Countrywide Care Homes Limited

Manor Park Care Home

Inspection report

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Tel: 01977604242

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 10 March 2016 and was unannounced. The service provides accommodation and nursing care for up to 75 people, some of whom may be living with dementia. There were 60 people living at the home at the time of the inspection.

There was a registered manager in post. 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.

Manor Park Care Home was previously inspected in August 2014 and was non-compliant in all areas inspected at that time and there were six breaches in the regulations. We found continued breaches in five of the six beaches identified at the last inspection.

Staff understood the safeguarding and whistleblowing procedures to follow to ensure people were protected from harm.

Risk assessments were incomplete and conflicting for some individuals.

Staffing levels were insufficient to meet people's needs, particularly on the nursing unit. This was a concern at the previous inspection.

Systems for managing medicines were ineffective; some medicines were not stored correctly and there were inaccuracies in stock balances.

The premises were well maintained overall, although the temperature in some parts of the home was too high for people's comfort.

Staff training was regular, although this was not always effective enough to ensure staff had the right skills and competencies. Not all staff had a secure understanding of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards which affected people's care.

Communication between staff was regular in staff meetings and supervisions, although staff handover documentation was poor between shifts.

People's nutrition and hydration was not sufficiently managed and monitored to ensure their good health, particularly within the nursing unit. Some people were unhappy with the quality of the food and there were insufficient opportunities for people to have a drink. This was also an issue at the previous inspection.

Staff demonstrated a kind and caring approach and they were patient and reassuring when assisting

people. Staff respected people's dignity in personal care, although at times they spoke about people over their heads and this was not always respectful.

Care documentation was incomplete and computerised information was not easy to locate. A large number of people were nursed in bed, with no clear information about the reason for this.

There was a new activities coordinator who had lots of ideas for engaging with people, although those who remained in bed were under-stimulated.

Some quality assurance systems were in place although these were not robust enough to address key aspects of people's care and support, or the breaches identified at the previous inspection.
The overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'.

The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were not enough staff to meet people's needs, particularly on the nursing unit.

Risk assessments were not sufficiently detailed and information in some people's risk assessments was conflicting.

Premises were well maintained, but too hot to be comfortable for some people.

Medicines were not managed safely.

Is the service effective?

Inadequate

The service was not effective.

Staff training did not ensure staff were skilled to carry out their roles effectively.

Handover documentation was poor, particularly on the nursing unit.

People's nutrition and hydration needs were not well met or monitored.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff demonstrated a patient and caring approach when interacting directly with people, although they did not always speak about people in an involving or considerate manner.

People's dignity and privacy was respected when staff supported them with personal care.

People's end of life care was delivered in a sensitive and compassionate way.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were incomplete and held inconsistent information. Information about people's care was not always recorded accurately or easy to locate.

There was a new activities coordinator in post who had many ideas for engaging with people, although had not yet put these into place. Many people remained in bed and some people had little to do to keep them occupied.

Complaints were recorded and people knew how to complain.

Is the service well-led?

Inadequate

The service was not well led.

Systems and processes for monitoring the quality of the provision were in place, but lacked rigour.

Breaches in the regulations identified at the previous inspection had not been sufficiently addressed.

The registered manager was not visible in the service.

Manor Park Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 10 March 2016 and was unannounced.

There were four adult social care inspectors and a specialist professional advisor in nursing and dementia care. We reviewed information we held about the service, such as notifications, information from the local authority and the contracting team. We displayed a poster to inform people and visitors that we were inspecting the service and inviting them to share their views.

We looked around the home, in people's rooms with their permission and in communal areas. We spoke with 12 people, seven care staff, the activities coordinator, the cook and the registered manager as well as four visitors.

We looked at care documentation for eight people, five recruitment files and records relating to quality assurance monitoring and the safety of the premises and equipment.

Inadequate

Is the service safe?

Our findings

People told us they felt safe. One person said: "I'm safe enough" and another person said: "Well I am sure I'm safe in here". One relative we spoke with told us their family member was 'very safe' and said they had 'peace of mind knowing there are staff on duty day and night'.

Staff we spoke with understood how to spot the signs of possible abuse and described the steps they would take to ensure a person was safeguarded. Staff told us they knew how to use the whistleblowing procedure if they became aware of poor practice. Staff said they had done safeguarding training by e-learning, although not all staff thought this was an effective way of learning. Staff were aware contact numbers for reporting safeguarding concerns were 'on display in the staff room and everywhere'. One member of staff said:" I wouldn't hesitate to report anything".

