HC-One Limited

Priory Gardens

Inspection report

Lady Balk Lane
Pontefract
West Yorkshire
WF8 1JQ

Tel: 01977602111
Website: www.hc-one.co.uk/homes/priory-gardens/

Date of inspection visit:
26 July 2016
02 August 2016

Date of publication:
20 September 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection of Priory Gardens took place over two days, 26 July and 2 August 2016. We previously inspected the service on 21 and 23 September 2015. The service was not in breach of the Health and Social Care Act 2008 regulations at that time, however, we did identify areas where improvement was required. During this inspection we checked to see if improvements had been made.

Priory Gardens is a nursing home currently providing care for up to a maximum of 72 older people. The home has three separate units which provide care and support for people with nursing and residential needs including people who are living with dementia. On the days of our inspection 51 people were living at the home.

The service has not had a registered manager in place since July 2015. 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.

Medicines were not managed safely. We found evidence one person had not received a prescribed medication on a number of occasions. A care plan recorded one person was allergic to a medicine but this information was not recorded on the medicine administration record. We could not evidence topical medicines were administered correctly. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Personal emergency evacuation plans were not all fully completed. Information regarding the correct settings for individual pressure mattresses was not completed. The information in care plans and risk assessment regarding peoples moving and handlings needs was inconsistent and did not always reflect the practices we observed. Positioning records for people failed to evidence people received pressure area care appropriate to their need. We noted a person's blood sugar had been recorded at 26mmol but was no evidence to suggest staff had rechecked this to see if they required medical attention. This was a breach of Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were bathed although not always to the frequency they preferred. People's daily care record was task orientated and contained gaps regarding the care of people's nails and teeth. Food and fluid records did not evidence people always received sufficient to eat and drink and snacks were not consistently recorded. This was a breach of Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived at the home and staff, told us there were not enough staff on duty. This concern had been raised in resident meetings but no action had been taken by the registered provider. People on the nursing and dementia unit did not receive their lunchtime meal in a timely manner. Staff received regular training but one to one supervision of staff was not completed on a regular basis. New staff had not received a

thorough induction to their role. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe and staff had completed training in safeguarding adults. Staff were aware of how to raise concerns about harm or abuse. Where people were deprived of their liberty, the home had requested appropriate authorisation from the local authority in order for this to be lawful and to ensure a person's rights were protected. Mental capacity assessments were in place but lacked sufficient detail to ensure they met all the requirements of the Mental Capacity Act 2005.

A programme of refurbishment had been completed at the home. This had enabled people in the dementia and residential unit to access the garden.

Staff were caring. Interaction between staff and people who lived at the home was kind and professional. Staff enabled people to make choices about their day and took steps to maintain people's privacy and dignity. There was programme of activities, entertainment and trips for people who lived at the home.

Care plans were individualised and not generic, although we could not consistently evidence people or their family's involvement in the planning and review process.

There was a system in place to enable people to provide feedback or raise concerns about the service they received.

The management of the home had been inconsistent since the departure of the registered manager in July 2015. There was no recorded evidence of senior management oversight in April or June 2016. Audits were completed in the home but evidence of action taken to address issues was lacking. Staff meetings were irregular. Meetings with people who lived at the home took place on a regular basis although issues identified at these meetings did not appear to be addressed by the organisation. Although the registered provider's governance system monitored the performance of the home it had failed to ensure people were satisfied with the service that the home was complaint withal relevant legislation. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures 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.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as

inadequate for any of the five key questions it will no longer be in special measures.

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.

The management of people's medicines was not always safe.

There were not enough staff to meet people needs.

Information regarding peoples moving and handling was inconsistent.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered provider's induction process had not been implemented for new staff and supervision for staff was irregular.

People were offered a choice of menu but food and fluid records for people did not evidence they received sufficient nutrition or hydration.

Where people lacked capacity, mental capacity assessments were not fully reflective of all aspects of their needs.

Is the service caring?

Good

The service was caring.

People told us staff were caring.

Staff interactions with people were kind.

Staff were able to describe how they enabled people to make choices and how they respected people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a programme of activities at the home.

An accurate record of peoples care and support was not always

maintained.

Complaints were being investigated and responded to.

Is the service well-led?

Inadequate

The service was not well-led.

The home did not have a registered manager in post.

The registered provider had systems in place to monitor and review the service but these had been not been effective in ensuring regulatory compliance.

Priory Gardens

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 26 July 2016 and was unannounced. The inspection team consisted of three adult social care inspectors. One of the inspectors also visited the home on 2 August 2016. This visit was announced and was to ensure the 'turn around' manager and deputy manager would be available to meet with us.

