or care and welfare needs. It was not always clear which of these applied. As a result it was difficult for care staff to know who held legal authority to make decisions or be consulted about health and welfare on someone's behalf.

We saw that one person had power of attorney for finances but was making decisions about a person's welfare and treatment when they did not have the legal authority to do so. Care plans did not indicate if evidence had been provided by the person holding the power of attorney. Therefore we could not be certain who had legal authority to act on another person's behalf for finances and/or health and welfare.

We saw that one person had not been involved in discussing a DNACPR decision although they had not been formally assessed as lacking capacity. There was no evidence of a PoA in place but a relative had been involved in giving permissions for aspects of treatment and had been involved in discussions about resuscitation. This had not placed the person at the centre of their care. We also saw that some DNACPR records had not been reviewed at least annually to make sure they were still relevant to people. If the registered provider has any concerns that a person's health has improved or there are errors on the form they can query this with whoever signed it.

This was a breach of Regulation11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Need for consent). This was because the registered provider had not acted in accordance with the requirements of the Mental Capacity Act 2005 to ensure that all those using the service, and those who could lawfully act on their behalf, had been supported to give consent.

We looked at the staff training records to see what training had been done and what was required. We saw that new staff had done induction training when they started working at the home. We could see that training had been provided for staff on dementia awareness to help that understand this and support people living with the condition. Staff had been given training on safe moving and handling of people, the Mental Capacity Act and deprivation of liberty safeguards.

Nursing staff had done some additional training required for their roles such as basic life support, tube feeding and verification of death. However we saw that nursing staff had not undertaken additional training on providing end of

Requires improvement

Is the service effective?

life and /or palliative care and the use of the equipment to deliver medication to provide symptom control and relieve distress. Nursing staff needed to be trained and competent to provide this care.

One of the senior nursing staff was doing a review of training to identify where people needed updates or additional training. We also noted care staff did not routinely have basic food hygiene training provided although they were involved in handling food at meal times. We asked the deputy to address this within the training review.

All of the care plans we looked at contained a nutritional assessment and a regular check was being done on people's weight for changes. We saw that if someone found it difficult to eat or swallow advice was sought from the dietician or the speech and language therapist (SALT). Information was in place if people needed fortified diets.

We recommend that the registered manager finds out more about training for nursing staff, based upon best practice, in relation to end of life and palliative care.

Good

Is the service caring?

Our findings

We spoke with people living in the home about how they were cared for and how staff supported them to live as they wanted. We were told by person living there "The staff are very kind and caring, they do treat me with dignity and respect because I have to have everything done for me, but they do allow me to have some privacy". We were also told "The staff are very kind and caring and always knock on my door before coming into my room" and "The care and support I get here are ideal". One person living there told us "I know the staff fairly well; they listen to me and will come and sit next to me and have a talk".

We spoke with relatives about how their relatives were cared for at the home. A visiting relative told us "[Relative] is here for end of life and is getting wonderful care here". Another told us that "The staff are knowledgeable about [relatives] end of life care and we are both supported very well by the nurses and carers. I am kept up to date about any changes". One relative said "The staff are very kind and caring with very good standards of care. I can visit at any time if fact I come in about three times a day".

We saw that staff kept people's personal dignity when assisting them with equipment and when helping transfer people from a wheelchair to an easy chair. Staff also explained what they were doing. During our observations we saw that most staff took the time to speak with people and took opportunities to chat and interact with them. As we spent time in different communal areas of the home we saw that the nursing and care staff engaged positively with people and we saw people enjoyed talking with the staff. We saw staff ask people what they wanted to eat and how they wanted to be assisted.

We spent time in different communal and dining areas of the home throughout the inspection and at lunch time. People who required support with eating received this with staff helping and prompting people with their meals. We saw staff talking to people in a polite and friendly manner. We saw that people had a choice of food and drinks throughout the day.

We saw that people had been able to bring some personal items into the home with them to help them feel more comfortable with familiar items and photographs around them. All bedrooms at the home were used for single occupancy. This meant that people were able to spend time in private if they wished to.

Care plans contained some information about people's personal care should their condition deteriorate.Their preferences about place of care and arrangements at the end of life were in care plans where this had been stated by them. Staff we spoke with were clear about the importance of giving people good care at the end of life. We were told "We stay with people at the end, that's very important".

Requires improvement

Is the service responsive?

