Golden Age Management Limited

Attwood's Manor Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

This inspection took place on the 16 and 26 January 2015. The first visit was unannounced. We arranged with the manager to return on the second day because of the concerns we identified at the first inspection and because we were unable to see all of the records we had asked for.

At the last inspection on the 9 September 2014, we identified a number of breaches which included concerns in relation to the care and welfare of people, supporting workers, assessing and monitoring the quality of the service provision and the handling of complaints.

The service is registered for up to 65 people who require residential care. On the day of our inspection there were 47 people using the service They also accommodate people living with dementia.

There was an acting manager in post who was taking the necessary steps to become registered. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

During this inspection we identified continued breeches.

There were not enough staff to meet people's needs or keep people safe. Risks to people's safety were not adequately monitored.

We identified poor practices around the administration of medicines which meant we were not assured people always received their medicines safety.

Risks to people's safety were not adequately identified or monitored so risks were not appropriately managed.

We found that the staff did not always act lawfully to support people who did not have capacity to make decisions about their care and welfare.

People's health care needs were not always met with regards to their nutrition and hydration needs and people were not adequately supported to eat and drink enough for their needs.

We identified inconsistent practices around recording so could not be assured that people's needs in relation to their health and welfare were met. Care plans were not kept up to date.

Most staff were caring but we observed some restrictive care practices which were task focused rather than based on people's individual needs.

Most staff had a good understanding of people's needs but we found some inconsistent practice and negative terminology used to describe some people's needs. This meant we could not see if staff had the skills they needed for their job role or that their performance was adequately monitored.

People had little opportunity to have their say about the service provided to them or influence the culture of care There were poor systems to monitor the quality of effectiveness of the care delivered.

There were inadequate systems to record and show what actions had been taken to minimise risks to people's safety, care and welfare.

There were poor quality assurance processes in place and not all complaints were recorded so we could not see if these were dealt with effectively.

We found a number of continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

There were not enough staff to meet people's needs in a timely way or to promote their care and welfare.

Risks to people's safety were not managed effectively.

People were at risk of not receiving their medicines as prescribed because staff did not follow safe practices as required in accordance with best practice.

Is the service effective?

Requires Improvement

The service was not always effective

People were not adequately supported to eat and drink in sufficient quantities for their needs.

Staff received basic training but not all staff had the necessary skills or understanding to support the health, welfare and safety needs of people.

People had access to relevant health care professionals.

Staff did not always act lawfully to promote and uphold people's rights, particularly where they were deemed to lack capacity.

Is the service caring?

Requires Improvement

The service was not always caring

People's privacy, dignity and independence was not always upheld.

Most staff were very caring but staffing shortages compromised the quality of the care people received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care needs were not adequately reviewed and records did not show the action taken to mitigate or reduce risks to people.

Complaints were addressed but not always recorded so we could not see how well these were managed.

Is the service well-led?

Inadequate

The service was not always well led

There was poor direction and leadership given to the new manager.

There was poor evaluation and analysis of risk.

Summary of findings

There were poor systems in place to audit the service to ensure its effectiveness, and or identify necessary improvements.

Attwood's Manor Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 16 and 26 January 2015. The first inspection day was unannounced and neither the manager nor provider were present. We returned on a second day which we arranged with the manager because we wanted to discuss our concerns with them and to see records which were not available to us on the first day. Our inspection team consisted of four inspectors.

Before the inspection we looked at the information we already held about the home. This included: any notifications and share your experience forms. A notification is information about important events which the service is required to send to us by law. We also made contact with the Local authority and other agencies. Prior to our inspection we found some concerns relating to the provision of care.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with eleven people who used the service, six visitors and thirteen staff including senior staff, care staff, activity staff and ancillary staff. We spoke with five health and social care professionals. We also looked at five care plans and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

There were insufficient staff to meet people's needs and to promote their health, safety and welfare. One person told us, "We wait an awful long time for different things; there is not always people [staff] available or wheelchairs." Another person said, when they needed help in the morning they pressed their buzzer. They said staff came but sometimes had to leave to attend to other things. One person told us they had not had a bath for two weeks when they wished to have one. They told us that staff had said they were too busy.