Prior to the inspection we had received some information of concern that suggested people's care was not being carried out safely or properly. We reviewed all the information we held about the service. We also contacted the local authority contracting team and clinical commissioning group. On this occasion we had not sent the provider a 'Provider Information Return' (PIR) form prior to the inspection. This form enables the provider to submit in advance information about their service to inform the inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home including spending time in the lounge and dining room areas and observing the care and support people received. We spoke with eight people who were living in the home and four visiting relatives. We also spoke with the 'turn around' manager, deputy manager, three senior carers, five care staff, two staff from the ancillary team and a visiting external healthcare professional. We reviewed six staff recruitment files, eleven people's care records and a variety of documents which related to the management of the home.

Inadequate

Is the service safe?

Our findings

People told us they felt safe. One person said, "Yes I do (feel safe)." Relatives we spoke with did not raise concerns with us that their family member was not safe. However, we found medicines were not managed safely, there were not enough staff to meet people's needs and the risks to people's safety were not always fully assessed.

As part of our inspection we checked to see if the management of people's medicines was safe. We observed the medicine round on two of the units and both staff were interrupted during the time they were administering medicines. One of the senior care staff we spoke with said, "The (medicines) round can take over an hour, you do stop and start." Enabling staff to administer people's medicines with minimal interruptions reduces the risk of errors occurring.

On the residential unit we found medicines were stored safely and securely. There was a dedicated medicines fridge which was locked; items in the fridge had a date of opening annotated on the packaging where appropriate. The senior carer told us some people were prescribed a particular medicine which needed to be administered prior to food; they explained the night duty senior carer administered these medicines to ensure people received them before breakfast. We checked four individual boxed medicines and found the stock tallied with the number of recorded administrations. The senior carer on the residential unit told us staff completed a 'five a day audit'. They said this was a random daily check of five medicines to check the medicine administration records (MAR) and to ensure stock levels tallied to the amount dispensed. We saw from the file this was not consistently completed. For example, the audit had not been completed between the 20 and 24 July 2016. Ensuring medicine audits are completed on a regular basis enables concerns to be highlighted at an early stage and appropriate action to be taken to reduce the risk of the incident reoccurring.

On the nursing unit when we reviewed a random selection of people's medicine administration records (MAR). We saw on one MAR chart the person had not been administered a medicine on a number of occasions, and this had not been acted upon by staff for over seven days. When this had been noted, we saw staff had requested a GP review to ensure the person had not come to harm as a result of this error.

We also checked documentation relating to the use of covert medicine for a person living with dementia who would otherwise refuse the medicines they needed to stay healthy. Covert medication is the administration of any medicine in a disguised form. We saw this person had a risk assessment in place and there was a GP letter on file agreeing to the use of covert medicines as this was in the person's best interests. But the mental capacity process had not been followed fully as they did not have a capacity assessment and there was no evidence of the involvement of other relevant parties, for example the pharmacist or the person's family. We also noted the prescribed medicines were all mixed together. We saw the GP had advised the medicines could be administered in a prescribed nutritional supplement but we could see no evidence this had been discussed with the pharmacist to ensure this method was safe. It may not be appropriate to mix some medicines as this may affect their safety and effectiveness. We brought this to the attention of the deputy manager on the first day of our visit. When we returned to the home the following

week, they told us this issue had been discussed with the pharmacist and they had confirmed this method was safe and they were awaiting written confirmation from the pharmacist.

We noted in one person's care plan they had a sensitivity to a specific medicine, in another care plan we noted the person was listed as allergic to some medicines. When we checked the MAR charts for these people, this information was not recorded. This meant there was a risk medicine may be prescribed which may not be safe for them to take. We highlighted this with the deputy manager and they assured us they would address this promptly.

Where people were prescribed topical applications (creams), we found the procedure was flawed. For example, we found five creams in one person's bedroom but the current MAR chart only listed two creams. Only one of the creams listed on the MAR was in the person's bedroom, yet staff had signed to say the other cream, which staff could not locate, had been administered twice a day, including the morning of our inspection. This meant this person was not receiving their topical medicines as prescribed and there was also a risk staff were applying creams which were no longer to be administered.

These examples evidence the registered provider had failed to ensure peoples medicines were managed and administered safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed six staff files, we saw potential candidates had completed an application form, there was a record of their interview on file and references had been obtained. On one of the application forms we looked at we noted there was a gap in the employment record of sixteen months, there was no evidence the reason for this had been discussed with them. We also checked to ensure Disclosure and Barring Service (DBS) checks had been completed. Two of the recruitment files were for staff who been employed less than six months and we saw evidence of DBS checks in both their files. Where staff had been employed for a longer period of time we could not see evidence of their DBS check. We followed this up with the registered provider and they provided evidence of DBS checks. We noted the DBS check for one staff member dated March 2013, we asked the registered provider if the DBS had been checked since this date. They told us, "We don't routinely renew DBS for staff, as part of their contract of employment they agree to advise us of any convictions which may occur after their start date and throughout their duration of employment." Although it is not mandatory that these checks are renewed, ongoing monitoring of staff DBS checks helps to ensure staff remain suitable to work with vulnerable people.

