

Pinerace Limited

Collamere Nursing Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 16 August 2016. The last focused inspection took place on 15 January 2016. This was carried out to see if the service had made the required improvements identified at the comprehensive inspection 21 October 2015. At the last inspection we found there was a lack of meaningful activities in line with people's interests and preferences. We told the provider to take action to meet the legal requirements.

This inspection was carried out to check on any action taken by the provider. The provider for this location is registered under the legal entity of Pinerace Limited. Pinerace Limited is part of the Morleigh group of nursing and residential care homes.

Collamere is a care home which provides nursing care and support for up to 46 predominantly older people. At the time of the inspection there were 27 people living at the service. Some of these people were living with dementia.

The service is required to have a registered manager in post. At the time of our inspection there was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A manager had been working in the service since April 2016. An application for the post of registered manager had not been submitted to the commission.

We looked at how medicines were managed and administered. We found it was not always possible to establish if people had received their medicines as prescribed. There were gaps in the medicine administration records (MAR). Handwritten entries on the MAR had not been signed by two people to help ensure the risk of errors was reduced. Prescribed creams were not always recorded when applied. Creams were not dated when opened. This meant staff were not clear on when the item might no longer be safe to use. The medicines refrigerator stored prescribed medicines that required cold storage. However, the refrigerator temperature was not recorded daily. This meant that any fault or increase in the temperature within the refrigerator would not be noticed in a timely manner and the safe storage of medicines inside could not be assured. Regular medicines audits were not consistently identifying when errors occurred.

Records were not always completed by care staff when care and support had been carried out. There were gaps in the daily care and nursing records. Care plans contained a great deal of information. Not all care plans had been updated to take account of any changes that had taken place. This made it difficult for staff to find the current accurate plan of care for each person. This meant that appropriate care was not always carried out by staff, such as regular weights being taken and observations carried out.

People's personal information and care plans were held in the nurses office. The door to this room was found open regularly throughout the day of our inspection with no one present in the room. This meant

people's care records were not held securely. Care planning was reviewed and people's changing needs recorded, although not always in a timely manner. Where appropriate, relatives were included in the reviews.

Some people had been assessed as requiring pressure relieving mattresses when cared for in bed. These mattresses were not regularly checked to ensure they were correctly set for each person. People were regularly re-positioned by staff and this was mostly recorded.

Staff were supported by a system of induction training, although this was not always recorded. The Care Certificate was not being used by the service to support the induction of care staff new to the role. Care staff supervision had increased since the new manager had been in post. Staff told us they did not have this support regularly. The nurses reported not having been provided with supervision recently. The manager did not have a system or process in place to monitor when each staff member was due to have supervision. Appraisals were not taking place at the time of this inspection.

Staff knew how to recognise and report the signs of abuse. However, not all staff had received annual updates in safeguarding adults training. Staff training had not been updated in line with the guidance stated on the service's training matrix, with many subjects requiring updating. Staff had not had annual fire training. Nurses training did not appear on the training matrix. The kitchen porter prepared food each day for people. However, they had not completed training in safe food management. This meant that staff were not always provided with appropriate training and updates to enable them to safely carry out their roles.

Staff meetings were held. These allowed staff to air any concerns or suggestions they had regarding the running of the service. However, staff told us they had raised issues at meetings and at supervision which they felt had not always been addressed.

The manager used a dependency assessment tool to identify the minimum number of staff required to meet people's needs. However, people and staff told us that there were not enough staff. Comments included, "Staff are always running for the bells" and "People are getting upset and are not getting the standard of care they should." The service had staff vacancies and was actively recruiting at the time of this inspection. Bank and agency staff were being used to cover shifts. However, the service was one carer short on the day of this inspection and the bank carer did not arrive to cover this shift. Some people reported having to wait for care and support to be provided. All staff told us they were rushed, stressed and did not feel they were able to carry out their role to the best of their ability. Staff told us they did not have time to spend time with people and provide activities. Activities did not take place each day, were not planned and did not reflect people's choices and preferences.