One relative told us, "It is badly run here, there are far too many patients for the number of staff they employ." One staff member told us, "There are not enough staff, and people staying upstairs in their rooms are left unsupervised for long periods of time."

Staff told us that there were not enough staff to meet people's needs in a timely way and they were always busy. One staff member told us that they did not finish assisting people up until lunch time and did not have time to sit with people. Another told us that people did not always get the care they needed. For example they tried to offer people baths but did not always have time to do this.

The provider told us they had enough staff and showed us the staffing rotas. They had the number of staff on duty they said they needed. However when we asked them how they determined the staffing levels required they did not have a specific tool to assess people's needs and decide how many staff they needed. They had not taken into account the views of people using the service or the staff who all told us there were not enough staff to meet people's needs.

We observed care being provided to people across the day. People in communal lounges were left unsupervised and unstimulated for most of the morning. Staff were busy providing personal care up until lunch time and were only visible when assisting people in to the lounge before going to assist the next person. A number of people on the day of our inspection were unwell and were unsteady on their feet and reported to be more confused than usual. They were walking round with no staff in the vicinity to assist them.

We observed other people sitting in the dining room up until almost lunchtime when they were assisted by staff to use the toilet. A number of people required staff assistance to go into another area of the home. This was not offered and some people missed the opportunity to join in a music activity taking place because they were not asked or assisted to the lounge.

At lunch we saw there were 3 staff to assist thirty five people. People were not given support or encouragement to eat their meal and we saw at least five people who walked off before finishing their meal without being noticed or supported by staff. Some people had to wait for over half an hour before their food was served and other people were still at the table 2.5 hours after they were first helped to the dining room. Medicines were also administered at lunchtime and the person administering medicines had to keep stopping what they were doing to help other staff. This meant they were not able to focus on giving out medicines to people safely.

There was no documentary evidence to support the rationale for the number of staff on duty and if it was adequate for the needs of the people using the service.

Staff were not employed in sufficient numbers for people's needs which is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations.

Staff did not follow the correct procedures when administering people their medicines thus putting them at increased risk of receiving the wrong medicines. We did not ask people about their medicines but observed medicines being given and spoke with staff. On the first occasion we observed a staff member with a tray of medicines in unlabelled pots. They went round administering medicines to one person after another without referring back to the medication record or signing for medicines immediately after they had been administered them. A second member of staff administering medicines at lunch time did so safely referring to the medicine administration chart each time they gave medicines and signing for the medicines immediately.

Following the inspection we spoke with the acting manager about the first staffs practice and they acknowledged that the staff member had not followed the homes medication policy. They told us that all staff administering medicines had received training and had been assessed as competent to give medicines safely. They were not able to give us an explanation as to why in this case medicines had not been administered safety.

Inadequate

Is the service safe?

We spoke with staff who were knowledgeable about how to give medicines safely to people and they confirmed they had receiving training to help them do this.

We looked at staff's training records and medicine competency assessments which showed staff had been adequately supported to give medicines correctly. However when we asked the manager on the second day of our inspection how they had dealt with the concerns we had raised about the one members of staffs practice. They were not able to provide us with any documentary evidence. The staff member in question had not received any additional supervision or training to help them administer medicines safety.

During our observation we identified additional concerns. Some medicines were stored in a designated treatment room. This was left unlocked and medicines were easily accessible and in an area where people's bedrooms were. When we asked the provider about this they were unable to provide us with a suitable explanation. We also found opened creams and medicines which were not dated so we do not now when the best before date was.