During our inspection of Priory Gardens on 21 September 2015 people told us they did not feel there were enough staff on duty. When we asked people and staff at this inspection, we were still told there were not enough staff to meet people needs. One person told us, "They think three staff can run this floor (nursing unit), they can't." We saw an entry on the resident and relative meeting minutes dated 20 May 2016 which noted 'all service users present raised concerns regarding staffing'. When we reviewed the June 2016 'comments made by relatives' summary there was an entry which read 'Staffing levels are inadequate'. There was also a second entry which read, 'Inadequately staffed, two care workers in the dementia unit falls far short of a satisfactory level of cover'. There was a residents meeting held on the first day of our inspection and one of the inspectors attended the meeting. They heard a person say, "We need more (staff), at least four during the day. On the nursing unit, four would be nice, so they can work in two's, the staff told me that." A relative at the meeting said, "My mum is up at half past eight but not getting washed until 12 o'clock."

When we asked staff if they thought there were enough staff on duty, staff who were employed in a direct care role said there were not. One said, "We could do with another member of staff on here." Another staff

member said about the dementia unit, "We do need extra staff; we are breaking off all the time (from the medicines round). It's quite intense on here." They told us the morning medicines round could take over an hour due the senior carer having to 'stop and start'. During our inspection we observed the senior carer had to break off from the medicine round as a person required prompt assistance and the second staff member was not available. On the residential unit one staff member said, "We don't get time to sit and chat to people."

We looked at the duty rota for the period 25 July 2016 to 31 July 2016 and 8 August to 14 August 2016. The nursing unit was rostered for a nurse and three care staff. An agency nurse was rostered to work on six out of seven day shifts on the first week. On the first day of our inspection, there was a nurse and three care staff, however, the nurse and two of the care staff were agency workers. We saw and heard the agency nurse trying to locate a member of care staff on the unit for period of ten minutes. On the second day of our visit there was an agency nurse on duty. The deputy manager told us it was the agency workers first shift at the home. We asked the deputy manager how long it took a nurse to complete the morning medicine round, they said it took them approximately an hour and a half but agency staff may take up to an hour longer. They told us there were twenty people on the unit, ten of whom were nursed in bed. This meant that people may not be receiving their medicines in a timely manner and during this time period, there were only three staff available to meet the needs of twenty people, some of whom had complex needs.

On the dementia unit, there were only two staff rostered to work on the unit from 8am to 8pm for the period 25 July 2016 to 31 July 2016 and 8 August to 14 August 2016. A member of staff told us there was a minimum of four people who required two staff to support them with aspects of their care. They also told us about another person who was at high risk of falls, if staff were not available. This meant that while staff were supporting these people, there was no one available to ensure the safety and wellbeing of the other people who lived on the dementia unit.

When we spoke with a member of catering staff they told us meals were sent to the units and care staff served them to people. At lunch time on the dementia unit we saw people were being sat at the table for lunch but as they did not receive their meal promptly they got up and left the table. We heard one staff say they had 'asked for more help'. A member of the kitchen staff came to the unit to serve the lunchtime meal to people. On the nursing unit we noted at 13.15 pm there was still five people who had not yet received their lunchtime meal. This issue was also observed during our inspection of Priory Gardens on 21 September 2015. The deputy manager told us they were aware there was an issue with people on the nursing unit receiving their meals late.

These examples evidence the registered provider had failed to ensure sufficient numbers of suitably deployed staff were available to ensure people's needs were met in a timely manner. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The deputy manager told us any accidents or incidents were recorded by staff and logged in the registered provider's online management system. They said the system sent an automated email to the senior management team to alert them of the entry. The 'turn around' manager explained analysis of falls was completed enabling staff to identify patterns or trends.

The deputy manager told us a variety of checks were made by the maintenance team within the home on a weekly basis. This included checks on the nurse call and fire detection system. When we asked to review these records we were told they were locked in the maintenance team's cupboard and the deputy manager did not have a key. Due to the time of our request, the maintenance team had finished work for the day. The 'turn around' manager told us they would ensure a key to this cupboard was obtained to ensure these

records were accessible in the future. The 'turn around' Manager was unable to locate the service records for some of the equipment at the home therefore this evidence was submitted to us after the inspection. We saw certificates to confirm the safety of the electrical system, gas boilers, fire detection system and the lift had been checked by an external qualified contractor. This demonstrated this equipment was maintained to ensure it was safe to use.

