Clifton View Ltd

Clifton View Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The service was previously inspected on 4 August 2016 and received an overall rating of Good. We returned to inspect this service because we had received information of concern about the care and treatment provided at the home.

We carried out an unannounced inspection of the service on 7 and 11 July 2017. Clifton View Care home provides accommodation for persons who require personal care or nursing, for up to a maximum of 76 people. On the day of our inspection 71 people were using the service. Care was provided on residential and nursing floors as well as a rehabilitation unit, with the aim of supporting people to return to their own homes.

There was a registered manager in place. 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.

People's medicines were not always managed safely. Medicines were not always securely monitored to ensure people could not gain access to medicines which could cause them harm. There were gaps in people's medicine administration records and also examples where medicines had not been given with no record of the reason why.

People, relatives and staff raised concerns about the number of staff working at the home. During busy periods people's needs were not always responded to in a timely manner. Equipment was not always stored safely.

We have made a recommendation about the numbers of staff working at the service and the safe storage of equipment.

Safe recruitment procedures were in place to ensure only appropriate staff worked with vulnerable people. Staff could identify the potential signs of abuse people could face. Risks to people's safety were assessed and reviewed.

The principles of the Mental Capacity Act (2005) had not always been followed when decisions were made about people's care. The process for ensuring decisions were made on behalf of people by relatives who were legally entitled to do so was not always followed. However, staff were observed offering people choices. Some care records contradicted the information provided by external professionals in relation to the decision of whether a person wished to be resuscitated or not.

People were supported by staff who completed an induction prior to commencing their role. The majority of staff training was up to date; however, a small number of refresher training was required. Staff received

supervision of their role, although the frequency, in which staff received this, was inconsistent. Staff felt supported by the registered manager.

People were supported to maintain good health in relation to their food and drink. People's day to day health needs were met by staff.

People and relatives spoke positively about the staff and felt they were kind and caring and supported them or their family member in a respectful and dignified way. Staff understood people's needs and listened to and acted upon their views.
People felt able to contribute to decisions about their care, although people's care records did not always reflect this. People were provided with information about how they could access independent advocates.

People's privacy was maintained and respected. People's friends and relatives were able to visit whenever they wanted to.
An activities coordinator was in place; however the hours provided was not sufficient to enable them to support people effectively with their hobbies or interests.

Before people came to live at the home assessments had been carried out to determine whether their needs could be met. This led to detailed care plans being put in place. However, some care plans needed to be implemented more quickly and be more person centred. People felt their preferences were not always taken into account when staff supported them.

People were provided with the information they needed if they wished to make a complaint and they felt their complaint would be acted on.

The registered manager required additional support to ensure effective care and support was provided for all people living at the home. Quality assurance processes were in place; however, these had not identified all of the concerns raised during this inspection. People's records were not always reviewed to ensure they reflected people's current care and treatment. The registered manager was well-liked by staff. People were encouraged to provide feedback about the quality of the service.

We identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the back 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 consistently safe.

People's medicines were not always managed safely or securely.

During busy periods of the day people's needs were not always responded to in a timely manner.

Safe recruitment procedures were in place

Staff could identify the potential signs of abuse people could face. Risks to people's safety were assessed and reviewed.

Is the service effective?

Requires Improvement

The service was not consistently effective

The principles of the Mental Capacity Act (2005), had been not always been followed when decisions were made about people's care.

The process for ensuring decisions were made on behalf of people by relatives who were legally entitled to do so, were not always followed.

People were supported by staff who completed an induction prior to commencing their role. Staff received supervision of their role, although the frequency was inconsistent. Staff felt supported by the registered manager.

People were supported to maintain good health in relation to their food and drink. However, where external agencies were involved; the care records did not always reflect this.

Is the service caring?

Good

The service was caring.

People and relatives spoke positively about the staff describing them as kind, caring and treating them in a respectful and dignified way.

Staff understood people's needs and listened to and acted upon their views.

People's care records were not always accurate.

People were provided with information about how they could access independent advocates.

People's privacy was maintained and respected. People's friends and relatives were able to visit whenever they wanted to.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Activities were in place however there were not sufficient hours to enable people to enjoy their hobbies or interests.

Assessments had been carried out to determine whether people's needs could be met. However, subsequent care plans needed to be implemented more quickly.

People felt their preferences were not always taken into account when being supported.

People were provided with the information they needed if they wished to make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The registered manager required additional support to ensure effective care and support was provided for all people living at the home.