Risk assessments we saw for individual people were incomplete and some contained conflicting information. For example, one person's risk assessment identified them as needing a posture belt in one section, then stated in another section that the posture belt was not required. One person required bedrails, yet their risk assessment stated low risk of falls. It was unclear from care records how individual risks to people had been assessed and there was a lack of detail for staff to know how to mitigate any risks.

Accidents and incidents were recorded and analysed, although there were gaps in the recording. Where accidents had been recorded for some people there were actions raised. For example, where one person had fallen from their bed, the action was to 'ask the unit matron for a low bed and a crash mat'. However, for another person, only the fall from bed was recorded but no actions or any further detail identified.

Staff recruitment files showed appropriate checks had been carried out to ensure staff were vetted and checked as suitable to work with vulnerable people. The registered manager told us the recruitment procedure was robustly implemented. We saw evidence of staff induction where new staff had been appointed.

Staffing levels were not adequate to meet people's needs, particularly on the nursing unit where people were highly dependent upon staff for their care and support. The registered manager told us they considered staffing levels were adequate throughout the home. However, we identified several occasions where people needed staff and staff were unavailable due to caring for others. For example, out of 24 people on the nursing unit we were told there were 11 people who required assistance with meals. There were five care staff plus the registered nurse on duty and we saw the people who needed assistance had to wait until staff were available. After 2pm, the number of care staff reduced to four.

We saw many occasions when the nursing unit lounge had no visible staff, yet people required assistance. One person repeatedly called out but no staff came for over 10 minutes. When staff appeared we saw they were rushed and trying to meet people's needs. Three relatives we spoke with said there were not enough staff. One relative said they visited every day and there was 'not a soul in sight' They told us it was difficult for them to locate staff to assist their family member with the toilet. They told us their family member reported

being denied assistance with the toilet until after their meal and staff only offered the toilet after meals. The relative said they felt a lack of staff impacted upon basic care, such as providing people with drinks.

Some people we spoke with said they thought there were not enough staff available to help them. One person told us staff did not always come when they pressed their buzzer. Another person said "I try not to bother them [the staff] but they don't come quickly. They can't, they've a lot on".

Staff we spoke with said there were not enough staff to meet people's needs without people having to wait a long time to be assisted.

The above examples illustrated the provider was in continued breach of the Health and Social Care Act (Regulated Activities) Regulations 2014, regulation 18, which corresponds with Regulations 2010 regulation 13, as there were insufficient numbers of staff available to meet people's needs.

We saw on the nursing unit there were 11 people who remained in bed, yet the registered manager told us there were only three people who needed to remain in bed. We asked staff on the nursing unit why so many people were in bed all day and staff were unable to tell us why this was. One member of staff told us they would not have time to get everybody up because so many people needed two staff at a time to assist them. Care records we looked at did not identify why people may need to remain in bed. We saw meeting minutes which showed this issue had been discussed at a recent staff meeting, but there was no evidence of what action had been taken.

The above examples illustrated the provider was in continued breach of the Health and Social Care Act (Regulated Activities) Regulations 2014, regulation 9, which corresponds with Regulations 2010 regulation 9, as there was a lack of person centred care.

Areas in the home varied in room temperature. We found the nursing unit environment was uncomfortably warm and some people said they were 'too hot'. We saw some staff were sweating and they told us it was difficult to keep cool. In addition to this we saw people did not have suitable access to regular drinks to keep them hydrated. Staff we spoke with on the nursing unit said this was because there were not enough staff. One member of staff said: "We can't manage to see to people's care and take the drinks trolley round, it's just not possible". We saw there were jugs of drinks and glasses visible throughout the home, although people who were unable to mobilise could not access these. We discussed this with the registered manager who said they would give priority to the temperature in the home and people's hydration.

We also had concerns about people's health care on the nursing unit with regard to people's pressure care areas and position changes when they were immobile and remained in bed. Position changes were not being documented consistently and staff were unable to demonstrate appropriate pressure relief was being given to prevent people's skin from becoming damaged. For example, one person had a grade two pressure ulcer and the records to show how this was being managed were unclear and entered into different places on the computerised records.