Unsafe practices around medicines meant there was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not able to tell us about risks to their safety. However we spoke with relatives, one told us about the number of falls their family member had, one as a result of faulty equipment. Another told us about the risk of their relative trying to access the stairs and their reluctance to eat and drink in which they suggested they had lost weight. Another relative told us their relative appeared to have difficulty in swallowing and was not eating or drinking enough for their needs, although they did say staff encouraged them to do so.

Risk assessments were not completed by care staff but by the acting manager and senior staff. They were not able to tell us if they were all up to date, but did demonstrate a good knowledge of people's needs. However the lack of documentation made it difficult for us to see what actions the home had taken to manage the risk.

We looked at some people's records and saw care plans and risk assessments were in place where a risk had been identified. These were in relation to falls, hydration, and moving and handling. The computerised record prompted staff to review information each month. Records were not up to date so we could not see if they reflected people's current needs, or showed us how the risk was being accurately managed. Records were an unreliable source of information.

We followed up the families concern where they believed their family member had lost weight. They had and the home was regularly weighing the person but had not taken any action in respect of their weight loss, although this was very slight. We learnt form the family that their relative needed support around food and preferred snacking to main meals. We could not see how the home were supporting this person adequately or mitigating the risk from malnourishment. This was fed-back to the manager.

People's hydration was monitored and staff kept fluid charts. These were in place whether a person required them or not. Staff told us they did not have time to complete the records contemporaneously. Staff did not have time to accurately record what each person had to drink and records were poorly completed and evaluated. One relative told us "My family member is not eating or drinking enough. " Their records had not been completed for the day so we could not see how staff were encouraging them to drink at regular intervals. They had developed an infection so was more at risk of not eating or drinking enough. This had not been documented. Their difficulty in swallowing had not been investigated or their lack of appetite explored. This meant we could not see how risks to this person had been assessed and actioned.

For another person that had a number of falls which were recorded but lacked detail within the record of what actions staff had taken. Bedrails were eventually introduced but only after a number of falls and significant injury to the person. The acting manager told us the falls team were not always proactive when they referred people to them but we could not see how this information was recorded as part of the persons care.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2010.

People were not protected from the risks should a fire break out. There was some information about people and the assistance they would require in the event of a fire. However risks to people's safety were identified during

Inadequate

Is the service safe?

both days of our inspection. We observed fire doors blocked, and fire doors propped open. When we brought this to the provider's attention they addressed it but on our second visit we observed the same hazards.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2010.

We asked to see records and saw maintenance servicing and records of drills. However the fire risk assessment had a number of actions recorded which required attention. The report did not tell us how and when these action points had been addressed. This report was dated July 2009. The provider said the fire risk assessment was being revised by a different company but we could not see how immediate fire risks were being managed. The home was not linked directly to the fire station and the fire procedures for staff were not clearly visible which could cause a delay in staff summoning assistance. This meant people were not safe.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2010.

We were unable to see from records if infection control procedures for the home were adequate. At our inspection we were told by relatives that the week before they were prevented from visiting their family members because of an outbreak of sickness at the home. The manager told us this was the case and they had contacted the relevant authority and said they had taken precautions to manage the infection and stop its spread including enhanced cleaning schedules and discussion with staff about infection control procedures. However they were unable to provide us any written evidence of this. We looked at cleaning schedules and found they were not dated and there was no evidence of enhanced cleaning schedules being completed. During our inspection we found poor standards of hygiene throughout the home which led us to conclude cleaning schedules were ineffective. For example we identified soiled sheets left on people's beds and wheelchairs and people's chairs were dirty. We also saw from the provider's notes and feedback from relatives' that the home was not always well maintained. We were unable to see what actions had been taken and see this as an area which requires improvement.

Where people were at risk of harm or abuse staff were able to recognise this and take appropriate action. Staff spoken with demonstrated a good understanding of what actions they should take if they suspected a person to be at risk of abuse or harm. Staff knew how to report concerns and were aware of the role of external agencies. Staff told us if they had concerns they would report them immediately to the acting manager or the provider, but also said if concerns were not addressed they would go to external agencies like CQC and the Local Authority. Staff confirmed they had received training and were aware of the policies and procedures. Information was around the home telling people, staff and visitors what to do if they believed a person was at risk.

