New Century Care (Caterham) Limited

Buxton Lodge Care Home

Inspection report

53 Buxton Lane
Caterham CR3 5HL
Tel: 01883 340788
Website: www.newcenturycare.co.uk

Date of inspection visit: 29 July 2015
Date of publication: 16/09/2015

Ratings

Overall rating for this service	Requires improvement
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?	Requires improvement

Overall summary

Buxton Lodge Care Home provides nursing and accommodation for up to 44 people who are elderly and frail, having a specific condition such as a learning disability or are living with dementia. At the time of our inspection 39 people were living in the home.

The inspection took place on 29 July 2015 and was unannounced.

There was a registered manager in post at the time of our inspection. 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 and associated Regulations about how the service is run. The registered manager was present during our inspection.

Staff did not always follow correct and appropriate procedures in relation to medicines to ensure people received their medicines safely. There was little guidance to staff for people who may request 'as required' (PRN) medicines.

There were insufficient numbers of staff to meet the needs of the people living at Buxton Lodge. We observed

Summary of findings

people waiting for long periods in the morning to be assisted to get up. The deployment of staff was not carried out appropriately to meet the needs of the people.

People could be at risk of harm from pressure sores as staff did not ensure they turned or repositioned them as often as they should. Risk assessments for people were not complete and we found two people being barrier nursed for a potentially serious infection, but signage to inform people of this was not clear. Barrier nursing is a procedure used to protect other people from the risks of the infection.

Some staff were behind on their training and we found some qualified staff were unable to demonstrate a good knowledge of medical emergencies.

Staff did not understand their responsibilities in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Best interest decisions were not made in line with legislation.

People were provided with a varied and nutritious diet and they had a choice of meals. However, people did not always know what was available to eat.

Staff did not always treat people with dignity, respect or consideration.

Care plans were not person-centred and not always accurate. Record keeping was not robust and the records were not suitably organised.

Activities took place and staff were working on developing more individualised, meaningful activities. Although the environment in the home was not currently suitable for people living with dementia we were told work was underway to change this.

Complaint procedures were available to people. People and relatives knew who to speak to should they wish to complain. However we heard that complaints were not always responded to the satisfaction of people.

Quality assurance checks were carried out by staff to help ensure the home was a safe place for people to live and people were provided with a good quality of care.

Staff supported people to access health care professionals, such as the GP or occupational therapist.

Staff knew the procedures to follow should they have any concerns about abuse taking place in the home. In the event of an emergency people's care would not be interrupted.

The provider had ensured safe recruitment practices to help them employ staff who were suitable to work in the home.

Relatives were made to feel welcome when they visited and were involved in the running of the home.

During the inspection we found some breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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 safe.

Staff did not follow safe medicines management procedures.

The provider had not ensured there were enough staff on duty to meet the needs of the people.

People may be at risk of harm from pressure sores.

Risks to people were considered but actions were not always completed.

The provider carried out appropriate recruitment checks.

Staff were trained in safeguarding adults and knew how to report any concerns.

Is the service effective?

Requires improvement

The service was not always effective.

Staff did not have a good understanding of the Deprivation of Liberty Safeguards and the Mental Capacity Act. People's movements were being restricted without the proper authorisation.

Some staff were behind on their training and some qualified staff lacked competency.

People were provided with a range of food and drink.

Staff ensured people had access to external healthcare professionals.

Is the service caring?

Requires improvement

The service was not always caring.

People were not always provided with dignity or respect. And staff did not always show people consideration.

People were encouraged to be independent.

Relatives were made to feel welcome in the home.

Is the service responsive?

Requires improvement

The service was not always responsive.

Peoples' care was not assessed based on their clinical needs.

People were given information how to raise their concerns or make a complaint. However, some complaints were not responded to.

People were supported to take part in activities.

Summary of findings

Is the service well-led?

The service was not always well-led.

There was a lack of management oversight at times.

Records for people were not kept in an organised or robust way.

Staff felt supported by the registered manager.

Quality assurance audits were carried out to monitor the quality of the service.

Requires improvement

Buxton Lodge Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 29 July 2015 and was unannounced. The inspection team consisted of three inspectors and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

As part of our inspection we spoke with seven people who lived in the home, six staff, five relatives, the registered manager and two healthcare professionals. We observed staff carrying out their duties, such as assisting people to move around the home and helping people with food and drink.