We saw fire evacuation slings were located at various points around the building. This equipment is required to assist people who have mobility problems in the event they have to be moved urgently. Each of the care plans we looked at contained a personal emergency evacuation plan (PEEP). This is a document which details the individual safety plan in the event the premises have to be evacuated. We noted not all the PEEP's we reviewed contained all the relevant information. For example two of the PEEPs did not record the number of staff required to enable the person to be safely evacuated.

We saw a variety of equipment was available in the home, for example, height adjustable beds, bed safety rails and pressure mattresses. We asked the deputy manager and a senior carer how staff knew individual mattresses were set correctly. They both told us this information should be recorded on people's individual position change records. We looked at the position change records for three people and saw this information was not recorded. This meant we could not evidence the specific needs of these people in relation to pressure area care were being met.

The care plans we reviewed contained a variety of risk assessments relating to moving and handling, skin integrity and the use of bed rails. We found the moving and handling information in people's records was inconsistent and was not always reflective of the practices we observed during our inspection. For example we noted the care plan for one person recorded 'can weight bear but only with stand aid', however, their risk assessment for moving and handling recorded they required the use of the oxford hoist and hammock sling. When we observed staff transferring this person from their chair, staff used an Alto hoist and a toileting sling. The moving and handling information in another person's records were also conflicting. Their mobility care plan referred to the use of a stand aid but the risk assessment for moving and handling indicated they were mobile with two staff and made no reference to the use of any equipment. When we asked a staff member how they supported this person to transfer, they said they required the use of a stand aid. We discussed our findings with the 'turn around' manager and deputy manager at the time of the inspection.

While reviewing a care plan we saw staff had recorded the person's blood sugar to be 26mmol. This result is outside of the normal parameters expected for people diagnosed as diabetic. The records noted 'discouraged from eating sweet things'. There was no evidence to suggest the person's blood sugar had been re-tested for accuracy or for further monitoring in the initial couple of hours after this was recorded. Where an abnormal blood sugar reading is obtained, it is good practice to re-check the reading within a short time frame. This helps in establishing if the original reading was an error or if the person maybe unwell.

These examples evidence the registered provider had failed to ensure people's care and treatment was provided in a safe way. This also evidences a failure to ensure accurate, complete and contemporaneous records were maintained. This was a breach of Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had completed training in safeguarding adults. One member of staff said, "It's everybody's job, we are dealing with vulnerable adults. I'd record and report immediately to the manager or the nurse on duty." We asked some staff about their understanding of whistleblowing. They told us they were aware of how to escalate concerns to either their head office or to external organisations, for example, the Care

Quality Commission (CQC). A whistle blower is someone employed by the registered provider, who reports concerns where there is harm, or the risk of harm, to people. One staff member said, "If I thought there was anything, I wouldn't hesitate, I'd whistle blow." This showed staff recognised their responsibilities for safeguarding people who lived at the home and were aware of how to raise concerns about harm or abuse.

We saw an entry in the resident and relative meeting minutes dated 8 July, '(names of three people) are not happy that another service user is wandering into their rooms at night'. Resident and relative meeting minutes dated 26 July 2016, the date of our inspection, also noted '(names of people) are still having problems with a service user walking in their rooms day and night and feel that rooms are not secure when leaving them'. We asked one person if they had a key for their room or if were able to lock their door, they said, "I don't think so, I wasn't aware you could lock it." We asked a senior care, they said, "No one has them (keys), if they wanted one they could have one." We raised this issue with the deputy manager.

Requires Improvement

Is the service effective?

Our findings

Prior to the inspection we had received some anonymous information of concern suggesting staff on night duty had not completed moving and handling training. We reviewed a random sample of staff including two night staff. We saw they had each completed this training. After the inspection the registered provider confirmed the moving and handling training dates for all the night staff, and we saw they had all completed this training. A refresher course was booked for staff who had gone over twelve months without refreshing their skills.

Staff told us they completed regular training, most of which was online. One staff member said, "All the training is online. It's fine, it doesn't bother me, I have a few to do. I do it at home but you can come in and use the computers here." Another member of staff told us they felt the quality of the training they received was good and it had prepared them for their role. Staff told us the moving and handling training included a practical element to ensure staff had the skills to complete this aspect of their work safely. Staff also said they felt supported by the registered provider to access training relevant to their role.

We reviewed how new staff were supported in their role. Two staff who had been employed for less than six months told us they had completed a variety of online training topics and a practical moving and handling session. They had also spent a week shadowing more experienced staff. We asked one of them if they had commenced the Care Certificate, they told us they had 'never heard of it'. This is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that all workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. In the manager's office we saw there were supplies of training files incorporating the induction process and the Care Certificate for new employees which the deputy manager told us had not yet been implemented for staff. Providing suitable and thorough induction for new staff helps them to develop the knowledge and skills they need.