Staff reported that there were concerns about the laundry service at Collamere. Comments included, "People have run out of clean clothes and needed to wear our gowns" and "The bed linen is often not ironed, and people's clothes are just bundled into drawers, even dresses. It just looks so poor and doesn't show any respect."

There was a planned menu which showed two choices were offered to people at mealtimes. On the day of this inspection each person in the dining room, and several people in their rooms were all having the same meal. People's comments included, "The meat in the sandwiches is so thin you can see through it" and "I don't like the food here, although the deserts are not bad." Staff comments included, "We are limited on food, we cant always provide a choice for people" and "The food here is terrible, very poor quality, I see it every day." Staff told us the service had run out of milk, tea and juice on a few occasions in the last month with staff needing to go out to the shop to buy items. The kitchen staff were aware of people's dietary

requirements and preferences. Two people had specific foods prepared for them on the day of this inspection, one person had sausages and another had an egg. Some people required nutritional supplements to their diet. Staff did not always record when these prescribed items had been provided.

Accidents and incidents that occurred at the service were mostly reported by staff and recorded in people's care files. However, the manager did not audit such events to help ensure the risk of reoccurrence was reduced.

The manager and staff were aware of their legal responsibilities under the Mental Capacity Act 2005 and told us how they ensured people's rights were protected. However, consent to care and photographs had in some instances been signed by the manager of the service and not the person or their legal representative. Applications had been made appropriately to the local authority for authorisation of potentially restrictive care plans. One authorisation had been granted. The manager was asked to ensure that the Care Quality Commission were notified of this authorisation as they are legally required to do.

Collamere provided accommodation on the ground floor only of the building. The upper floor was in the process of being refurbished and was not in use at the time of this inspection. The lift to the upper floor was not in working order. Fire escape doors led from main corridors and communal areas such as the dining room. The dining room fire doors were locked. No key was present in the immediate vicinity. One exit door opened with a simple turn knob to the outside. This door was not alarmed. Another exit door had an alarm which sounded when the door was approached. The alarm sounded as we approached the door, there was no response from staff. We were told by the manager that this door was used regularly by staff to take out rubbish and the alarm went off all the time, so staff no longer responded to the alarm. A further fire exit door was unlocked with the key hanging nearby but no alarm sounded when it was opened. There were people living at the service who were living with dementia and independently mobile. This meant there was a potential risk that people could leave the service through these exits without staff noticing.

In the entrance hall of the service there were family and staff questionnaires available for people to fill in. Families told us they had completed these forms in the past. We asked the manager about any recent quality assurance survey responses. We were told there was no information available regarding the views of people and their families about the service. No residents meetings had taken place. This meant that the service was not effectively seeking people's views and experiences of the service provided or taking any action that may be needed to improve the service.

Regular audits were being carried out by the manager and deputy manager on care plans, medicines and pressure mattresses. However, the concerns found at this inspection had not been identified through these audits. This meant the audit process was not being effective.

We walked around the service which was comfortable and personalised to reflect people's individual tastes. People were treated with kindness, compassion and respect. People reported the staff were caring.

The new manager was supported by a deputy manager, nurses and senior care staff. The manager was also supported through supervision with the Head of Operations and regular meetings took place with the managers of the other services in the Morleigh group. People, families and staff all reported things had improved since the new manager had joined the service. Comments included, "They (the manager and deputy) are very approachable and supportive" and "It is work in progress. Things have improved although there are still things to be addressed."

We found breaches of the Health and Social Care Regulations 2008 (Regulated Activities) 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not entirely safe. Medicines were not always managed safely

People and staff told us there were not sufficient numbers of staff to meet the needs of people who used the service.

Care plans recorded risks that had been identified in relation to people's care.

Requires Improvement ●

Is the service effective?

The service was not entirely effective. Staff were not provided with regular training updates and supervision. No appraisals were provided.

People were not always provided with a choice of meals, and people told us that the quality of food was not always good.

The management had a clear understanding of the Mental Capacity Act 2005 and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected.

Requires Improvement ●

Is the service caring?

The service was caring. People who used the service and relatives were positive about the way staff treated the people they supported.