We reviewed a variety of documents which included eight people's care plans, three people's clinical files and food and fluid charts, five staff files, medicines records and policies and procedures in relation to the running of the home.

In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because we were carrying out this inspection in relation to some concerns we had received about the home.

The home was last inspected in April 2014 when we had no concerns.

Inadequate

Is the service safe?

Our findings

People were not cared for by a sufficient number of staff. The registered manager told us there were normally seven or eight care staff and two nurses on duty in the morning, four or five care staff and one or two nurses in the afternoon and three care staff and one nurse on duty at night. In addition, there was a senior housekeeper, two or three housekeeping staff, a kitchen assistant, two cooks, a maintenance person and an activities co-ordinator. We noticed that at 10.20am eleven people on the first floor of the home were still in bed and later, at 11.00am there were still people waiting to be assisted with personal care. People had had their breakfast, but had gone back to sleep. We asked staff about this and were told by one member of staff, "It's because there aren't enough staff to get people up." One person told us, "I wish they'd hurry up and bring the hoist in to get me up, I want to go to the hairdressers." Relatives told us they had raised the issue of staffing levels at meetings.

Staff weren't always deployed appropriately in the home. For example, at one point six staff were in the lounge for a period of time which meant people being nursed in their rooms were unattended. One person told us they had to wait sometimes to be taken back to their bed after lunch. They said this was because staff were attending to other people and they had to wait their turn. We found one person in their room had not received their lunch by 1.25pm although most people had lunch at 12.30pm. They told us they were hungry. We alerted staff who brought them lunch straightaway. We saw the activities co-ordinator help out with lunches and refreshments during the morning and afternoon. During the morning hairdressing session the co-ordinator was escorting people to the hairdressing room rather than undertaking activities with people.

People were cared for by some staff who worked long hours. We read in the staffing rotas that some staff worked a sixty hour week and others worked five night shifts in a row . We noted the area manager carried out monthly visits and read from the record of the June 2015 visit staff felt the home was busy and thought there was a lot expected of them.

We received a mixed response in relation to staffing levels. Two people told us, "There is always somebody there (if needed)" and, "If I ring my bell staff come quite quickly and there is no difference between day or night." One person said, "There are enough staff, but there are times when they need more." And a relative told us, "There are not enough staff and other relatives say the same. I see staff being overworked." During the relatives meeting relatives raised concerns that sometimes there were not enough staff to assist people with toileting. Sometimes there were lots of staff and on other days less. They were told by the registered manager that staffing levels were consistent but it may because people were being attended to and two care assistants had been introduced as 'lounge monitors'.

Staff told us there were not enough staff at times which they said they felt impacted on the care provided. One member of staff said if there were only seven care staff on duty in the morning it resulted in people being in bed for too long which, "Wasn't right."

The lack of appropriately deployed staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicine administration records (MARs) were not always completed correctly. We saw MAR charts contained a photograph of people and included allergy details. However, we found one chart where the diagnosis and GP details for the person was blank. Another MAR chart had confusing information regarding the person's condition and although they required cream to be applied twice daily it wasn't recorded whether or not this had been done. During the day we saw a nurse holding a medicines pot for one lady who was refusing to take the medication. When we looked at the MAR chart we found it had already been signed by the nurse to say this lady had taken her two tablets. There was information for staff about PRN (as required) medicines. Although it may be for 'pain', staff were not provided with guidance as to behaviours which may indicate if a person was in pain.

People told us they received their medicines on time. We observed a nurse giving medication and saw they were gentle and reassuring with people. We saw the nurse wait for people to swallow the medicine before she left the room.

The lack of robust medicine practices was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

People may not be able to call for assistance. We saw in some people's room that their call bell was out of their reach, or hanging down from the bed. One person told us, "The staff often leave my call bell out of my reach and then I just have to call out."

People may be at risk of pressure sores. We read from people's turning charts that they were not always turned or repositioned as often as they should be. For example, we saw on four people's charts (who should be turned every two hours) that on occasions they were not turned for a period of four hours or more. However, we noted during the night the record showed people were turned on the hour, every two hours.