Quality assurance processes were in place; however, these had not identified all of the concerns raised during this inspection.

People were encouraged to provide feedback about the quality of the service.

Clifton View 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection was carried out on the 7 July 2017 by one inspector, a specialist advisor, who was a nurse 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. On the 11 July 2017 our inspector returned alone to complete the inspection.

Prior to the inspection we reviewed information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies. This included the local authority who commissioned services from the provider.

During the inspection we spoke with nine people living at the home, four relatives, the cook, five members of the care staff, a nurse, an activities coordinator, a senior care coordinator, two visiting health care professionals, the registered manager and two representatives of the provider.

We looked at care records relating to eight people living at the home as well as medicine records for 25 others. We reviewed other records relevant to the running of the service such as staff recruitment records, quality assurance audits, training information for care staff, staff duty rotas, meeting minutes and arrangements for managing complaints.

Requires Improvement

Is the service safe?

Our findings

We observed the administration of medicines on all three floors. We noted on the ground floor and the second floor the medicine trolley, used to transport medicines around the home, was left unlocked when staff administered medicines to people in the communal areas. On one occasion we opened the door of a trolley and removed a medicine without staff noticing. It was only when we returned it to the trolley and closed the door loudly that the member of staff noticed. This meant there was a risk of unauthorised access which presented a risk to people using the service.

Medicines were stored in locked rooms. Most medicines were stored in medicines trolleys however; the cupboards used to store additional medicines were not locked on one floor. The temperature of the rooms used to store medicines was monitored daily. We did note that prior to the 22 June 2017, the recording of these temperatures had not been recorded daily as required. However, this was identified by the registered manager and subsequent recordings showed improvements had been made.

We reviewed people's medicine administration records (MAR). These are used to record when a person has taken or refused to take their medicines. We found a total of eight gaps in the administration records of three people and when we checked stock levels, we concluded these medicines had not been given. We also saw a person frequently was not given their night time medicines because they were asleep and there was no indication this had been reported to the medicines prescriber or action taken to ensure they received their medicine. This meant people were not always receiving their medicines as prescribed.

When medicines were handwritten on people's MAR there was frequently only one staff signature on the MAR (on the ground floor and second floor). When medicines are handwritten they should be checked by a second person to ensure accuracy of information.

The provider was failing to ensure that medicines were being given as prescribed and stored securely. These were examples of a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities).

The majority of the people we spoke with told us they were happy with the way their medicines were managed. One person said, "I have paracetamol for my [condition], they are equally handed out and the nurse waits with me while I take them." A person who had been assessed as being able to take their medicines without staff support said, "Sometimes they leave them with me. I knock them back on my own." A relative said, "The medication seems well supervised."

People's medicine administration records (MARs) contained a photograph of the person to aid identification, a record of any allergies and information about the person's preferences for taking their medicines. This helped to ensure staff were provided with the appropriate, personalised information to support them with the administration of people's medicines.

Processes were in place for the timely ordering and supply of medicines and we did not find any gaps in the medicines administration record due to a lack of availability.

When topical skin patches were administered, staff recorded the site of application of the patch to ensure the site was rotated in line with good practice. Protocols were in place to provide staff with additional information about medicines prescribed to be given only when required. These protocols reduce the risk of inconsistent medicines administration.

Staff told us and records confirmed that they completed medicines administration training prior to commencing medicines administration and their competency to administer medicines was regularly checked.

All but one of the people and relatives we spoke with during the inspection raised concerns with us about the number of staff available to support them or their family members. One person said, "They're [staff] under pressure all the time." Another person said, "They have problems at times and borrow staff from other floors. It's mad in the mornings, it's their pressure time." A third person said, "No, there's not enough staff. Mornings and breakfast time are the worst time." A relative said, "Staff are rushed off their feet, a few extra bodies would help." Another relative told us they had asked staff to assist their family member with getting ready for an external appointment, but when they arrived they were not ready. This placed the person at risk of being late for their appointment.

People told us they felt their personalised care needs and preferences were not always acted on and responded to quickly enough by the staff. One person said, "They've [staff] got their set way of doing things so we just fall in line really. I wish it was better organised at the top to organise the staff better so they can spend more time with us. It's all a bit rushed." Another person said, "They don't linger long. I said I needed the toilet the other morning when the girl was dressing me. I was desperate but by the time she'd found another free girl to help move me, I only just made it in time." During the inspection we overheard a member of staff say to a person, "There's 28 of you that are feeling hungry, so we just have to take it in turns sometimes." This was a further example of staff not being able to respond to people's needs in a timely manner.