However we were aware of concerns about people's care and welfare which had not been reported to us by the provider and not referred to the Local Authority safeguarding team for proper investigation which meant they had failed to protect people properly.

Requires Improvement

Is the service effective?

Our findings

Staff did not have the necessary skills to meet people's needs effectively. Staff told us they had received training in dementia care but not in managing challenging behaviour. Dementia care training should help support staff in understanding the reasons for people's behaviour and how to support a person with their behaviour rather than trying to manage it. Staff referred to people as 'challenging ' or as 'wanderers,' which demonstrated a lack of insight into people's behaviour and why people might behave in a particular way as a result of a cognitive impairment or because they were not getting their emotional needs met. This meant we could not be assured that the training staff had received had enabled staff to provide person centred care.

Staff told us that most of their training was based on e-learning, which meant videos were shown to staff. They then had to demonstrate their knowledge by answering questions on what they had seen. Face to face training would give staff the opportunity to learn from each other and share ideas. Staff did not have this opportunity and rarely had the time to meet as a staff team. There were poor systems in place to monitor staffs practice to ensure it was appropriate to the needs of people using the service. Staff told us they were supervised but there were limited records of this. We were unable to see how the acting manager used staff supervision to address poor staff practice or identify staffs training needs were.

We observed poor practice around medication administration and this was not addressed effectively by the acting manager to ensure staff were able to give medicines competently or that this had been reassessed.

We looked at staff training records which showed us that some staff training had lapsed and in the absence of other records we could not see what impact this had on staffs ability to effectively manage people's needs.

People's decisions about their care and welfare were not always upheld. Care plans told us how people wished to have their needs met. However we found in practice people's choice was restricted because of the number of staff on duty and their inflexible approach to care.

Where people were deemed to lack capacity their records did not always give us enough information or show a clear decision making process of how conclusions had been reached. For example one person was described as having dementia and unable to retain information. It was therefore deemed in their best interest to make decisions on their behalf. Their records did not specify what decisions needed to be made or if there were any aspects of their care which they could influence. Families were asked to consent for aspects of people's care and it was not clear if they had power of attorney. If not they had no powers to act on behalf of a family member.

A decision had been made that one person should move downstairs because they were considered unsafe upstairs. However because they were likely to go into other people's room a decision had been taken to lock everyone rooms downstairs. We asked if people who wanted them had keys and were told very few. This meant the acting manager had made decisions about the care and welfare of one person and had not considered the impact of this on others or if it infringed on their rights. We noted a stair gate had been put in place as a result of people trying to access the stairs safety. However the rationale for this gate was not clear and there was no risk assessment in place, or a consideration of how this impacted on others.

People were given limited choices around their food preferences. However they did not receive adequate support to eat and drink enough for their needs.

We asked people if they had a choice at mealtimes. One person told us, "The food is not too bad although there is not much salt, I have to ask for salt as there is none on the tables. There is a tea trolley which comes around about 7 to 8 in the evening; it is mostly tea and coffee. Sometimes I am asked if I would like a hot chocolate which I love but this is very much a one off."

Most people spoken with said the food was alright.

Staff told us they were aware of people's dietary needs and who required supplements to promote weight gain. This was recorded in people's care plans and there was a list in the kitchen. Staff told us people had access to biscuits and snacks throughout the day. Staff told us they kept records about what people ate and drank but could not tell us how this information was evaluated.

The chef told us some people had supplements and they added extra calorie intake to some food to boost people's weights where required. They were unable to tell us how people had input into the menu. They told us snack plates

Is the service effective?

were provided once a day for those who needed additional calories and biscuits were also provided. We identified at least one person who 'snacked' throughout the day. Snacks were generally provided by their family and not the home.