One person's pressure mattress should have been set at 50, however we found it nearer to 90. The staff member did not initially know where to find the monitor and then told us it must have been knocked when staff made up the bed. We asked staff how they recorded pressure mattress settings and were told it was done on people's weights. However, we found there was no easy and quick way for staff to look to see if a person's pressure mattress was set at the correct level. We found in some care plans evidence (such as photographs) relating to improvement of pressure sores was not recorded. This meant staff may not be able to see if sores were healing or not. For example one person should have had photographs taken monthly but the last one was dated 15 June 2015. The registered manager told us more detailed information may be available in the dressings book, but this was not readily accessible to all staff as it was held in the locked nurses office which had a key coded door. Some staff had told us they did not know the code for the office, although the registered manager advised us this information was being rolled out to staff as they came on shift. Therefore information in the care plans did not always reflect the most up to date information which may be held in the wound documentation.

Although risk assessments were drawn up to help keep people safe we noted there was little guidance to staff on how to manage people's risks. For example, it was recorded in one person's care plan, 'due to her condition x can be at risk' but there was no information about what this person may be at risk of or what actions could be taken to reduce or remove any risks.

The lack of ensuring people had safe care and treatment was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw from information in two people's room that they had a potentially serious infection. Staff had not informed us of this and we saw that notices warning people of this were placed inside people's rooms, rather than on their doors to prevent people going in or to advise them of any action to take before entering. This meant there was a potential of cross-infection.

We recommend the provider make it more evident when people are being barrier nursed.

The provider carried out safe recruitment practices. Staff recruitment records contained the necessary information to help ensure the provider employed staff who were suitable to work at the home. We saw evidence of information being obtained, such as references, health declarations, full employment history's and Disclosure and Barring (DBS) checks. DBS checks identify if prospective staff have a criminal record.

Staff had an understanding of the different types of abuse and described the action they would take if they suspected abuse was taking place. They were able to tell us where to find the policy which would give them guidance on what to do. However not all staff were able to tell us of the role of the local authority in relation to safeguarding. Staff had access to a safeguarding policy which gave details and guidance to staff on what to do if they suspected abuse was taking place.

In the event of an emergency people would be evacuated from the building in a safe way. We read people had individual personal evacuation plans (PEEPs) in their care plans. This gave information to staff on what this person should need in the event of a fire or emergency.

People told us they felt safe. One person said, "Safe? I don't even think about it." Another told us, "I feel safe – no concerns, no worries." A relative said, "My father is perfectly safe and well cared for."

Requires improvement

Is the service effective?

Our findings

Staff did not have a good knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring that any restrictions to people's freedom and liberty have been authorised by the local authority as being required to protect the person from harm. Staff had not carried out proper assessments where restraint was being used. For example, we saw 'blanket' applications submitted for people in respect of receiving 24-hour care in the home, rather than applications for individual decisions around restraint. We found no suitable judgements, best interest decisions or reviews for the use of for example, bedrails.

Consent was not being properly recorded. Do not attempt resuscitation (DNAR) forms were found in some people's care plans and we read decisions had been made by relatives. However, staff had not checked to ensure people's relatives had the legal authority to make decisions on their family member's behalf.

Staff were unable to describe their understanding of MCA and DoLS and one member of staff asked us what DoLS stood for. Another told us it was about activities and planning for all capacities when doing quizzes.

The lack of following legal requirements in relation to consent to care was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always have access to relevant training or have the knowledge expected of them in their role. Some nursing staff were not able to provide us with the correct information in relation to people or what to do in a medical emergency. We asked two nursing staff what they would do if someone was choking or not breathing and only one was able to describe the correct techniques to us. We also asked them to describe the different types of dementia to us and the difference between type one and type two diabetes. Again, we found one did not know this information. One person told us they had induction and training when they started in the role. Another staff member said they had a half day training on dementia when they first started, but had looked up the rest on websites they'd been recommended. The recent area manager visit identified some staff were behind on their safeguarding, infection control and health and safety training.

The lack of supporting workers was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People felt comfortable with staff competency. One person told us, "I know by the way they treat me when handled and moved. I receive good personal care and I can discuss personal issues with them." Another person said, "Staff are trained and know how to deal with my medical condition." A relative commented, "Staff have been trained – they know use a hoist to move mum as her skin tears and this has improved."

We received mixed comments about the food, although everyone was very complimentary about the home made cakes and biscuits. One person told us the food was, "Awful." Other people said it was, "Adequate." People told us that what was written on the menu rarely coincided with what they were offered on the day. A relative told us, "The food is rarely the same as the menu." The chef told people each day what the main meal was and offered them a choice if they did not like this. The chef said they did not always follow the menu as it depended if what she had ordered was delivered in time. For example, they told us they had changed the evening meal to egg on toast as they had a lot of eggs in stock. This was different from what was advertised to people.