We observed people being assisted to take their medicines. Staff administering medicines wore red tabards to demonstrate they should not be disturbed during this process. We saw medicines were given patiently and with individual support from staff for people where needed. Staff explained what people's medicine was for, reminded people to take their time and sat with people individually whilst they had their medicines. We saw staff returned to their locked trolley and updated the computer after each person's medicine had been given.

On the nursing unit in one person's bedroom we found a pink tablet on the mattress; we gave this to the nurse on duty and asked her to identify the tablet and whether it had been recorded as being given. The nurse told us 'it could be anything' and said it was 'probably a night time tablet' but was unable to establish from the records when this had been missed for the person concerned.

We had concerns about the storage of medicines. We looked in two of the three treatment rooms and found the temperatures in these to be too hot to store medicines. Room and refrigerator temperatures were recorded daily and there were recorded room temperatures of 27°C and 28°C. This meant storing medicines at too high temperatures may alter their effectiveness. In the residential unit treatment room there was a large fan under a table and the circulation of air was obstructed by oxygen bottles. Oxygen cylinders require storage in a well ventilated area; when we spoke with staff they were unsure whether this was appropriate storage for these cylinders. We saw an ampoule of insulin was stored on the worktop instead of the refrigerator; staff could not explain how this should be stored and this was moved to the refrigerator when we discussed this with staff. Fortified drinks were stored in treatment rooms when instructions stated 'store in a cool dry place'. The medication trolley in the dementia nursing unit was not secured to the wall and the recording book for homely remedies could not be located. We raised our concerns with the provider regarding the temperatures of medicines storage.

The registered manager told us there were audits done every six months by the pharmacy and the home was in the process of being audited. We found discrepancies with some people's medicines we checked. For example, for one person it appeared there were two paracetamol tablets missing, for another there were seven senokot tablets missing. On one person's medicine packet it stated these were opened 4 March 2016 but according to the medicine administration record sheet (MARs) it should have been 5 March 2016. We checked each of the medicines for this person and found two had the correct amount, two had an extra tablet and one had a tablet missing.

The above examples illustrated the provider was in continued breach of the Health and Social Care Act (Regulated Activities) Regulations 2014, regulation 12, which corresponds with Regulations 2010 regulation 13, as medicines were not managed in a safe or robust way.

We saw there were appropriate systems and recording for the disposal of medicines. The nurse we spoke with told us they had been trained in how to use the computerised MAR sheets, but training in specific areas such as how to use a syringe driver had not been done since 2014.The nurse said their competency was checked, but could not remember when this had last been done.

Staff we spoke with told us they knew when they needed to wear personal protective equipment (PPE) such as gloves and disposable aprons and we saw these were in good supply throughout the home. The home was visibly clean although we saw staff did not always follow safe infection control practices. For example, on the nursing unit we saw a member of staff put a yellow clinical waste bag that had a strong malodour, into a laundry skip and take this through several areas before finally taking this to the sluice room. This may have posed a risk of infection to others. Staff told us they felt cleanliness in the home had improved recently. The registered manager told us they were working to improve standards in the home following their most recent external infection prevention and control audit.

Inadequate

Is the service effective?

Our findings

Some people and some relatives told us staff were able to do their jobs. One relative said: "These lasses are great, they know [my family member] well and they know what they're doing. There could do to be more of them though". One relative did not feel the staff were skilled or interested in their work. One person said: "I'm sure staff are trained as they need to be. They seem to do a good job with me". One person said: "I suppose it's as good as anywhere else", but then pulled a face which intimated a lack of confidence in the statement.

All staff we spoke with said their training was done via e-learning. Some staff said this was not at all effective in making them skilled to do their work. One member of staff said: "I just don't feel I have the skills; the training is unhelpful, it's just a process we go through, that's not learning". The training matrix showed staff had completed training in areas such as fire awareness, safeguarding, manual handling, health and safety, dementia awareness and mental capacity. Staff told us they had not had any training in equality and diversity or dignity, or any specialist areas relevant to their role, such as managing challenging behaviour.

The registered manager told us new staff were inducted over a period of 12 weeks and worked towards obtaining the Care Certificate. They told us they carried out informal observations of staff practice as part of monitoring staff suitability and although there were none currently done at night time, these were planned for the future. Staff we spoke with understood the requirements of their role and the line management structure.