We carried out observations over lunch. This took well over two hours and some people were sat for more than half an hour before receiving their food. Because of the delay some people left the table before being served food and staff redirected them to the table. However other people left during their meal with it half eaten and this went unnoticed by staff. People were not prompted with their food or given encouragement to eat a little more. One person was trying to eat chips with their spoon. Staff did not notice and therefore we do not know if this was the person's choice or with a bit of support they might off used the other condiments. Some people were too far away from the table which made it difficult for them to eat without spilling food on clothing.

People were given a drink with their meal but were not offered a choice and jugs of juice were not left on the table so we could not be assured that people had enough to drink. We observed tea trolleys being taken round mid-morning and mid-afternoon. People were given a drink and handed a biscuit but were not offered more which meant they might of still been thirsty. Staff were not on hand to encourage people to drink their tea.

One person asked for a drink which was acknowledged by staff but not provided in our half an hour observation. This resulted in the person becoming distressed.

We looked at people's records to see if people were getting enough to eat and drink and saw poor monitoring of this. For example we saw one person's record that the person had unplanned weight loss had been referred to dieticians but continued to be weighed monthly. Their records did not clearly show what they were eating or drinking and they were continuing to lose weight which meant that interventions were either not being actioned by staff or were not enough to achieve the goal or increasing a person's weight.

Another person had consistently lost weight over four months but there was nothing recorded in terms of action taken by the home to monitor, or prevent continued weight loss. Malnutrition universal screening tools, (MUST) records which were used to give an indication of the person's risk of malnutrition through a series of body measurements were not kept up to date so we could not see if the risk had increased or decreased. The majority of people had food and fluid charts in place with no rational for this. They were not completed throughout the morning of the inspection. This meant we could not see what people had eaten or drank. We looked at previous records and saw big gaps in recording so could not establish if this was a recording or practice issue. A number of people were unwell on the day of inspection and their records did not show if their fluid intake was sufficient. Staff handover records reported that one person had very dark urine, so their fluids should be promoted. We could not see how this was actioned as where they were sitting they did not have access to drinks outside of meal times and mid/ morning/mid-afternoon drinks. Their family member said they were inclined to refuse drinks, but this was not recorded either.

Records showed us how staff responded to a change in people's health care needs. People were supported to maintain good health and changes to people's health were recorded. However we found it difficult to establish from care records how staff monitored changes in people's health or if actions taken were always effective because of gaps in records. During our inspection we met with a number of health care professionals who were regularly in the home. The nurse practioner told us they were there at least three times a week.

We received mixed feedback about the home. One professional said they had offered advice to staff about a person's health. They said on a return visit staff had not acted on the advice and not all staff were aware of the advice offered. Another health care professional said that staff were all very friendly and very busy particularly in the morning. They said some care staff were better than others and one professional commented on the level of skill and knowledge some staff had which they felt was insufficient

Requires Improvement

Is the service caring?

Our findings

People did not always receive care which was dignified or upheld their wishes, independence or dignity. People told us that the staff were nice. One person said. “It’s okay here, staff are kind but I am not going to stay here.” We spoke with people’s relatives, one said they had not seen anything that concerned them and staff work hard. All the relatives said the staff were friendly and kept them informed about their family members care. However one relative told us people did not always get baths when they needed them but suggested it might be because people were uncooperative around their care.

We asked staff about this and they told us they did not have time to go back to people to try and persuade them and people did not always get baths when they needed or wanted one.

People’s records did not show us how people’s wishes were upheld or how often they received assistance with personal care. We could not see from people’s appearance that they had received the support they needed to help maintain good personal hygiene. Care plans did not tell us how people would like their appearance to be maintained and how they would like to be dressed.

Through our observations we saw that staff were busy and people did not receive attention or positive stimulation from staff. A music activity was taking place and this clearly enhanced people’s well-being. However we did not see many people joining in or being given the encouragement to do so as there were no staff around to assist the person providing the activity.