A number of shifts at the home were being covered by agency staff. The deputy manager told us they received a profile of the staff member from the agency which helped ensure they had the relevant skills. We asked if an induction was completed with the agency staff on their initial shift, to assist in orientating them to the home and providing basic information, for example, what action to take in the event of the fire alarm being activated. The deputy manager said this was done but they were unable to provide evidence to confirm this as the documentation was amongst a large pile of paperwork awaiting filing. This meant we could not evidence the quality of the orientation and induction provided to agency staff at the home.

Staff feedback about supervision was mixed. Staff who had been employed for over a year told us they had received supervision but this was not on a regular basis. Two staff who had been employed for over three months told us they had not yet had supervision. Evidence in staff files confirmed supervision was sporadic; one staff member had not had supervision since November 2015. We looked at the file for one of the staff who told us they had not received any supervision since they commenced employment and there was no evidence of any supervision with them. The deputy manager told us staff should receive supervision six times per year. Having regular supervision enables managers to monitor staff performance and highlight

future development needs.

These examples evidence the registered provider had failed to ensure staff received appropriate support, training, professional development and supervision as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We asked people about the food at the home. Feedback included, "It's quite alright" and "It's getting better, the menu is the same all the time." Another person said, "The food is fine, plenty of it. They ask you what you want."

Dining tables on the units were set with cutlery and crockery and menus were on display. Staff on the dementia unit told us they had to encourage a number of people on the unit to eat as they would forget. We heard staff ask people where they would like to eat and encouraging people to go to the dining room for lunch when they said they did not wish to dine.

The kitchen staff told us there was a choice of menu at each meal time and people made their choice 'today for tomorrow'. Where people have short term memory problems this may mean people are served a meal which they have no recollection of requesting or which they may no longer prefer to eat. We saw staff served people their pre-chosen meal from a heated trolley and offered gravy at the table. We saw staff offer people a choice of hot or cold drinks. Food looked hot and the portions sizes were generous. Staff asked if people had enjoyed their food and if they had finished before removing their plates. When pudding was served on the residential unit, staff told people they were serving pudding but did not tell them what the pudding was. One person asked the staff what the pudding was, when they were told, they said they did not like it. The staff promptly offered an alternative. At the evening meal on the residential unit people were offered soup but a number of people were served before we heard a member of staff tell someone what flavour the soup was.

Prior to the inspection we had received some anonymous information of concern that suggested people were not receiving sufficient to drink. We spoke to one person who said they liked to get up 'with the night staff'. We asked them if the night staff offered or provided them with a drink once they were out of bed, they said they did not and the first drink of the day was when they were served breakfast. An entry in the resident and relative meeting minutes dated 13 July 2016 noted '(name of person) is concerned the drinks round in the morning and afternoon is not always happening, particularly in the nursing unit'. We saw drinks being offered to people during the day but on the first day of our inspection there was no evidence people were offered snacks. We asked a member of staff about this and they said, "Sometimes they get snacks." We shared this information about people not getting drinks until breakfast with the 'turn around' manager.

We reviewed the eating and drinking records for one person on the nursing unit whose care plan contained an entry on 9 June 2016 which stated 'weight loss, daily diet records to be completed'. We looked at the food and drink records for seven days, no snacks were recorded for either mid-morning or mid-afternoon. The section for staff to record if the person required a special diet was also blank although we saw three entries on the food records which referred to the meal provided being pureed. The fluid records for the seven days only evidenced one day when the person drank over a litre, and one further day only 250mls were recorded. We also looked at the food and fluid records for a six day period for a person on the dementia unit. Snacks were recorded for the mid-morning and mid-afternoon on most days, however, the section for staff to record if the person required a special diet was blank although an entry on the food record referred to the meal provided being pureed. Fluids were only totalled up on two of the days; we totalled the fluid on one day and found it to be only 490mls. This meant the records did not evidence people

were consistently provided with sufficient nutrition and hydration.

During our inspection of Priory Gardens on 21 September 2015 we found food intake records lacking in detail. On this inspection we found this to still be the case. These examples demonstrate a failure to ensure peoples care and treatment is delivered in a safe way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This also demonstrates a failure to ensure accurate, complete and contemporaneous records were maintained. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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) as described in MCA schedule A1 together with any conditions on authorisations to deprive a person of their liberty set by the supervisory body as part of the authorisation. The deputy manager told us they had submitted a DoLS application to the local authority for a number of people who were living at the home and to date, three had been approved. This showed although some people had been deprived of their liberty, the home had requested DoLS authorisations from the local authority in order for this to be lawful and to ensure a person's rights were protected and were awaiting the outcome of other applications.