The staff we spoke with also felt more staff were needed to enable them to carry out their role safely and effectively. One staff member said, "We have a lot of people who require two staff to help get them ready in the mornings. With the staff we have it is difficult to get everybody up." Another staff member said, "Mornings can be very hectic, you can have people waiting a while."

A visiting health care professional told us they had seen people living at the home wait a long time for assistance. They also commented that they felt staffing levels were based on the number of people living at the home and should focus more on people's complexity of need.

We checked the records which showed the response times of staff when responding to people when they have pressed their nursing call bell. We found response times during less busy periods, such as when people were up in the afternoon, to be acceptable with people waiting no longer than a few minutes. However, we noted regularly in the morning, normally between 6.00am and 9.00am there were regular examples of people waiting for ten minutes or in some cases longer for staff to respond to them.

A dependency assessment was in place. This helped the registered manager identify how many staff were needed to ensure people received safe and effective care and support. Whilst the dependency assessment and subsequent staff rota showed the numbers of staff working corresponded during the inspection, it was clear from the response from people and relatives, and the response times to call bells, that a review of the staff numbers was needed, especially in the mornings.

We raised this issue with the registered manager and a representative of the provider. We were told they were aware of the concerns and had plans in place to recruit more staff for identified busier periods. This included a member of staff being made available with the main responsibility to respond to calls immediately, advise people that assistance would be coming and also to reduce the risk of emergencies not being identified in a timely manner. The representative of the provider was confident this would help reduce the length of time people waited for assistance.

We recommend that the service ensures there are always enough competent staff on duty who have the right mix of skills to make sure that practice is safe, staff can respond to unforeseen events and staffing levels are adapted to meet people's changing needs.

Safe recruitment procedures were in place. Checks on staff suitability to carry out their role before they commenced work were carried out. This included checks to establish whether a potential member of staff had a criminal record, whether they had sufficient references and proof of identity. This reduced the risk of people receiving care and support from unsuitable staff.

People and relatives told us they or their family members felt safe at the home. One person said, "I feel safe as the care staff are brilliant." Another person said, "I feel safe enough. I can choose to have my door shut in the day but the heat can be awful." A relative said, "I've no worries really about [my family member's] safety." Another relative said, "I've no concerns about safety, [my family member] can't come to any real harm here."

Staff were aware of the signs of abuse and how to reduce the risk of people experiencing avoidable harm and could explain who they would report any concerns to. The registered manager was aware of their responsibilities to ensure the CQC and other external agencies were made aware of any concerns. Records showed these had been investigated appropriately. We noted there had been a recent increase in the number of referrals made to the CQC and the local authority safeguarding team. A small number of these were still under investigation by the local authority at the time of the inspection.

Individual risk assessments were completed in a number of areas such as, people's risk of developing pressure ulcers, falls and nutritional risk. These were reviewed monthly. When risks were identified actions were taken to reduce the risks, such as the use of pressure relieving equipment and assistance with re-positioning.

When accidents and incidents had occurred the manager ensured these were investigated thoroughly. Agreed actions were in place and these were regularly reviewed to ensure the possibility of reoccurrence was reduced.

Regular servicing of equipment such as hoists, walking aids, gas installations, fire safety and prevention equipment were carried out, with specially trained external professionals used to service the more complex equipment such as lifts. People and staff commented that the second floor of the building was regularly very warm and at times made living or working on the floor uncomfortable. A representative of the provider told us they were in the process of having air conditioning units installed to ensure the temperature could be more closely monitored.

Regular assessments of the environment people lived in were conducted to ensure that people were safe. We noted some beds were stored in the corridor by the exits to the stairs on the top floor. This narrowed the corridor and whilst there was sufficient room to walk by, it may not have been possible for a wheelchair to get by in an emergency evacuation situation. This was raised with a staff member and action was taken to

remove it.

We recommend the service ensure all equipment is stored safely within the home to reduce the risk of injury caused by the environment people live in.

People had individualised personal emergency evacuation plans in place that enabled staff to ensure, in an emergency, they were able to evacuate people in a safe and timely manner. These were regularly reviewed to ensure they met people's current needs.

Requires Improvement

Is the service effective?