We spoke with staff about meeting people’s needs and several staff did not reflect a sufficient understanding of people’s care needs or show a respectful attitude towards them. For example, one staff member told us that some people had challenging behaviours and referred to people as ‘wanderers.’ One staff member said,” Sometimes they play you up, other times they do what you want and its fine. Some of them are more difficult than others. We ‘toilet’ them before lunch and we try to take in ‘the wanderers’ last.”

Staff told us people’s bedrooms on the ground floor were locked because of the ‘wanderers.’ This showed a lack of understanding of people’s needs and did not show a respectful attitude towards people.

We observed people sitting in wheelchairs and arms chairs which were not clean and did not help to uphold people’s dignity. We saw some people’s appearance did not uphold their dignity, for example people dressed in clothes that were not clean or ill fitting.

We also identified names on people’s door which should help to orientate people. However in some instances people had changed rooms and the wrong name was on the door which could be very confusing.

We observed some poor care interactions such as one person who had to wait for thirteen minutes to be assisted by staff to go to the toilet. The first member of staff saw but did not acknowledge the persons request to go to the toilet. This increased the person’s distress. Another member of staff responded when they shouted out but then took a while to locate a chair. We noted some people were not offered a comfortable seat out of their wheelchair which they remained in all day. Other people were still sat in the dining room over two and half hours later after lunch being served because staff were still assisting people with personal care. We saw people unoccupied for long periods of time.

This meant people did not get the support they needed in line with their individual needs and in a way they wished to receive their care.

People were not fully supported to express their views or be involved in making decisions about their care, treatment and support.

We spoke with people about how they were involved in decisions about their care and welfare. People were unable to tell us but one person said they did not get a bath when they needed one and through our observations we saw that care was very task focussed. Some relatives told us they had been asked to complete a document ‘All about Me,’ which asked for personal information about their family member, such as past history and family tree. This should help staff provide individualised care and meant families were consulted about the care needs of their relatives.

Staff had a good understanding of people’s needs and how to involve them in decision making but said they did not have time to update themselves on the information available for each person. The care we observed was not person centred or driven by people’s choices and preferences

Requires Improvement

Is the service caring?

One relative told us resident/relative meetings were held, but not very often because of a lack of interest. The manager showed us minutes of the last meeting but was not able to demonstrate that these were held regularly.

They were not able to show us what changes had been made to the service as a result of people's feedback. This meant people were not adequately consulted about their care and how they wished it to be provided.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection we identified a breech with Regulation 9, Care and welfare and have identified a continued breech at this inspection.

People did not receive care which was responsive to their individual needs or that promoted their health and welfare. One person told us, "I can't do much here as my sight and hearing is not good. Can't go out or do crafts. I enjoy a quiz but we don't seem to do that here. Some lounges have the TV on full blast I prefer to sit here as there is nothing on."

A relative told us they were concerned about the number of people who they described as high dependency and all needing attention from staff. They felt their family member was under stimulated which had led to a sharp decline in their mental health and said they had become increasingly apathetic.

We spoke with staff who told us there were not enough staff to meet people's needs in a responsive way although they said they did try their best.

The acting manager told us staffing numbers had increased to meet the increased numbers of people who used the service but could not show us how their dependency levels were assessed or detail the specific support required by each person. The number of activity hours had not been assessed to see if they were sufficient to meet people's needs responsively and provide one to one support where required, and specifically for people unable to join in group activities.

We observed poor care practices and poor experiences for people using the service. During the day we saw very little to engage people or keep them stimulated. Activities were provided by one staff member who was not supported by other staff. They did their best to engage people but most people were not asked or included in the activity because they were not supported to be. People's different needs were not accommodated by the homes activity programme and most people were left sat in front of televisions which were on in most of the lounges. Social activities had been planned and these were advertised on notice boards around the home. They included: arts, crafts, singing, baking, and physical leg exercises. However without enough staff to support this programme of activity they did not benefit the majority of people living in the home. Outside organised activity there was little in the way of stimulation for people.