Where people lacked capacity we saw some evidence of capacity assessments. One care plan contained a capacity assessment and evidence of best interests regarding the use of bed rails. Other capacity assessments were generic, for example the capacity assessment for one person referred to 'unable to make choices with day to day living…care staff to make decisions for (person) in their best interests'. There was no detail recorded as to the choices they were able or not able to make or how staff were to support them with decision making. This meant the requirements of the Mental Capacity Act 2005 were not consistently applied in line with legislation.

We asked staff about their understanding of mental capacity and their replies demonstrated they understood their role with people who may lack capacity such as supporting people to make decisions about what to wear or what to eat. One staff member said, "We never assume people don't have capacity." A second staff member said, "It's about peoples' capacity to make choices."

We saw evidence in people's care plans they received input from other healthcare professionals. For example, general practitioner, district nurse and speech and language therapists. We spoke briefly to a visiting external healthcare professional on the residential unit, they expressed no concerns regarding the care and support people received and felt staff made appropriate and timely referrals to their service. This showed people received additional support when required for meeting their care and treatment needs.

Since our last inspection refurbishment work has been completed. This included building patio doors in the dementia unit to enable people access to the secure garden. The nursing unit has moved upstairs and the residential unit was now on the ground floor, this enabled people living on this unit to freely access the garden via patio doors in the dining room. The nursing and residential units had separate lounge and dining rooms and the dementia unit had a large area with defined lounge and dining areas. All the units had a

kitchenette in the dining area to enable staff to provide drinks and snacks for people. There was seating and coffee making facilities in the reception area for people and visitors to access.

Bedroom doors on the dementia unit were painted in various colours; toilet and bathroom doors were painted yellow. People's bedroom had their names on them and memory boxes were located outside their bedroom doors. Pictorial signage was used throughout the home to indicate shower and toilet facilities. This enables people who may no longer be able to fully comprehend the written word to be able to navigate around the home.

Good

Is the service caring?

Our findings

People told us staff were kind. One person said, "They (staff) have been very good to me. You get up when you want and go to bed when you want." Another person told us the staff were 'lovely'. We saw feedback from a relative on a recent review form, '(person) loves the staff'.

Staff spoke with us about the people they supported in a caring and respectful manner. One of the staff said, "It's about their wishes, how they want things. Their likes and dislikes and how they want to be treated."

Throughout the inspection we observed staffs interaction with people who lived at the home, which was, kind, caring and professional. We observed staff assisting a person in the hoist; staff explained their actions and provided reassurance through words and touch. We also heard staff ask people what they would like to watch on the television prior to them changing the channel. We heard a senior carer speak with a person when they were administering their medicines, they said, "I've got your tablets here for you. Do you want to take them today? I've got some juice, is orange juice ok for you?"

At lunchtime people received appropriate support to eat, we saw one person who was struggling to get the cutlery to their mouth, this was noticed by the deputy manager and they promptly sat with the person to help them. One person was dozing, the staff spoke gently to wake them up for their meal. We saw a number of people who were sat in their rooms and we found where appropriate, the call bell had been placed to enable them to request staff support if they needed it.

Each of the care plans we looked at contained a simple profile of the person. This included brief information about their needs, likes and preferences. One person's record noted 'I like to look nice'. However, there was no further information as to what 'nice' meant to that person. Having this information enables staff to provide care which is tailored to meet individual preferences.

Staff told us how they enabled people to make day to day choices. One staff member said, "They get up when they want to get up. If they don't want to get up, they don't have to." Another staff said, "(Person) didn't like the dress they had on today, so (name of staff) took her to choose what she wanted to wear." Care plan reflected people's right to make choices. The care plan for one person recorded, 'likes to be shown two sets of clothing so she can make her own choice of which she wants to wear'. Offering people choice and control over their daily lives is a key aspect of maintaining a person's dignity and life skills.

One person told us staff always knocked before they entered their room, "They are very good that way." Staff were able to tell us how they maintained people's privacy and dignity. One said, "We make sure we close curtains, that doors are closed. We tell people what we are doing and explain to people."

Staff did not discuss other people's needs in front of others. One staff told us, "If we talk to family about residents, we do it in an enclosed space, not in the corridors." This reduced the risk of confidential information being shared with other people.

Requires Improvement

Is the service responsive?

Our findings

People told us about the activities provided by the home. One person said, "I join in everything they have." Two people told us they had been to a 'donkey place', one person said, "I loved it." Although this person also said there needed to be more activity as they got bored.