Our findings

During our inspection we received comments from the people living there about their daily life in the home. We were told "They [staff] answer my call bell quickly and I have a nice room" another said "I would like to get out more, we do have a bus but it is not used much". One person commented" If I have ever had a problem it has been dealt with promptly and in a sympathetic manner". A relative said "[Relative] seems happy here, settled and very well cared for. I always feel I can speak to staff if I have any questions or queries".

We found that the service had procedures in place to allow people to raise a complaint. This was included in a welcome pack and formed part of the service guide. The registered provider told us these were normally kept in the foyer. We did not see the policy on display in the home for ease of access to the information or that it was available in formats people living there might find easier to read or use such as large print or easy read formats. There was a complaint log that showed that the service had not received any complaints since the last inspection.

People living there told us they had raised issues verbally but these were not on record. Some people told us they were not sure about how to make a complaint. Other people told us "I would go to the manager or her deputy if I had any complaints but my [relative] deals with all that for me". One person who lived there told us "I do not think I know who to complain to.

We looked at care plans for six people. We saw that people's needs and risks were being assessed and identified but they had not been acted upon in response to the risk or need. Some people did not have appropriate care management plans in place to inform the support they needed from staff. For example we saw that three care plans we looked at were for people that had been assessed as at 'high risk' of skin damage. There were no care plans in place as to how staff would manage this. One person had been assessed as at high risk of falling but there was no management plan as to how this would be managed.

Accident forms we had looked at indicated that one person could be "verbally and physically aggressive" towards staff and that their behaviour was unpredictable but there was no reference to this in their care plan. There was no record of behaviour monitoring or management plans for this behaviour and to make sure staff knew how to handle it consistently. One person had a management plan to inform staff about behaviour management but the behaviour was not being monitored so the plan could not be evaluated to make sure it was still effective.

Care management plans did not always reflect the strategies and actions needed to support for more complex care needs. We saw this in regard to the management of some people's medicines, such as anticoagulants that were required to prevent blood clots developing. There was not a management plan for this and the care plan in place was regarding a discontinued medication.

Some of the care plans we looked at had not been reviewed and updated over time. This was to make sure that people's goals or plans were still being met and were still relevant. One person had a DNACPR in place from 2013 that had not been subject to review to make sure it was still required or relevant to the person. Another person had not had their preferred priorities of care reviewed for two years so may not be still an accurate reflection of their wishes. Five of the people we spoke with told us they had not been asked if they had a preference about the gender of the carer staff supporting them and this choice was not evident in their care plans.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Person centred care). This was because the assessments of people's care, treatment and support needs were not always in place or in sufficient detail to support person centred care and individual choice.

We found that there were some organised activities going on in the home and planned for future dates and musical events. There was some information in care plans about people's interests and religion. On the day of the inspection people were sat around the lounge in chairs watching the television, reading papers, seeing visitors or asleep. The home is visited by the churches in the area and the people have the opportunity to take part or have their spiritual needs are met by their own ministers if they wanted.

We recommend that the registered provider seeks guidance and advice upon how to make sure there was an accessible system for raising a complaint and

Requires improvement

Is the service responsive?

verbal complaints available in the home. We recommend that they also take advice on how to provide alternate formats to aid people's understanding of the complaints process.

Inadequate

Is the service well-led?

Our findings

People living at the home made a range of comments about how the home was being well run for them. One person told us "I cannot tell you who the manager is and I don't feel valued here" and another said "As far as I know I have not completed a survey about the services or the home". Three of the people we spoke with did not know if there were meetings for them in the home but another person said "There are residents and relative's meeting but nothing ever happens".

We found that the registered provider had not ensured that CQC had been notified of incidents and accidents in the home that they were required to inform CQC of under the regulations. We looked at records for the last six months and found that there had been a failure to notify CQC about injuries people had sustained following falls and not reporting two possible safeguarding incidents. One person told us that things had gone missing from their room but CQC had not been notified and there was no record of what action had been taken. Although the person told us a new lock system had been put in so the problem had been addressed.

The failure to notify CQC meant we had not been able to check that the registered provider had taken appropriate action at the time of these incidents and accidents so that, if needed, action could be taken to protect the person or their rights. We told the registered manager they needed to do so immediately.

The failure to notify us of matters of concern as outlined in the registration regulations is a breach of the provider's condition of registration and this matter will be dealt with outside of the inspection process. We spoke with the deputy and later the registered manager about this failure and the breach of regulation. We informed them that that we would deal with this breach separately and take further action if future incidents that needed to be notified were not reported to CQC without delay.