Staff were kind and compassionate and treated people with dignity and respect.

Staff respected people's wishes and provided care and support in line with those wishes.

Good ●

Is the service responsive?

The service was not entirely responsive. Records were not always completed when care and support had been provided.

There was some increase in activities since the last inspection.

Requires Improvement ●

However, meaningful activities were not planned or provided on a regular basis.

People knew how to make a complaint and were confident if they raised any concerns these would be listened to. People were consulted and involved in the running of the service, their views were sought and acted upon.

Is the service well-led?

The service was not well-led. There was no registered manager in post and no application had been made. However, there was a manager who had commenced working at the service in April 2016.

People's care plans were not stored securely.

There were no effective quality assurance systems in place to make sure that any areas for improvement were identified and addressed. Some audits were not effective in identifying concerns found at this inspection.

Requires Improvement 

Collamere Nursing 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.

The inspection took place on 16 August 2016. The inspection was carried out by two adult social care inspectors.

Before the inspection we reviewed the information we held about the service. This included past reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with six people who lived at the service. Not everyone we met who was living at Collamere was able to give us their verbal views of the care and support they received due to their health needs. We looked around the premises and observed care practices.

We looked at care documentation for five people living at Collamere, medicines records for 27 people, three staff files, training records and other records relating to the management of the service. We spoke with seven staff and one visitor during the inspection. We spoke with one family following the inspection.

Is the service safe?

Our findings

We checked the medicine administration records (MAR) and it was not always clear that people received their medicines as prescribed. There were gaps in the MAR. We saw staff had handwritten 34 items of medicines for different people, on to the MAR following advice from medical staff. These handwritten entries were not always signed and had not been witnessed by a second member of staff. This meant that there was a risk of potential errors and did not ensure that people would always received their medicines safely. Some people had been prescribed creams and these had not been dated upon opening. This meant staff were not aware of the expiration of the item when the cream would no longer be safe to use. Staff did not always record when they had applied prescribed creams.

The service was storing medicines that required cold storage. There was a medicine refrigerator at the service. There were no recent records that showed medicine refrigerator temperatures were monitored daily. There were months of gaps in these recordings. As a result any fault leading to a possible temperature rise in the medicine refrigerator would not be identified in a timely manner. This meant it was not possible to be assured that medicines that required cold storage were stored safely. Regular medicines audits were not consistently identifying when errors occurred.

Staff training records did not show the training that had been completed by nursing staff. This meant it was not possible to establish if nurses, who supported people with their medicines, had received recent updates of medicine administration training.

During our tour of the service we found fire exit doors that were not alarmed and could be opened easily. One fire exit door had a simple turn knob and opened out on to an uneven grassed area leading up to a steep drop on to concrete with no barrier around it. Another fire exit door was unlocked with a nearby key and opened without any alarm sounding, to access the car park. A third fire exit door did have an alarm which sounded as people approached the door. We activated this alarm. No staff responded. The manager told us that this door was regularly used by staff to take out the rubbish so the alarm was regularly activated and staff no longer responded. Staff told us the dining room emergency exit was locked and there was no key available to them. We did not see a key to this door nearby. There were people living at the service who were living with dementia and were independently mobile. Some of these people's care records stated, "Disorientated to time and place, risk of leaving" and "Mobile and very confused." This meant there was a potential risk that people could easily leave the service without anyone noticing. The provider had been advised by the manager of the alarms not operating prior to this inspection. The provider assured the manager someone would come to the service to repair the alarms on the day of our inspection. This did not take place.

Each person had information held at the service which identified the action to be taken for each person in the event of an emergency evacuation of the service. However, some of this information was not accurate as different people had moved in to rooms or left the service.