One of the staff on the dementia unit told us the activities organiser had spent time placing sensory items in the garden for people. They had also brought in a 'comfort cat' and a 'comfort dog'. These were soft toys, designed to be as realistic as possible, to encourage people to spend time stroking them. They also said an entertainment company had visited a couple of weeks ago, "The residents were lit up, they loved it." A staff member on the residential unit said the activities organiser organised film afternoons, entertainment and trips out for people.

On the second day of our inspection we saw a Pets as Therapy dog was visiting people. In the entrance to the home there was an activity schedule listing the dates and times of planned activities at the home. There was also a hair salon, coffee making facilities and seating in the reception area. In the lounge on the residential unit we saw magazines and jigsaws were readily available for people.

The deputy manager told us the activities organiser completed a monthly care plan evaluation for people reflecting the activities they had participated in. The activities organiser was not on duty on the second day of our inspection to enable us to gain further insight into how they supported people to engage in meaningful and person centred activities.

A senior carer told us when a new person was admitted to the home staff implemented a seven day care plan which was a simplified care plan document. They said following on from this a more comprehensive care plan was developed using the information gained from the person, their family and staffs knowledge of the person as they settled into the home. The care plans we reviewed were person centred, written about the individual needs of the person. For example, one care plan detailed '(person) likes to sleep until breakfast and have breakfast in bed'. Another care plan recorded, 'likes to be up early, requires help fastening buttons'. This level of information is important, particularly when people have memory impairments and may not be able to communicate their preferences.

Care plans contained a document to record people and/or their family's involvement in their care plan, but this was not completed in all the care plans we reviewed. We asked one person about their care plan, they said, "I expect they (staff) have one. I'm not aware of it". In some of the care plans we reviewed we saw a care plan review document, this recorded the date and name of the family member involved in the care plan review. The deputy manager also showed us a log where they recorded the reviews which had been completed for people. We saw four had been completed in February 2016, one in April 2016 and two in May 2016. Involving people and consulting with them in the care planning process is key to ensuring the care and support they receive is designed around their individual needs.

In the nurses office there was a large stack of MAR charts and other care related documentation in an untidy

pile. On the second day of our visit the office door which had a coded lock, was found to be open. This meant there was a risk confidential personal information could be accessed by people without the authority to do so, this also meant that in the event staff needed to refer to previous documentation, they would have to search through a significant volume of paperwork to locate the information they required.

Daily care records were tick box and not person centred. There were significant gaps in the records we reviewed for nail care, teeth and denture care. We saw evidence people received baths or showers, but these were not always as often as the person preferred. One person told us they bathed daily at home but were only offered a bath once a week. Another person said, "I would like a bath every day but its once a week if you are lucky." We looked at the bath records for these two people and saw they had been bathed seven times and eight times, respectively, over a two-month period. We reviewed the bathing records for people who were living in the dementia unit, this evidenced from 1 to 26 July 2016, with the exception of one person, everyone had had a minimum of four baths in that time frame. On the nursing unit we looked at the bathing record, dated July 2016, for one person. Between the 1 and 26 July 2016 the records indicated they had only had two baths, on the 17 and 23 July 2016. There was no indication from the record, they had been offered or had refused a bath at any other time during this time frame.

We looked at the position change records for three people. We found frequency of position changes was recorded as four hourly but only nine of the twenty daily charts we looked at noted this information. The recording of people's position changes was sporadic on each of the charts we reviewed and there were no position changes recorded between the hours of midnight and 06.00 for two people. On one chart dated 26 July 2016 the chart recorded no position change between the hours of 14.26 and 23.49. This meant we could not evidence people were receiving pressure area care appropriate to their needs. We informed the deputy manager of our findings.

One person had a plaster cast on their arm. We asked the senior carer if there had been any amendments to the care plan to reflect the changes in their care needs or to provide information for staff, such how to care for the cast, for example, not to get it wet. They told us there had no changes had been made. Ensuring care records are accurate and up to date reduces the risk of people receiving unsafe or inappropriate care.

These examples demonstrate a failure to ensure peoples care and treatment is delivered in a safe way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This also demonstrates a failure to ensure accurate, complete and contemporaneous records were maintained. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In the reception area there was the facility to register any comments or concerns via an online management system. The 'turn around' manager told us this information was sent directly to the registered providers head office. Prior to our inspection we became aware that some people had been dissatisfied with the quality of care provided by the staff at Priory Gardens. We looked at the complaints file and saw evidence of five complaints during January 2016; these had been investigated and responded to by a previous 'turn around' manager. There were no further complaints logged until July 2016. The 'turn around' manager told us they had begun to investigate the complaints which had been raised. We saw two complaints had been investigated and we saw the letter which had been sent to the complainant detailing the findings of the investigation and, where appropriate, an apology. This showed that complaints were fully investigated and resolved, where possible, to their satisfaction.