The registered manager told us there were regular supervision meetings for staff and we saw the supervision matrix recorded these as having been carried out regularly. Delegation for supervision was given to team leaders. Staff we spoke with said they did not all feel supported to do their job and did not all regard the supervision process as helpful or supportive. Staff told us they attended staff meetings and we saw minutes from these which had addressed themes such as staffing, staff sickness and safeguarding.

We saw verbal communication between staff was regular with regard to meeting people's needs. However, staff did not always know each other's whereabouts and had to ask people if they had seen staff. One person who was on the nursing unit told staff which direction the nurse had gone as the nurse could not be located. Handover information between shifts was poor on the nursing unit and staff we spoke with said there was not enough information shared when they came on duty. We asked to see the handover notes and saw there were some in a file in the registered manager's office, but these were few in number and were not consecutive. We looked at handover documentation on the nursing unit and saw these were variable in content and format. Some were written on the handover sheets, but the information for the day of the inspection was annotated on a notepad from the night before. There was no day handover information and we asked the nurse about this. They told us it was 'just noted down on the pad'.

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We discussed with the registered manager the people that were subject to DoLS. We looked at the file that contained applications for people whose mental capacity was considered. Although no mental capacity assessments were in the file, each application indicated where a person may lack capacity to make particular decisions. Some staff had an awareness of the legislation that affected people in relation to their mental capacity, but other staff were not at all sure. Staff told us training for this was not adequate. One member of staff said they had not had training since the home was run by another provider several years ago.

The above examples illustrated the provider was in continued breach of the Health and Social Care Act (Regulated Activities) Regulations 2014, regulation 11, as not all staff were able to act in accordance with the requirements of the MCA.

We observed staff sometimes consulted with people regarding activities of daily life, such as what they wanted to eat and where they wanted to sit. When people were assisted with moving and handling, staff asked them first and then explained what they were doing, with regular checks to see if the person was alright. People told us staff asked them before helping them with their care. One person said: "They always ask me if I need help, or what they can do for me, they never just do it". We saw staff asked people if they wanted to wear an apron for their lunch time meal or if they wanted to wear their slippers. Care records referred to people's choices and how they should be encouraged to make these for themselves. There was inconsistent practice throughout the home and we observed there was less choice offered to people on the nursing unit, particularly where people remained in bed.

There was mixed opinion in the home from people, relatives and staff about the quality of the meals provided. Some people said they enjoyed the meals. One person told us: "We are never hungry, there's always something. The staff will make something for you if you need it". Some people were not happy with the meals or with the lack of choice. One person said: "There's two choices, take it or leave it". Two relatives told us the meals were repetitive and one said they brought food in for their family member because they wanted them to have more variety. The registered manager told us they were already looking at ways to improve the quality of the meals.

The dining experience was varied for people throughout the home. In the dementia nursing unit, people were offered the choice of meal components and the food appeared appetising. Plate guards were not in use, even though it was identified on several people's care records these were required. People ate their meals and appeared to be happy with the content , although we saw some people lost interest as the service was slow due to the temperature of the food being tested. However, staff were prompt in redirecting people back to their meal if they became distracted.

In the residential unit, meals were given to people already plated up with no choices offered for portion size or content of the meal. We saw plenty of encouragement given to people to eat their meal, although when staff supported people on a one to one basis there was little engagement or interaction. People said they enjoyed their meals on the residential unit and staff took time to ask them whether they had. There was a calm atmosphere during the lunchtime in this unit.

In the nursing unit staff told us there would not be many people using the dining room as people were assisted in their rooms. Staff interaction with people was limited and staff spent time together waiting for meals to be plated up. We saw people were in need of staff attention during this time, but staff did not respond appropriately. For example, one person repeatedly shouted out that they did not want to eat. Staff placed their meal in front of them, cut the food up and warned them it was hot, even though the person did not want this. When one person refused dessert, care staff accepted this without further choices or encouragement, yet when another person did not want their food they were offered a sandwich.