Accidents and incidents that took place in the service were recorded by staff in people's records. There were

forty individuals accident and incident reports from November 2015 to August 2016 that were all held together in one book which was held openly in the nurses office. Care plans were held in the nurses office which was open throughout this inspection visit. These practices are contrary to the guidance in the Data Protection Act 1998 which provides guidance on the management and processing of sensitive personal information. Accidents and incidents were not audited by the manager. This meant that any patterns or trends would not be recognised, addressed and the risk of re-occurrence was not reduced.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

An audit trail was kept of medicines received into the service and those returned to the pharmacy for destruction. The service was holding medicines that required stricter controls. We checked the stock of these medicines held against the records and they tallied. There had been regular audits of these medicines to help ensure they were managed in accordance with the legal requirements.

People living at Collamere told us they often had to wait for staff to respond to their calls for assistance. During the inspection visit we heard bells ringing regularly. Staff were seen to be rushing to respond to people's calls for assistance. The service used a dependency assessment to plan for sufficient numbers of staff to meet people's needs. The staff rota showed there had been six care staff scheduled to work in the morning and four in the afternoon supported by a nurse. All the staff we spoke with commented on the shortages of not just care and nursing staff, but laundry, cleaning and catering staff. Staff told us there was an occasion when a person living at the service needed to use a gown belonging to the service as they had run out of their own clothes to wear. Staff also told us, "The bed linen is often not ironed, and people's clothes are just bundled into drawers, even dresses. It just looks so poor and doesn't show any respect." On the day of this inspection a bank staff worker did not arrive and this meant there were a reduced number of care staff on duty. The manager and the deputy manager regularly provided care and support to people during the day to support the care staff team. The manager told us they had just worked two 12 hour nursing shifts at the service prior to this inspection. The manager told us they were very tired. Staff comments included, "Staff are always running for the bells," "People are getting upset and are not getting the standard of care they should," and "Its difficult when staff are off sick we are often short staffed, we can only do the essentials nothing else." Staff mostly worked 12 hour shifts and told us that when they were short staffed for a long shift it made a real impact on them. Records of supervision showed where staff had raised staffing levels as a concern. Staff told us they felt under pressure and were concerned at the shortage of staff. The service was recruiting care staff and nursing staff. Staff told us, "I love working here but the staffing could be better," "Staffing is the main issue" and we "Don't always have the right equipment that works."

This contributed to the breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014

People and their families told us they felt it was safe at Collamere. Comments included, "It feels safe here" and "I think it is fine."

Staff were confident of the action to take within the service, if they had any concerns or suspected abuse was taking place. They were aware of the whistleblowing and safeguarding policies and procedures. However, many staff had not received recent training updates on safeguarding adults and were not aware that the local authority were the lead organisation for investigating safeguarding concerns in the County.

The service held personal money for people who lived at the service. People were able to easily access this money to use for hairdressing, toiletries and items they may have wished to purchase. These personal monies were managed by the manager. We checked the money held for two people against the records kept

at the service and both tallied.

The environment was clean and hand washing facilities were available throughout the building. Personal protective equipment (PPE) such as aprons and gloves were available for staff and were used appropriately. All cleaning materials were stored securely when not in use.

Care plans contained risk assessments for a range of circumstances including moving and handling, supporting people when they became anxious or distressed and the likelihood of falls. Where a risk had been clearly identified there was guidance for staff on how to support people appropriately in order to minimise risk and keep people safe whilst maintaining as much independence as possible. For example, how many staff should support a person to move them safely. Some people were at risk of becoming distressed or confused which could lead to behaviour which might challenge staff and cause anxiety to other residents. Care records contained information for staff on how to avoid this occurring and what to do when incidents occurred. For example, one care plan guided staff to, "Reassure if (person's name) shows signs of distress when talking to you. Be patient and re orientate them." Risk assessments were mostly reviewed and updated to take account of any changes that may have taken place.

Fire safety drills had been regularly completed and all firefighting equipment had been regularly serviced. However, not all staff had received annual fire training.

Recruitment systems were robust and new employees underwent the relevant pre-employment checks before starting work. This included Disclosure and Barring System (DBS) checks and the provision of two references.

Is the service effective?