People's individual needs were documented but we could not be assured that people's needs were sufficiently reviewed or adequately met. People needs were assessed before moving to the service to ensure staff knew what their needs were and were confident they could be met. Care plans were then put in place and were informative.

People we spoke with were not aware of their care plan or content. Some relatives told us they had been asked for information about their family members needs but said they had not been asked to contribute to the care plan. However they did say staff kept them up to date with any changes to their family member's needs.

Staff told us they kept care records up to date. However we identified inconsistent practice. Some staff were recording the care provided to people that they had not delivered so we could not be sure it was accurate. Information about people's care needs were recorded in different places in both computerised and manual records which make it difficult for us to determine what care people had received.

We asked the acting manager about their record system and they told us some staff needed support with written documentation and that was why not all staff inputted into the written care record. We said we had found it very difficult to find out if people's needs were being met adequately from the records provided. The acting manager was able to provide us with an update on people's needs but not able to show us where this had been recorded. We asked them if they carried out record audits and they told us they did not. We asked them if they carried out care audits and they said they did but were unable to evidence.

Some risk assessments and care plans had not been updated for several months which meant we could not see how people's needs were monitored. Where a risk had been identified the risk assessment did not always tell us how to manage the risk or take into account other environmental factors we identified. Due to a lack of evaluation and planning we could not see how risks were effectively managed.

Our observations of care were poor and not in line with people's individual needs. We observed task based care which was based on routines dictated by staff and not

Requires Improvement

Is the service responsive?

around people's individual needs. For example we saw the home had a bath rota and the aim was for people to have a bath at least once a week. Staff told us this was not possible but, 'They tried their best.' We spoke with the acting manager about the bath rota and they acknowledged it was not up to date without recognising that care should be driven by people's preferences and not system based on staffing levels. Staff also told us they had 'toileting times,' rather than having a more responsive approach to people's individual needs.

Lunch was task focussed with little social interaction either between residents or residents and staff. There was no audible music planning and other than staff serving food they did not sit with people or encourage them with their meals.

At the previous inspection we identified a breech with Regulation 19 Complaints. At this inspection we identified improvements but were still not confident people's concerns were listened to and responded to appropriately.

Most people spoken with said they had no concerns; another raised concerns but had not raised these with a member of staff.

Relatives told us if they had any worried they would report them to the office but could not tell us who they would specifically refer to. We had concerns raised with us prior to and following the inspection by relatives and were told these were not dealt with effectively by the provider One resulted in us raising a safeguarding concern to the Local Authority to investigate.

All staff said the manager was responsive and listened to their concerns. Staff said they would not hesitate to report concerns.

We spoke with the provider and manager about complaints received and they showed us how they logged complaints and then were able to track through a complaint to show us what actions they had taken. We saw that one complaint had been recorded since last September. However we saw from minutes of senior meetings that other complaints from relatives had been raised and these had not been recorded within the complaints log. This meant that we were not provided with an accurate record of complaints and could not see what actions the provider had taken to address them. We also found that people who used the service had little opportunity to raise concerns or would be unable to without support from staff or others.

Inadequate

Is the service well-led?

Our findings

At the last inspection we identified a number of breaches of regulation including regulation 10 Assessing and monitoring the quality of service provision. The provider wrote to us telling us what actions they would take to become compliant and told us they would be compliant by the end of December 2014, over three months from the date of our last inspection on the 7 September 2014. However during this inspection on the 16 January 2015 we identified continued breaches which meant the required improvements had not been achieved and we did not consider the service well led or safe.

People were not able to comment on the overall effectiveness and quality of the service. Some people said the service was okay; others expressed a wish to go home. Some people told us staff were kind. We did not see that people had the opportunity to comment on the service provided to them. We used our observations to assess if care was effective and if the service was well led. The care we observed was not consistently good and people unable to do things for themselves had to wait and did not always get the care they needed.