We saw there were 11 people who remained in bed and who required assistance to eat. These people had to wait until staff were available to support them, which was a considerable time after the meal trolley had been brought to the nursing unit. For example, the trolley was brought to the unit at 12.35pm and some people had not been assisted with their lunch by 1.30pm. We saw these people were in their rooms and had not been offered their lunch or a drink. However, when we looked at the care records on the computer, we saw entries had been made prior to the meals being offered. For example, one person's food entry was made at 12.45pm and another at 1.15pm, before they had eaten anything. One person's lunch was recorded as being given at 12.30pm, before the trolley had even come to the unit. We asked staff if there was a chance this person may have been brought their lunch before the trolley, such as from the kitchen, and staff confirmed this had not happened.

We had particular concerns about one person's dietary needs not being met. We saw they had not been assisted by 1.30pm. At 1.40pm we spoke with a member of staff who had just returned from assisting the person with their meal. They told us the person had been given potatoes, broccoli, lamb, sponge and custard and a beaker of juice. We questioned whether 10 minutes was an appropriate space of time for the person to have been given this. We also queried the type of diet the person had been given and why this was in beakers. Staff told us the food was pureed but we saw it would need to be very runny for it to come out of a beaker, which would question the quantity of food being offered. We discussed this with the registered manager who agreed this was not pureed food. We saw documented on the person's care plan the food was to be given in beakers, but no one could explain the reason for this or who had made this decision. The registered manager said it may have been the person could not open and close their mouth, but our observations showed this person could do that. We looked at the person's fluid charts and saw the first drink of the day was recorded at 11am, from 4.30pm the previous day. Staff we spoke with said people nursed in bed were offered frequent drinks but we found care records did not evidence this. The registered manager said they would arrange a review of this person's care.

Throughout the home we found there were insufficient opportunities for people to drink. Staff told us they did not always have time to take the drinks trolley round each morning and afternoon. Although we saw there were jugs of juice and snacks on each unit, people who were not mobile could not help themselves and relied on staff to offer drinks. On the nursing unit there were jugs of drinks but these were very full and would have been heavy to lift; and there were no accessible cups or glasses. We saw jugs of drinks remained largely untouched and un-replenished during the day.

In the nursing unit, we saw one person did not want their drink and they told staff it did not taste alright. Staff took the drink away without offering an alternative. People who remained in bed, some of whom were completely dependent on staff, did not have sufficient opportunities for drinks.

Recording of people's food and fluid intake was inconsistent. In all of the units there were gaps in dates within food and fluid record charts and there was no robust oversight of these records to identify if a person was at risk of dehydration or malnutrition.

One relative we spoke with in the nursing unit said they had particular concerns around hydration and felt staff did not do enough to ensure drinks were offered to people regularly. They said their family member had a congealed drink when they visited and 'their voice had gone'. They told us when they had spoken with staff they did not feel staff understood the importance of regular hydration.
With regard to people's weight loss we saw evidence of some management oversight during a three-monthly care plan audit, in which the registered manager had noted action to be taken to monitor a person's weight loss on the dementia nursing unit. However, although the person had lost weight for two months, the food chart had not been completed since 28 February 2016 and was stated as being no longer required.

The above examples illustrated the provider was in continued breach of the Health and Social Care Act (Regulated Activities) Regulations 2014, regulation 14, which corresponds with Regulations 2010 regulation 14, as people were not protected from the risks of inadequate nutrition and dehydration.

There was evidence of other professionals involved in people's care. The nurse we spoke with said they had autonomy to be able to refer to GPs dieticians and district nurses when the need arose.

One relative we spoke with said the staff were proactive in seeking medical help if their family member needed this.

We found the environment for people who were living with dementia was in need of improvement and was not used to best effect. For example, we saw a small garden room that was not used and the door remained closed much of the time we were there. We saw there were pictures of interest placed around the home and day, date and time boards which were updated, although there was limited signage. The registered manager told us they were giving consideration to the environment for people living with a diagnosis of dementia.

Requires Improvement

Is the service caring?

Our findings

People told us they thought staff were caring. One person said staff 'care enough to do this work'. One person said: "I'm sure if they didn't really care, they'd find somewhere else". Another person said: "Oh yes, they look after me very well, they're all lovely". Another person said: "Staff are lovely. I never hear them say a bad word about anyone". One person said: "It's better than being on the streets" but was unable to add anything further.