People were supported to keep hydrated. We saw drinks being provided and available throughout the day and each person had a water jug available in their room.

People could eat their meals where they wished. We saw the dining room was attractively laid out and people could have an alcoholic drink with their meal if they wished. One table of four people was quite lively with people talking to one another. Only eight people chose to eat in the dining room and the rest ate in the lounge or their own rooms. We saw people being supported in an appropriate manner with staff sitting with them where required. One person instructed the staff member as to what they would like from her plate next and we saw the staff member follow this. Another person was on a pureed diet and we saw their meal was served out on their plate in an appropriate way.

Requires improvement

Is the service effective?

We recommend the provider reviews meal experiences for people to ensure it is clear they have a choice and are provided with the meals they are expecting.

People said they had access to health care professionals when needed. They told us the GP visited every week and that access to the GP was arranged, "As needed." We saw evidence in people's care plans they had involvement from other healthcare professionals such as an optician, hospital or occupational therapist. The healthcare professionals we spoke with said they had involvement in the home and the clinical lead was extremely competent.

Requires improvement

Is the service caring?

Our findings

One person told us staff did not speak to them at all when providing personal care, or, that they "Gesticulate, rather than speak." Another said they were not happy with the night staff. They said they were, "Sharp and sarcastic about keep pressing the buzzer" and their English was poor. They told us they had complained about this but nothing had changed.

Staff were not always considerate. We saw a member of staff go into a persons rooms and take their shower gel in order for another person to have a bath. They did not ask if they could do this. Another person had asked staff to change the bulb in their small table lamp on several occasions over a period of days, but this had not been done. The same person told us when staff came in to the room at night they turned on the big overhead light, rather than a small lamp, which woke them up. We heard televisions left on in people's bedrooms when the room was empty which meant there was an 'echo' from televisions between rooms.

Staff did not always show people respect or dignity. We heard one member of staff tell another loudly, "X needs to be toileted as well." This person asked staff were they were taking them and was told, "To the toilet I think." We saw that staff did not take this person to the toilet, but instead moved them to three different places in the lounge and it was 20 minutes before a member of staff assisted them. On other occasions we saw staff transfer people with a hoist, but did not check their clothing before they lifted them. As a result people's underwear or bare skin could be seen. We saw the majority of people in the lounge had their side tables positioned in front of them. We saw staff put aprons on people eating their lunch in the lounge without seeking their permission. One person was refusing to take their medicines and the nurse was speaking quietly to her, however another member of staff who was assisting someone to eat called across the room, "Why aren't you taking your meds?" The staff member responded, "She isn't all there today."

Staff did not always know people. We asked staff about people and they were able to describe them and tell us why they lived in the home and the type of care they needed. However, one nurse was unable to tell us about the clinical needs of people. They told us, "He is probably behaviour and disablement." Another person they described as, "Has dementia" but they didn't know what type and a further person she told us was, "99% sure it's dementia, I don't remember, she has no other medical needs."

People could not always have privacy. The registered manager told us the home lacked space. This meant when relatives visited they had to sit in the lounge area and if they wanted privacy they only had the option of going to people's rooms.

The lack of dignity and respect was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were encouraged to be independent. One person told us, "We are allowed to do our own thing here. We make our beds and keep our room tidy." Another said, "They know I like to make my bed and to stay in my room." People's rooms were personalised. We saw people had brought in their own furniture, belongings, pictures and ornaments.

Some staff talked to people in a caring way, using their names and helping with drinks or eating. We heard one staff member ask a person if they wished a shower, when the person didn't respond the staff member said, "I'll take that as a 'no', let's get you out of bed then." Another staff member entered someone's room and said, "Morning wakey, wakey, time to get out of bed, here you go darling, here are your glasses." A further member of staff who was providing personal care to one person talked through exactly what they were doing and when the person became anxious they re-assured them. We heard them both have a moment of laughing together. A relative said about their family member, "They (staff) can describe him accurately. I am satisfied with his care and pleased he is in good hands." And another told us, "They (the staff) treat him in a caring and respectful way." People said, "Staff take care of our needs", "Look after me well" and, "Always nice to me."

Some staff spoke with people discreetly. We heard one member of staff whisper in someone's ear when they wished to provide person care. Another member of staff adjusted someone's sitting position in a discreet way to make them more comfortable.