Our findings

Staff demonstrated a good knowledge of people's needs and told us how they cared for each individual to ensure they received effective care and support. Staff told us they were provided with some training. The manager held a training schedule which showed each member of the care and ancillary staff and the mandatory training they had completed. The schedule stated that many subjects should be updated annually. Such annual updates had not always taken place and a good deal of the staff training was out of date. Nurses training did not appear on the training schedule. Some staff did not have the necessary training in order to carry out their role safely. For example, the kitchen porter prepared food each day for people. However, they had not completed training in safe food management and told us, "I have 'Never done this work before.'"

Staff supervision had not taken place regularly prior to the new manager joining the service. Some care staff reported that supervision had improved recently. However, the nurses told us they had not had regular supervision. Staff files did not always contain records of supervision. For example, one staff member who had worked at the service for over a year did not have any record of supervision in their files. The manager did not have an overview of staff supervision that informed them who had had supervision and when they needed the next session booked. Appraisals were not taking place.

This contributed to the breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Newly employed staff were required to complete an induction before starting work. This included training identified as necessary for the service and familiarisation with the service and the organisation's policies and procedures. The induction for new staff was not always recorded in their files. This meant there was no evidence that they had completed the induction and had been deemed to be competent to carry out the role. The induction did not incorporate the Care Certificate which replaced the Common Induction Standards in April 2015. It is designed to help ensure care staff that are new to working in care have initial training that gives them an adequate understanding of good working practice within the care sector.

This contributed to the breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014

The service held a menu plan which showed two options for each meal. We asked people if they were aware of what was for lunch as there were no menus on the table to prompt people. People could not always recall if they had been offered a choice of meal or not. We observed the lunch time period in one of the dining rooms. All the people eating in the dining room had the same meal. We checked six further people's lunch and they also had the same meal. People's comments included, "I don't like the meals I just have sandwiches, but the meat in the sandwiches is so thin you can see through it" and "I don't like the food here, although the deserts are not bad." Staff comments included, "We are limited on food, we cant always provide a choice for people" and "The food here is terrible, very poor quality, I see it every day." Staff told us the service did not always have the appropriate food to provide the planned meals and had run out of milk,

tea and juice on a few occasions in the last month with staff needing to go out to the shop to buy items. The kitchen staff were aware of people's dietary requirements and preferences. Two people had specific foods prepared for them on the day of this inspection, one person had sausages and another had an egg. Some people required nutritional supplements to their diet. Information in care plans indicated when each person should have prescribed supplements. However, staff did not always record when these prescribed items had been provided. We were told that the cakes, freshly baked each day for people to enjoy with their tea, were sometimes, 'inedible and not always cooked through.' We saw records that showed that on occasions, "The food prepared for supper has not been fit for consumption," and "Cakes raw in the middle."

Some people required their meals pureed. Staff told us that the pureed meals were often the same in the evening as the lunch meal and people were not offered a choice.

Care plans directed staff to weigh people regularly where there had been concerns about a person's food intake. One care plan dated 6 January 2016 stated, "Has lost some weight and needs to be weighed weekly". The person had lost 2.3 Kgs between March and May 2016. Nutritional supplements had been prescribed for this person in February 2016 to be given twice a day. It was not clear from the records when the supplements were given to the person. The last weight for this person was May 2016 following this the care plan stated, "Not been well." The weekly weight record sheet held the names of several people living at the service but no weight measurements for them had been recorded on it. There was a monthly weight sheet with several people's names on it. This sheet had many gaps on it where people had not had their weight recorded. The monitoring of the weight of people that were at risk of weight loss was not being carried out adequately.

Care plans indicated when people needed additional support to maintain an adequate diet. Staff were seen supporting people with their meals as needed. Food and fluid charts were kept when this had been deemed necessary for people's well-being. However, the food and drink charts did not state how much was enough for each person each day. Such charts were not totalled each 24 hours to show how much food and drink the person had received during that day. There was no evidence of the records having been regularly monitored to ensure people were having an adequate intake of food and drink.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The kitchen staff held information about each person living at the service, including their dietary needs, where they chose to eat their meals and what assistance was required from staff for them to eat their meals.

People living at the service were not always able to communicate their views and experiences to us due to their healthcare needs. We observed care provision in order to help us understand the experiences of people who used the service.