Staff demonstrated a kind and caring approach when speaking with people and they used pleasant facial expressions and tones of voice. Staff were respectful and spoke with courtesy to people. We saw staff paid people compliments, which made them smile. For example, some people had come back from seeing the hairdresser and staff told them how nice they looked. We saw some staff made reassuring gestures to people, such as hugs and hand holding or hand stroking which we observed were all made in an appropriate and therapeutic manner. However, much of the staff interaction with people we saw was when carrying out physical care or in passing, when staff were on their way to attend to other people and we did not see many opportunities for care staff to engage in meaningful conversation with people for any length of time. Staff we spoke with told us they cared about the people and they would like more time to spend in quality interaction, but they had other tasks to undertake which meant that they had not time to spend as they would wish in order to support peoples' social and emotional needs.

People's independence was not always fully promoted. There were several people who remained in bed and staff we spoke with did not know the reasons why some of those people could not be assisted to sit out of bed. Staff made limited effort to involve these people and explain what they were doing.

Staff were mindful to preserve people's dignity, such as when moving and handling, they ensured people's legs were suitably covered. Staff knocked on people's doors before entering and ensured bathroom doors were closed when assisting people with care. We noted the terminology staff used when describing people was not always appropriate or respectful. For example, staff referred to people who needed assistance with meals as 'feeders'.

At times, some staff appeared detached and often did not acknowledge people. For example on three occasions we saw staff enter the nursing unit lounge and walk past people without looking at or speaking with them. We heard staff speak about people loudly in their presence. For example, on the residential unit one staff member called across the room to another staff member that the district nurse was coming to attend to a person's pressure sores. Staff on the nursing unit spoke about one person within their earshot and said they were 'getting agitated'.
Staff told us they did not have any training in dignity or equality and diversity. One member of staff we spoke with did not know what diversity was or how to promote this within the home.
The above examples illustrated the provider was in breach of the Health and Social Care Act (Regulated Activities) Regulations 2014, regulation 10 as people were not treated with dignity and respect.

We saw in care records people's end of life wishes were discussed and respected. People's care at the end of

their life was managed well and for one person we saw there was a comprehensive care plan in place. This included palliative care, pain management and the person's wishes. We spoke with the person's family and they were complimentary about the care of their relative. They told us: "My [family member] is well looked after. We have no complaints about this home. The staff are wonderful. The staff have really looked after us at this time". We observed sensitive and compassionate interaction between staff and the person and their family.

Inadequate

Is the service responsive?

Our findings

Some people told us they had 'plenty to do' whilst others said they were 'bored'. One person said they liked 'reading and doing crosswords, and chatting to people, especially at mealtimes'. People said they looked forward to having their hair done. One person said: "It perks me up, makes me feel so much better". People who remained in bed that were able to speak with us indicated they were under-stimulated. We spoke with a relative of one person who was in bed. They told us their family member had their television but they could not see this properly, only hear it because of the position of the furniture. The relative said they did not know why their family member was always in bed; they told us they used to be helped to sit in a chair.

We spoke with the activities coordinator who had only held the post for two weeks. They told us they had lot of ideas for getting to know people as individuals and plan activities according to their personal interests. The activities staff member was enthusiastic about their role and we saw when they communicated with people this was in an animated way which people enjoyed. One person said of the activities coordinator: "[They] are a good 'un. They know me". We were told one person liked to be read to and we saw a selection of books for people to choose from. The activities staff created a sociable area for people to chat together whilst waiting for the hairdresser and we saw conversation was meaningful; one person chatted with another about their favourite author and another person spoke about their family.

Where we saw the activity coordinator work with people, interaction was positive. For example in the residential unit, there was laughter in conversation as they chatted with a person about their family, their interests and any outings the person might like.

However, for a large proportion of the day, where activities staff were not available, we saw staff were busy with care tasks and had little time to spend with people. In the lounge areas we saw people sat passively with the television on, but without watching the programme. Some people in wheelchairs were positioned in front of the television with little consultation from staff. More particularly, people who were nursed in bed had very little to occupy them and for some people their bed was positioned so that the outlook for them was their wall. Some people had music playing in their rooms but others had nothing going on which meant they were at risk of being socially isolated..

The registered manager told us care records had been accessible to staff 'live' on the computer system since January 2016. There were also paper copies of care documentation, although we found the information between paper and computer records did not always correspond, such as with Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders. We were told staff had received training on the computer system and there was an expectation they would update information in real time as it occurred, such as people's care, diet, medicines and any interventions and staff had access to portable computer notebooks. The registered manager told us if people and their relatives, where appropriate, wished to see the care plans these could be printed off.