Visitors could visit whenever they wanted. There were no restrictions on relatives or friends visiting and they felt welcome in the home. We saw several visit throughout the day.

Requires improvement

Is the service caring?

One relative told us, “Lovely – really good with Mum” and, “Staff work so hard to keep standards high.” Another said, “The quality of care is good. I see how caring staff members are with my father and with other residents. There is no evidence of irritation from staff. They sit with different residents – chat to them – stroke their hand if looking sad. They take time with residents.” And a further told us, “One or two of the staff have a sense of humour – nice to have a laugh.”

During the afternoon two staff members were wearing white tabards with ‘lounge monitor’ written in large writing. We were told this was as a result of relatives expressing concern there were not staff in the lounge at time.

Requires improvement

Is the service responsive?

Our findings

Responsive care was not always provided by staff. We noted in one person's food and fluid chart on three occasions it appeared this person had not received any food or fluid for over five hours. We looked at the weight charts for people and noted six people had lost three or more kilograms in a six-month period. Seven other people had lost around two kilograms. Although staff had asked the GP to check these people we did not find evidence of any involvement from a dietician or nutritionalist to support people to maintain a healthy weight. One person told us staff made them wait for 30 minutes between their main course and pudding because of guidance from the Speech and Language Therapy team, however when we looked this person's records we could not see any such advice for staff. One person caused sores on their head by scratching and staff told us they tried to keep their nails short, although we found there was no note within this person's care plan about this. However, another person required their legs to be elevated most of the time they were out of bed and we saw this happen.

Staff did not follow guidance from professionals. For example one person had clear guidelines from the occupational therapist (OT) describing exactly how they should be positioned in their bed using pillows. We saw a handwritten sign about their bed stating, 'a pillow should be placed between his legs' and the OT guidelines were not followed on the day of our inspection.

People's care plans were not specific to their medical condition. One person suffered from progressive brain damage but there was no care plan for staff on how to manage this. Another person had mental health needs but there was no care plan or risk assessment relating to this. A further person was diabetic. Although staff were able to describe blood sugar levels and what to look out for, there was no information in the care plan or clinical notes about the care for this person.

Care plans were not personalised and did not contain a plan of care for specific conditions, such as diabetes. Generic statements were written in care plans. For example, 'because of their condition' or, 'due to their illness'. This meant the detail of a person's condition was not considered when writing the care plan.

The lack of personalised person centred care, responsive to people's needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives all felt able to complain. One person said, "I would speak to staff. I don't know the manager." Another told us, "I can always talk to the manager if I had a complaint, she is approachable." However, some people felt their complaints weren't always resolved to their satisfaction. Two people told us they had made complaints to the registered manager, one about the food and another about staff, but were still waiting for a satisfactory response. One relative told us how they had complained about their family member's false teeth going missing. They told us, "This was not taken seriously and nothing was done or happened." Another relative has complained about the lack of regular toileting for their mother and as a result she sat in wet or soiled underwear. The relative felt the attitude of the registered manager was not responsive to her requests or concerns. However a further relative told us they had complained about the urine smell in their family members room. The registered manager had responded by removing the carpet and fitting a wooden floor.

The lack of acting on complaints was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One member of staff told us the activities were really good. They said they were individualised. For example, one person liked gardening and staff enabled them to 'potter' about in the garden. We saw an activity board in the lounge detailing the activities for the week, such as crosswords, crafts, walks, sing-alongs and flower arranging, but noted the activity for the morning was the 'hairdresser' and it was not until later in the afternoon that staff involved people in an activity. Although we were told by people this was unusual for the activity to take place in the afternoon.

We saw about 20 people in the lounge area after lunch. Some were speaking with visitors, others watching the television and others looking at books or a newspaper. Two people had a beer which they had brought through from their lunch. The atmosphere in the room was 'lively' with quite a lot of chatter as there were several relatives visiting. The layout of the lounge was not conducive to people interacting with each other. We saw rows of chairs set out in cinema style which meant people sitting at the back of the room may not be able to see the television. We spoke with

Requires improvement

Is the service responsive?

the registered manager about this who agreed the layout was not suitable. They showed us evidence they had attempted to make changes to the layout, but people weren't happy with it and so they had had to move the furniture back.

People's life histories were not always completed which meant staff may not know of their specific interests or hobbies. The activities co-ordinator told us they had handed these to relatives, but had not received many of them back and this was work in progress. We asked about catering for people's religious and cultural needs and were told there were visits from the Catholic church.