Our findings

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. We checked whether the service was working within the principles of the MCA.

When people could not make some decisions for themselves, we saw mental capacity assessments and best interest decisions were completed for some of these decisions, including people's ability to manage their medicines and their personal care. However, we also noted that some care plans contained 'consent to care and treatment' forms which had been signed by a 'representative' when people were not able to consent for themselves. These representatives did not have a lasting power of attorney (LPA) for decisions relating health and welfare and therefore were unable to consent on behalf of the person. An LPA is a legal document that lets you appoint one or more people (known as 'attorneys') to help you make decisions or to make decisions on your behalf if you are not able. A representative of the provider told us they would ensure a full review of all people's records was carried out to ensure decisions were only made by people who had the legal authority to do so.

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 are called the Deprivation of Liberty Safeguards (DoLS). We looked at the documentation for two people and found the registered manager had applied for the DoLS appropriately and that staff adhered to the terms of the DoLS.

Some people also had documentation which stated they did not wish to be resuscitated if their conditions worsened. DNACPR forms were in place where needed. A DNACPR form is a document issued and signed by a doctor, which tells your medical team not to attempt cardiopulmonary resuscitation. We looked at six of these forms. We found the content within three of them did not match the care plan that was in place for each person. For example, one form stated the person did not have the capacity to consent to this decision; however the person's care plan stated the decision had been discussed with the person. This conflicting information could cause confusion in an emergency and could place the person's health and welfare at risk. The senior care coordinator told us they would discuss this with the registered manager and would ensure all documentation was reviewed to ensure a consistent approach.

People told us staff offered them choices and requested their consent before offering care or support. One person said, "I'm always offered or asked if I agree first." Another person said, "They give me options to do something or not." A third person said, "I make all my own decisions on what I do when."

Staff could explain how they would support people who presented with behaviours that may challenge. One staff member told us that they would step back and walk away. They also said they would try again later or ask another member of staff to see if they could gain the person's cooperation. We observed staff react in a positive way when supporting people throughout the inspection.

People and their relatives told us they or their family members had access to external healthcare professionals when needed. One person said, "The carer does our nails and hair day is Tuesdays. The chiropodist comes quite often and I had new reading glasses from the optician which are an improvement." Another person said, "The NHS foot lady comes to do me. I've had the dentist and optician since I've been here. I like my weekly hair do."

People on the first floor received rehabilitation and community nursing services from staff employed by another provider who were based within the service during the day from Monday to Friday. These staff carried out an initial assessment and provided staff at the service with a moving and handling plan and a pressure ulcer risk assessment. They ensured the appropriate equipment was provided from the community equipment service. They also carried out home assessments and home visits with people and planned their discharge.

During the inspection we identified a concern that care was fragmented when other agencies contributed to a person's care. We saw staff worked together with other agencies; however, we found it difficult to obtain a holistic picture of each person and their health and support needs when other professionals were involved. For example, when people were receiving input from the rehabilitation team and the community nurses, we found little evidence of this in their care records and it was not always clear what actions staff needed to take, for example in relation to a person's pressure ulcer or wound. Records of the input of the rehabilitation team were kept on their electronic system and was not easily accessible for care staff.

We raised these issues with the registered manager and a representative of the provider. They acknowledged that more needed to be done to ensure people's records contained sufficient information when they received care and treatment from agencies and told us they would address this. Failure to ensure accurate recording of the care and treatment people received could impact on the staff's ability to provide people with effective care that met all their needs.

People told us they felt staff understood how to support them and did so effectively. One person said, "I'd say they're fair at what they do and willing to help." Another person said, "They look after me well and seem capable." A third person said, "I can't fault them. They manage me well."
A relative said, "They seem very good with people here. [My family member] has never complained to me."

Staff received an induction, with new staff undertaking the care certificate training. Records showed almost all staff had either completed or were in the process of completing the care certificate. The care certificate is a set of minimum standards that can be covered as part of induction training of new care workers. Following their induction staff received an on-going training programme designed to equip them with the skills needed to support people effectively. The majority of staff training was up to date; however some staff did require refresher training in some areas such as, safeguarding adults. We were assured by the registered manager that future staff training was being addressed and refresher courses were booked for those that needed them. Records showed staff were also supported with completing externally recognised qualifications in adult social care. The continued professional development of staff ensures the care they provide people is effective and in line with current best practice guidelines.