We looked at care records for eight people and found information was difficult to locate without spending time searching the system. When we managed to locate the information we needed, we found a variation in

the quality of the recording. For example, some people's care records appeared to be clear and detailed but in others there were gaps in the recording and inconsistencies in where the information was input.

Although we were told information was entered as it happened, we saw in the case of people's dietary intake on the nursing unit, this was not the case and therefore information was incorrect and unreliable. Staff confirmed to us they found searching for information time consuming and some staff said they were not confident with the system and did not have time to read care plans. We heard mixed information about whether agency staff had received training in the use of the computer records.

We checked the computer records for eight people. Care records we looked at did not identify why people may need to remain in bed Where people's preferences were detailed on their care records, we saw in practice staff had regard for these. In some care records we found gaps in progress notes and in recording of people's care, such as food and fluid intake. Risk assessments identified the risk but did not explain what the level of risk was or what staff should do to minimise the risk to people. The registered manager told us staff were still getting used to the computer systems.
This illustrated the provider was in continued breach of the Health and Social Care Act (Regulated Activities) Regulations 2014, regulation 17(2)(a) (b) (c) as risks were not robustly assessed and monitored and there was not an accurate, complete and contemporaneous record in respect of each service user.

Residents' and relatives' meetings were held and we saw these were scheduled frequently. One relative we spoke with said they tried to attend these and they thought their views were valued. People said they knew how to complain and they would approach any member of staff. We saw complaints were recorded and responded to although there was limited investigation detailed. Staff we spoke with said they were not informed where complaints and compliments were received.

Inadequate

Is the service well-led?

Our findings

The home had a registered manager who had been in post since November 2015. People we spoke with did not all know who the manager of the home was. Some relatives were aware there had been a change of manager but one relative told us they visited every day and had 'never met the manager'. There was mixed opinion among people and visitors as to whether the registered manager was visible in the service; some said they knew the registered manager by sight and others said they had been introduced.

Staff acknowledged the registered manager was new and was still becoming familiar with the home. Not all staff reported feeling supported by managers to do their work and some staff said they did not feel valued. Some staff said it was too early to say whether the registered manager had made a positive impact upon the standards in the home. Staff reported the culture in the home lacked openness and was one in which they did not feel fully valued or supported.

The registered manager told us they had received a thorough handover from the previous manager and therefore were prepared for the work they were undertaking. They highlighted the areas they had begun to work on, including the infection control action plan and said they felt supported by their line managers and by the staff team. They told us there was a buddy system in place for new managers to team up with existing managers within the organisation for advice and support. The registered manager identified one of the strengths of the home was the 'lovely families and residents'.

We looked at records which supported the maintenance of the premises and the equipment, such as fire equipment, lifting equipment, gas, electricity, and water supply. We saw these were kept up to date by the maintenance staff to ensure people's safety.

We saw some monthly safety checks on areas such as bedrails, window restrictors and call bells. Where action needed to be taken this was recorded and dealt with. Room temperatures were checked twice weekly, although we found in spite of this some parts of the home were too hot.
The registered manager told us there was some oversight of the quality in the home through regular visits from the quality manager and regional director. However, we found the issues identified at this inspection had not been picked up on or acted upon. The actions required from the previous inspection were still not met and there was no monitoring of the action plan to drive improvement.

Some audits were not robust and did not highlight areas of concern noted at the inspection and the registered manager and provider lacked oversight into the varied practice that was taking place throughout the home. For example, although we saw some evidence of care plan audits we found gaps in recording of significant aspects of people's care. Medication audits were not rigorously done. The registered manager told us they carried out a home manager's daily audit. We looked at the records for these and saw these had not been carried out daily as stated, with none recorded since 5 February 2016. The registered manager stated they carried out the audits, but not always daily; yet there was no evidence of a clear oversight of practice in the home, such as staffing levels, room temperatures and the quality of interaction. Insufficient progress had been made to improve standards at the home since the last inspection as there were

continued breaches in the regulations.

This illustrated the provider was in continued breach of the Health and Social Care Act (Regulated Activities) Regulations 2014, regulation 17(2)(a) which corresponds with Regulations 2010 regulation 10, as systems to assess and monitor the quality of the provision were not robustly in place.