Inadequate

Is the service well-led?

Our findings

A person who lived at the home said, "(Deputy manager), she is good." However, another person told they did not know who the manager at the home was. Comments from staff included; "(Deputy manager) is really nice. She is easy to approach", "(Deputy manager) we have a good relationship." And, "I think we are feeling it having so many different managers. We are aiming for the right thing, it is good here… One manager comes in saying do this; another will say you should be doing that. It has made it difficult."

The home has not had a registered manager in post since July 2015. The 'turn around' manager at the home at this inspection was different to the one we met at our previous inspection in September 2015. The deputy manager said this was the third 'turn around' manager who had been assigned to the home since the departure of the previous registered manager. Throughout the two days of our inspection we found the deputy manager to be knowledgeable about the home, the staff and the people who lived there. They were candid but professional in their dealings with us. They told us they had managed Priory Gardens, on a temporary basis for a number of weeks but since the arrival of the new 'turn around' manager they were to revert to their previous role of deputy manager and unit manager for the nursing unit.

The 'turn around' manager told us a member of senior management visited the home at least monthly and compiled a report. They said the information on these reports had raised concerns within the organisation regarding standards at the home. They said senior managers had requested 'turn around' manager visit the home, which they did the week prior to our first visit, to complete an audit. They told us they were to be based at the home with effect from 1 August 2016 but a new manager for the home had been recruited and was completing pre-employment checks prior to commencing employment.

We reviewed the senior management reports for the home, there were no reports for April or June 2016. There were three reports in May 2016 and three reports for July 2016; each one had been completed by a different individual. Our inspection, 21 and 23 September 2015, rated the home as Requires Improvement; we identified a number of areas which needed attention, including concerns regarding staffing levels, staff supervision, food and drink records. On this inspection we found these concerns had not been addressed. This demonstrated the senior management governance system had been ineffectual at ensuring the home was complaint with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the deputy manager about the auditing systems within the home. They showed us a walk around audit which they completed on a regular basis. We looked at the records for June and July 2016 and saw this had been completed on 28 occasions. There were comments on the reports relating to the dining service, service user care and infection prevention and control. We saw evidence the deputy had picked up on matters which needed addressing, however, it was not always evident from the report, that these issues had then been followed up and addressed. They also showed us medicine audits which they said were completed on each unit on a monthly basis and a health and safety audit dated January 2016. Where issues were identified we were unable to evidence action had been taken to address the issues. We saw evidence of regular care plan audits.

A member of staff told us staff meetings were held but they were irregular. The deputy manager said the most recent meeting had been held in June 2016, we saw hand written minutes of separate meetings held with day and night staff. They said the meeting prior to that had been around the time of the last CQC inspection in September 2015, but they were not aware of any minutes relating to this meeting. The deputy manager told us flash meetings should be held Monday to Friday with the senior person on duty in each department. We looked at the records of the flash meetings for July 2016; only six meetings were recorded from a potential 17. A staff member said, "We usually have flash meetings but I can't remember the last time I had one. They used to be daily." Staff meetings are an important part of the provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and support for people living at the home

People told us there were resident and relative meetings and we saw from the minutes, they were held at regular intervals. The minutes recorded the names of the attendees and topics discussed, including feedback from people who lived at the home. The 'turn around' manager said a monthly report was also forwarded to the home from head office with a summary of the previous month's feedback from the online feedback system in the homes reception. There was no evidence the feedback was reviewed by the registered provider or any action having been taken to address the issues which were raised.

These examples demonstrate a failure to ensure systems and processes of governance are operated effectively to ensure regulatory compliance. This also shows a failure to act on feedback from people who live at the home and staff. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents. Prior to the inspection we saw evidence the registered provider submitted these notifications in a timely manner. During our inspection we did not identify any issues which the registered provider had failed to notify us about.

There is a requirement for the registered provider to display ratings of their most recent inspection. We saw the registered provider had due regard for the duty of candour, there was a link to our most recent inspection report on their website and the rating was on display both on the website and within the home.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to ensure sufficient numbers of suitably deployed staff were available to ensure people's needs were met in a timely manner. The registered provider had failed to ensure staff received appropriate support, training, professional development and supervision as is necessary to enable them to carry out the duties they are employed to perform.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to ensure people's medicines were managed safely. The registered provider had failed to ensure people's care and treatment was provided in a safe way.

The enforcement action we took:

A warning notice was issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to ensure secure, accurate, complete and contemporaneous records were maintained. The registered provider had failed to ensure systems and processes of governance were operated effectively to ensure regulatory compliance. The registered provider had failed to act on feedback from people who live at the home and staff.

The enforcement action we took:

A warning notice was issued.