Staff told us they felt supported by the registered manager and were able to discuss any concerns they had about their role. One staff member said, "I've never had any problems with the manager. She always seems supportive when I've needed any help with anything."

Staff received supervision which enabled the registered manager to be aware of any areas of development and/or improvement for their staff. We reviewed the supervision schedule. This showed that whilst some

staff had received recent supervision, others had not since February 2017. Records also showed that in the absence of a deputy manager, the registered manager was currently carrying out all supervisions, which they acknowledged was difficult to complete. However, the recruitment of a new deputy manager which we were told by a representative of the provider was imminent, would help with this.

We received mixed feedback from people in relation to the food and drink provided at the home. One person said, "I like most things – we get a choice of two things at lunch." Another person said, "We get a choice each day, it was a good lunch today. They'd do a snack between meals if we asked." However, one person said, "The food can be a bit rubbish, it needs a decent chef. We get a choice, but it's take it or leave it." A second person said, "I'm not wild about the food, sometimes it's a bit cold."

We observed lunch being served in all three dining rooms. The menu was written on a white board in each dining room, with no pictorial equivalent to support people with communication needs. Whilst two of the dining rooms had condiments ready and out for people, one dining room did not. However, when one person asked for salt this was brought to them. When people were served their meals, the staff in the majority of cases explained what the meal was and where appropriate offered alternatives. In each dining room, where people needed support from staff with eating and drinking this was provided. Specially adapted cutlery and equipment was provided for people who wished to eat independently without staff support.

Some people had their meals in their bedrooms. Whilst this was their preference and was being respected, there was a risk meals could be served not hot, due to the them being transported to their rooms uncovered which is recommended.

A variety of drinks were provided for people at regular intervals throughout the inspection. People told us they received enough to drink throughout the day. One person said, "I just drink water so they give me a fresh jug and glass every day." Another person said, "They encourage us to drink water." A third person said, "They give us lots of fluids here." A relative said, "[My family member] seems to get given plenty to drink."

Risk assessments in relation to people's nutritional needs were completed and reviewed monthly. In the majority of cases these were completed correctly, although for one person the records showed no risk when the person had lost weight. If this weight loss continued, it could place the person health at risk. However, records showed another person had lost weight and they were referred to a dietician for advice. When people had been assessed as being at risk of dehydration, fluid intake charts were in place to record how much fluid a person consumed with a daily target recorded. This helped staff to identify any trends that could affect the person's well-being.

Good

Is the service caring?

Our findings

The majority of people told us they thought the staff were kind and caring and that they liked them. One person said. "They're mostly nice girls." Another person said, "I find them kind enough." A third person said, "The staff are perfect." A fourth person said, "They're kind and make time to talk when they're not so busy." However we did receive some comments that sometimes the way some staff spoke to people could be improved, with some people saying this appeared to be because the staff were busy. One person said, "Some are very kind, others are a bit offish. They've got more than they can manage, flying from room to room." Another person said, "One or two can be a bit sharp, I see them under pressure."

People's care records included detailed guidance for staff to enable them to communicate effectively with people. Due to the wide ranging needs of the people living at the home staff were required to use a variety of different methods to communicate and engage with people. Throughout the inspection we saw staff doing so effectively. For example, we observed staff talk slowly with some people, to ensure they understood what was being said to them. A visiting professional told us they thought this was one of the best homes they had visited in terms of the way staff communicated with people who used the service. They said staff showed kindness and understanding towards all people.

Staff interacted with people in a friendly, thoughtful and caring way, showing empathy and patience where needed. We observed many positive interactions with a staff member who was serving tea and cakes making a particular effort to engage positively with people.

People felt listened to and respected and had built positive and trusting relationships with staff. One person said, "I feel very happy with them. I can tell them something and they'll do something about it, like they offered to make a phone call for me to see how my relative was doing."

People told us their relatives took control of their care planning for them and discussed their care needs with them and then made agreements with the care staff on how to support them. One person said, "[My family member] comes in every day and sees to my care needs."

People's care records showed efforts had been made to ensure people and, where appropriate, their relative's views were recorded when decisions were made about the care and support to be provided. We did note this was not the case for all records that we looked at and raised this with the registered manager, who told us they would ensure people's records accurately reflected their and their relative's views.

People's life history was recorded which enabled staff to have a good understanding of the person and what was important to them. Staff we spoke with demonstrated a good understanding of people's character and treated everyone as individuals. They were aware of people's likes and dislikes and how this could affect the care they provided. People's care records showed their religious and cultural needs had been discussed with them and support was in place from staff if they wished to incorporate these into their life.