In the last few months a new manager had been appointed. The last registered manager left shortly after registration and was not effective in their role; Before this the home was without a registered manager. During this inspection we could see the acting manager was trying very hard and their efforts were recognised by both staff and visitors to the home. One person told us, “The manager is trying hard to change the culture of the home”. A staff member told us, “The new manager is really trying to turn things around, the team work is much better and residents have been out shopping.”

The acting manager said they were well supported by the provider but they were unable to provide us of evidence of how they were supported by the provider through a structured induction programme and agreed priorities for the forthcoming year. They were not clear of the visions and values of the service or how they would engage with staff to communicate those visions and values. Staff did not have the opportunity to contribute to the overall development and improvement of the service.

We found a lack of clear leadership and the culture of care did not focus on the needs of individuals. People had little opportunity to be involved in the service delivery and where surveys had been completed we could not see how these had been acted upon or influenced the care provided. Concerns about care were not acted upon robustly and there was a lack of transparency. There was a lack of clinical governance to monitor the quality and effectiveness of the service which meant poor care practices went unrecognised and the provider failed to provide sufficient direction to their staff about what was expected.

For example we found there was no system in place to regularly review different aspects of the practice in the home which meant the shortfalls we had identified had not already been recognised by the provider. We identified concerns around cleanliness and infection control and the lack of audits to identify these. We identified risks to people’s health and safety particularly around fire safety which had been identified but not addressed by the provider. The fire risk assessments were not up to date and did not show what actions the provider had taken to control the risks. We found accident reporting was unreliable and did not include any analysis or clear details of actions taken. The lack of systems meant the provider was not ensuring the needs of people were met in regards to their health welfare and safety.

We found the acting manager was not proactive in identifying improvements they needed to drive the service forward. We asked the acting manager about how they determined their priorities and they said these were decided on a day to day basis and there was not a system in place to audit different aspects of care.

At the last inspection we raised concerns about the lack of systems to assess if staffing levels were sufficient to meet people’s needs. During this inspection we found staffing levels were inadequate to meet people’s needs. Staff told us staffing levels were insufficient but the provider said they had enough staff. They were not able to show us how they reached to these conclusions or provide evidence of how they determined people’s dependency levels to ensure staffing levels were appropriate.

The provider said they were often at the home and assessed the quality of care but were not able to evidence this or show us what improvements had been made as a result of their observations.

Inadequate

Is the service well-led?

Staff providing personal care did not necessarily write in the persons care record to say what care they had given This was allocated to one member of staff who would write up all the care records. This opened up the margin for error and records were not a reliable source of evidence. Staff recorded in both manual and computerised records and they were not sure of the purpose of each record or which one they should be recording in. There was no analysis of records to make sure they accurately recorded people's needs This made it difficult for us to assess if people's needs were being met. This meant the provider would not be able to do this either with any deal of accuracy.

People's records were poorly evaluated and there was no overarching system to analysis events or factors affecting the well-being and, or safety of people using the service. For example accidents records did not include sufficient detail as to the steps taken by the provider to reduce the risk to the person. We also noted a delay in notifying the relevant agencies to ensure a proper review of the facts and actions taken by the provider could be assessed. We were notified by family members of their experience and where care had fallen below an expected level. BY writing to the provider we established they had failed to notify us or the Local Authority or complete a proper investigation. This meant they were not acting within the law or learning from their mistakes. It also meant we did not have the information we required to help us make a decision about when to inspect the service according to the level of risk.

We found that this service was not well led. The provider did not identify, assess and manage risks relating to health, welfare and safety of service users or the quality of the service. This is a breach of Regulation 10 health and Social Care Act 2008(Regulated Activities) 2010.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **There were not enough staff to meet people's needs in terms of their health and welfare. Regulation 22.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **We found that the service's arrangements for the management of medicines did not protect people. This was a breach of Regulation 13.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People did not get their needs met in respect to their health and welfare. This was a breach of Regulation 9.**

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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The provider did not identify, assess and manage risks relating to health, welfare and safety of service users or the quality of the service.**