The environment was not particularly appropriate for people living with dementia. We spoke with the registered manager about the patterned carpet, lack of sensory items and signposting for people. We saw the menus were in very small print. The registered manager told us they were aware of this and changes were underway to make the home more, "Dementia friendly."

We recommend the provider reconsiders the types of activities they offer to people and develop way to ensure people are provided with more activities that are meaningful to them.

Requires improvement

Is the service well-led?

Our findings

People's records were not robust. For example, records indicated people did not receive regular baths. The daily notes for people in which staff recorded bathing or topical cream applications were incomplete. One person appeared to have gone nine days without a bath, and a further two people were recorded as not having washed for seven days. These people appeared not to have had creams applied for over two weeks. The registered manager told us this was a recording issue as she was certain staff would have applied the cream as required.

People's care plans were not up to date or complete. Care plans did not always contain any historical information about the individual or their likes and dislikes. We saw people had risk assessments in their care plans, but some were old and had not been reviewed recently. One care plan had records to show a person had some body wounds, but the notes did not record whether these wounds had healed or treatment was still required. We saw one person's dietary care plan was dated 2012 and the notes recorded, 'is able to communicate her needs'. However we found a MCA assessment which stated this person lacked capacity.

We found every person had at least three different places where their information was stored, making it difficult for staff to ensure they kept all paperwork up to date or knew where to look for information. In addition to these records, peoples' weights, pressure mattress settings, dressings and communications were all recorded in a separate folders. One member of staff told us, "The paperwork gets overlooked (because information is held in so many different places) and we are always having to remind staff to complete the paperwork." We spoke with the registered manager who told us the care plan information was held in this way following work with a local clinician as that was how they wished it. The registered manager acknowledged the current record keeping system meant information was held in more than once place which could make if difficult to ensure all records were up to date. She advised us she would reconsider how the records were held to enable them to be maintained more accurately.

The lack of good record keeping was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One relative said, "I think it is well-led by management. I would go to the (registered) manager with any issue. She is approachable and helpful and would want to follow up." Another told us, "Service is well managed. I have seen the (registered) manager and can approach her and explained things and she tries to sort it out." However two others said, "It is not managed well. The (registered) manager is not always here. We are told she goes to other care homes. Never seen her walk round and talk to people. She cannot know what is going on on a daily basis." And, "Well managed? Don't know. Needs more structure. Need to improve levels of structure so someone checking/knowing what has happened. Need better handover at shift change." We observed during the day there were often times the registered manager's door was closed. We spoke with the registered manager about this who explained it was difficult to keep their door open as the stop was broken.

We found there was little direction from the nursing staff and although care staff worked independently, not all of them had access to the locked nurse's room which contained a lot of the information about people. This meant care staff may not know all the information about someone's care. The registered manager told us they were in the process of giving all care staff the key pad number for the nurse's office so they could access all of the paperwork.

We recommend the provider ensures there are suitable management arrangements in the home at all times.

Quality monitoring visits were carried out to assess the service. The latest report showed the area manager had identified some outstanding training and supervisions for staff.

The registered manager undertook in-house audits. For example, fire checks, infection control audits and medicines. Actions from these audits were identified and we read the registered manager had taken steps to remedy the shortfalls. For example, refresher medicines training was to be completed by end August 2015.

People had the opportunity to be involved in the running of the home. There was a relatives and residents meeting during the afternoon of the inspection. We saw three relatives attended. The registered manager told us people had been told about it, but had chosen not to attend.

Staff told us they felt supported by the registered manager and involved in the home. Staff told us there was also a

Requires improvement

Is the service well-led?

clinical lead who undertook their supervisions and that she was very approachable. We heard that the registered manager took everything on board and would always listen to staff ideas. Staff felt there was a good team and everyone pulled together to help each other.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered provider had not ensured appropriately deployed staff.** **The registered provider had not ensured staff received appropriate support and training.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered provider had not ensured the proper and safe management of medicines.** **The registered provider had not ensured safe care and treatment.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered provider had not ensured legal requirements were followed in relation to consent to care.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered provider had not ensured people were always treated with dignity and respect.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **The registered provider had not ensured staff always acted on complaints.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered provider had not ensured that care and treatment was provided to ensure people's needs were met.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered provider had not ensured good quality records were kept.**