Information was available for people about how they could access and receive support from an

independent advocate to make decisions where needed. Advocates support and represent people who do not have family or friends to advocate for them at times when important decisions are being made about their health or social care.

People told us they were encouraged to do things for themselves and staff supported them to remain independent wherever possible. One person said, "They let me try as much as I can so I can get home." Another person said, "I'm left to get on if I can, I ring otherwise."

People living on the first floor of the home received rehabilitation with the prospect of them being able to return home and live independently. A relative told us they had recently had a meeting with an occupational therapist with the aim for their family member to return home soon. They told us they were happy with this process.

People told us staff respected their privacy and treated them with dignity when providing support with personal care. One person said, "My door's open in the day so I can see if anyone passes. But they close it when I'm dressing." Another person said, "I prefer to keep my door closed in the day for some privacy. The staff always knock first." A third person said, "I get my door and curtains closed when we're dressing. They always knock first." A fourth person told us when a new male member of staff was training; the experienced staff member they were working with asked the person's permission for them to assist them. The person agreed to this and appreciated being asked first.

There was sufficient private space throughout the home if people wished to be alone, or to spend time with family and friends. Relatives told us they were able to visit their family members whenever they wanted to. One relative said, "I'm not restricted at all on times." Another relative said, "It's flexible here."

People's care records were not always handled discreetly and respectfully. When we arrived at the home on day one of the inspection we noted daily records for a number of people were stored outside of their bedrooms which could place their privacy at risk. However, on day two of the inspection, after we had raised this as a concern, the records were no longer on display.

Requires Improvement

Is the service responsive?

Our findings

People raised concerns there were not enough activities provided at the home and people were not always able to follow their hobbies and interests. One person said, "There's been nothing to do since I've been here. I get daily visitors but otherwise we just sit. I've not been in the garden yet." Another person said, "Not a thing happens up here, or in my room. I just read my papers." A third person said, "They just do crosswords up here. I wish I had a large print crossword I could see and keep my brain working. I don't want to go downstairs all the time as it's the same old thing going on."

Relatives also raised concerns about the lack of meaningful activities at the home. One relative said, "They don't do anything in the mornings here. In other places [my family member] has been used to having a lot happening. Now, [my family member] just sits and watches people. They don't take them outside a lot." Another relative said, "There's not often anything on when I visit. [My family member] might not participate anyway but will watch."

We spoke with the activities coordinator. They told us they currently worked 30 hours per week and covered all three floors of the home when trying to provide meaningful activities for people. This meant, on the day of the inspection, the activities coordinator was supporting 71 people with their activities. They told us they tried to spread their time across the three floors to ensure they saw as many people as possible and put on group events to try to integrate all three floors together. However, they also stated that due to the limited time they had this was often quite difficult.

Staff told us that whilst they tried to do some activities with people to support the activities coordinator, this was not always possible due to them having to complete their own daily duties.

We raised our concerns with a representative of the provider. They acknowledged that one person was not enough to support people with meaningful and personalised activities and told us they would look at ways to provide more staffing hours to support people.

We did note some success stories in relation to activities. The home acquired a specially adapted table tennis table which enabled people with physical or mental disabilities to be able to play the game. We were told that one person who had previously spent their time in their bedroom had been persuaded to come and use the table. They are now a regular player and have started to socialise. We saw others using the table as well as other group activities taking place in the afternoon. However, people's records showed significant gaps in their activity recording logs, which showed, despite the best efforts of the activities coordinator, engagement in activities was limited for most people living at the home.

Care records contained information about each person and their care and support needs in the form of transfer documents, a resident profile and a range of care plans. Some people had an initial 48 hour care plan where people were given a list of options about how they would like their immediate care, upon coming to the home, to be provided. However not all of this information was completed. We also noted there were sometimes delays in implementing more detailed care plans for people after they had settled

into the home. For example, we noted one person had been at the home for over two weeks and had no care plans in place. This meant it was not possible to determine the person's care and support needs from their care records.

Where care plans were in place for people they contained adequate information about the person's care and support and a description of their personal preferences in relation to their care. However there were some inconsistencies in the records. For example a person's care plans stated they required a motion sensor by their bed to alert staff to their movements and this was highlighted on their care plans. However, we saw a record of an assessment by an external professional which stated they did not require the motion sensor as they were safe to mobilise within their bedroom and when we checked the sensor was not being used.