We asked people living there how their home was managed for them and how involved they were in this. One person told us "I have complained about a member of staff to the management but nothing happened". Another person said "I don't know who the manager is but I suppose I can always talk to the carers". Some people we spoke with had not been aware of 'residents and relatives' meetings taking place. One person told us "I am not sure if we have any meetings". We looked at the records held of meetings held in the home, for the people living there, relatives and staff.

Staff meetings were recorded with the last nurses meeting on record in March 2015 although care staff had met in August 2015 and kitchen and domestic staff in January 2015. However the staff we spoke with told us that they had regular meetings, formal supervision and felt they were supported in their work.

We saw that the registered provider had installed CCTV cameras in the home. Some were to monitor the entrance and the grounds for security purposes. Other cameras had been installed in the two communal lounges in the home. We asked the deputy managers about these and they told us they had only been installed two months previously. Relatives we spoke with knew about the cameras being put in and told us about the new entry system "with cameras on the door" and how "People can now be seen coming into the home".

We looked at the policies and procedures in use in the home to provide guidance to staff. We found that these had not been reviewed as they were out of date and did not reflect changes in legislation and regulation. There was no procedural guidance for staff in the home on the CCTV cameras and their use for surveillance in the communal lounges or on complying with the Data Protection Act. There was no record of the steps taken when the provider was deciding to use surveillance and why this was needed and if less intrusive methods had been considered.

We asked the registered manager, when they were back on duty, how people living there and their relatives had been consulted about the use of cameras and about any concerns they might have about the use of cameras affecting their privacy. We discussed with the registered manager that when deciding to use cameras in communal areas consideration needed to be given to the best interests of individuals lacking in mental capacity. This included whether and how they could be supported to enable them to express their views and if consultation had been with people's families, friends and representatives as appropriate. The registered manager told us the information had been put in the home's newsletter before

Inadequate

Is the service well-led?

installation and there had not been any negative feedback. The registered manager agreed they would also be sending letters to relatives and would discuss it at the resident's and relative's meeting.

The implementation of the CCTV system had not been well managed as there was no evidence that an open and inclusive consultation had not taken place with people living in the home and people who visited or worked there before installation. For example there was no procedural guidance or a clear record of who was responsible and accountable for the oversight of the operation of the system and for the use and protection of any information obtained.

We found that audit systems were not being fully effective in monitoring the quality and effectiveness of the service and to identify where improvements were needed. For example we saw medicines audits had been completed over a year ago with some actions taken to make improvements. We were told an audit had been completed a few weeks ago but there was no record of this to verify what was found or what action was being taken. Care plans were not being effectively reviewed and updated and care management plans were not in place for some needs, risks and treatment needs. One person was recorded as having their care plan audited and reviewed in September 2015 but their care plan contained out of date information including around a complex medication. Therefore monitoring was not been effective.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance). This was because the registered provider did not have effective monitoring and communication systems in place to enable them to identify and assess risks to people's welfare or consult effectively with them on the running of the home.

We found that work was underway with nursing staff to improve care planning and the monitoring of training and that progress was being made. We saw in care plans that audits had been carried out and areas of improvement had been identified. However there was nothing to show how the issues found had been followed up to make sure the omissions were addressed promptly.

We looked at the latest satisfaction survey the registered manager had undertaken with people living there and families. There were positive comments about the cleanliness of the home and the good personal care being provided. A relative commented on being made to feel welcome when they visited.

The home had a registered manager in place as required by their registration with the Care Quality Commission (CQC).

We recommend that the service seek advice and information from a reputable source about supporting people to express their views and involving them, their families and representatives in decisions within the home. We also recommend that the registered provider took advice on using surveillance to monitor aspects of the service and the key issues they need to consider.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: Assessments of people's care, treatment and support needs were not always in place or in sufficient detail to support person centred care and individual choice. Regulation 9 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The registered provider had not acted in accordance with the requirements of the Mental Capacity Act 2005 to ensure that all those using the service, and only those who could lawfully act on their behalf, have given or are supported to give consent. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The management of medicines and the procedures in use did not reflect current national guidance for the safe management of medicines and had not been properly reviewed. This meant people might be at risk of receiving unsafe care and treatments. Regulation 12 (1) (2)

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: This was because the registered provider did not have effective quality monitoring and communication systems in place to enable them to identify and assess risks to people's welfare or consult effectively with them on the running of the home. Regulation 17 (2) (a) (b) (c)