In addition there was a lack of information about some aspects of people's care particularly when the care was being shared with other agencies. For example a person had a skin condition on their legs which required dressings by the community nurse. Their tissue viability care plan did not mention any issues with their legs and there was no information for staff on how they should manage these between the community nurse visits. We saw that staff assisted the person to remove the dressings on the morning of the community nurse visit so they could have a shower prior to the nurse re-dressing their legs, although there was no information about this in their care plan. We noted there was a record of the dates the community nurse attended and that they had redressed the person's legs on the record of professional visits but this was the only reference to the problem. The inconsistent and sometimes contradictory information recorded in people's care records could mean people received care and treatment that was not appropriate to their needs.

People's care records contained some person centred documents which showed discussions had been held with them about the things that were important to them, their likes and dislikes and personal preferences. However, some people raised concerns that their preference for a male or female member of staff to support them with their personal care had not been taken into account. One person said, "I've not been asked." Another person said, "I wasn't asked but I'm used to either." A third person said, "No, I'm not asked. I have both sexes and am ok with that."

People told us they knew how to make a complaint and when they had done so, these had been acted on appropriately by staff. One person said, "I've not had to make a complaint yet." Another person told us about a complaint they had made and it had been acted on."

A complaints policy was in place although the format it was written may make it difficult for people with communication needs to understand. The senior care coordinator told us they would ensure a more 'user friendly' version was in place for people to address this. Records showed when complaints were received they were handled appropriately and in line with the provider's complaints policy.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection a registered manager was in place. The registered manager had an understanding of their role and responsibilities and that they carried out this role in line with the requirements of their registration with the CQC. The manager had ensured that the CQC were notified of any issues that could affect the running of the service or people who used the service.

The representative of the provider acknowledged that the registered manager needed additional support with their role to enable them to have the resources to ensure the home was running effectively and people's needs were met. We were told a deputy manager was due to be appointed imminently and a new senior care coordinator would also be recruited. They told us they felt this would provide the registered manager with more time to address the on-going care needs of the people living at the home.

Staff spoke highly of the registered manager and told us they were knowledgeable and supportive. However, people living at the home told us they would like to see more of the registered manager, with some people on the rehabilitation floor stating they had not yet met her. One person said, "I've met her a few times and think I could raise any concerns." Another person said, "I've seen her but not spoken to her." A third person said, "I've not seen her yet, it's just the staff up here." A relative said, "I've only spoken to her twice. I suppose I could raise things with her." A second relative said their family member had now been at the home for over five weeks but they were still to meet the registered manager.

We spoke with a representative of the provider who told us regular quality assurance visits were carried out to identify any areas of concern and to offer support to the registered manager in order to address any identified areas of improvement. The registered manager also carried out regular quality assurance audits and reviews. However, the provider's own systems and quality assurances processes had not identified the issues we identified during this inspection. People's records were not appropriately monitored to ensure they always accurately reflected the care and treatment people were receiving. The representative of the provider told us they would ensure that improvements would be made in the areas we had identified.

We recommend the provider carries out a review of all documentation relating to people's care and treatment and ensure that it is up to date and reflective of people's current care and support needs.

People, relatives and staff were invited to give feedback about the service. Regular staff, relative and 'resident meetings' were held. Where actions had been identified, these were recorded and then delegated to staff members to act on. For example, action was agreed to support a person who was reluctant to come out of their bedroom and socialise with others. Action had been taken to address this with the person now integrating more frequently.

People told us they felt some improvements were needed at the home to help improve the quality of the experience of living at the home. One person said, "Air conditioning or at least a fan, it's so terribly hot up here, especially at night with our door is closed." Another person told us they wished the staff were better organised so they could spend some time quality time talking with them

People were supported by staff who had an understanding of the whistleblowing process and there was a whistleblowing policy in place. Whistleblowers are employees, who become aware of inappropriate activities taking place in a business either through witnessing the behaviour or being told about it.

Following our previous inspection, we noted the rating for that inspection was on display in the main reception of the home. The provider operated in an open and transparent way ensuring people living at the home, relatives, visitors and healthcare professionals were aware of the home's current CQC rating.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe care and treatment 12.—(1) Care and treatment was not always provided in a safe way for service users. 12 (2) (g) the registered person did not always ensure the proper and safe management of medicines;