The premises were mostly in good order. Some bedrooms had been refurbished. A large lounge, currently used as storage for equipment, was in the process of being redecorated. There was an additional lounge area for people to use. Bathrooms and toilets were clearly marked with pictures and bedroom doors had nameplates with people's name on. Such signage supported people who required prompting with knowing their immediate surroundings and how to find places such as the bathrooms. People were able to decorate their rooms to their taste, and were encouraged to bring in their personal possessions to give their rooms a familiar feel.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The service had considered people's ability to make decisions for themselves and referred them for appropriate assessment by healthcare professionals. There was evidence of consent, to care being provided and photographs displayed, having been sought from people where appropriate. However, we saw many of these documents had been signed by the previous manager rather than the person themselves.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Authorisations had been applied for and one had been granted. The service was supporting the conditions attached to the authorisation. The manager was aware of changes to the DoLS legislation and the service held an appropriate policy.

People had access to healthcare professionals including GP's, opticians, tissue viability nurses and chiropodists. Care records contained records of any multi-disciplinary notes.

Is the service caring?

Our findings

Not everyone at Collamere were able to tell us about their experiences of living at the service due to their healthcare needs. Relatives of people living at the service told us they felt they were involved in the care of their family member.

People told us, "Staff are very caring and understand what I can do and where I need help" and "Love the staff they are very kind to me." One person specifically referred to one member of staff saying, "He is a lovely lad, very competent in what he does, he knows how to care for me."

During the day of the inspection we spent time in the communal area of the service. Throughout the inspection people were comfortable in their surroundings with no signs of agitation or stress. Staff were kind, respectful and spoke with people considerately. Relationships between people and staff were relaxed and friendly.

Bedrooms were decorated and furnished to reflect people's personal tastes. The service encouraged people to have things around them which were reminiscent of their past.

People's dignity was respected. For example moving and handling equipment such as slings were not shared and were named for individuals use only. Privacy was respected by care staff who ensured doors and curtains were closed during personal care visits.

People's life histories were documented in their care plans. This is important as it helps care staff gain an understanding of what has made the person who they are today. Staff were able to tell us about people's backgrounds and past lives. They spoke about people respectfully and fondly. Staff told us they knew the people who lived at the service well including their preferences and dislikes.

Visitors told us they visited regularly at different times and were always greeted by staff who were able to speak knowledgeably with them about their family member. People were well cared for.

No residents or families meetings had been held to gain their views and experiences of the service. However, families could meet with the manager on an individual basis to discuss any matters they wished to raise. Relatives told us they knew about their family members care plans and the manager would invite them to attend any care plan review meeting if they wished.

During the inspection staff were seen providing care and support in a calm, caring and relaxed manner. We saw people moving freely around the service spending time where they chose to. Staff were available to support people to move to different areas of the service as they wished.

Is the service responsive?

Our findings

Care plans contained a large amount of information. They were detailed and informative with guidance for staff on how to support people well. There was information on a range of aspects of people's support needs including mobility, communication, nutrition and hydration and health. The information was not easy for staff to find as although there was an index, information was not always held in the correct section. The care plans had been reviewed but not always monthly as directed by the Morleigh group operations manager in the managers meeting of May 2016. Care plans were not always updated when people's needs changed to help ensure they were accurate and up to date. For example, one person's care file stated staff were to use a turnsafe piece of equipment, with two staff to support the transfer from bed to chair. This meant the person was able to stand. Staff told us they had been using a hoist and sling for the past four weeks to move the person safely due to a deterioration in the person's health. This care plan had last been reviewed in June 2016.

One person's care plan stated they had an 'allow natural death order' (ANDO) in place since May 2015. This means they would not be resuscitated if they became seriously unwell. Further on in the same file it stated the person, "Would like to be resuscitated." Another care plan for a different person stated, "Pressure mat in place," but this mat was not in use at the time of this inspection visit. On visiting one person's room we saw staff had been keeping, 'Line of sight' records. This meant that staff were ensuring each hour that they knew what this person was doing and where they were in the service. There was no mention of this monitoring in their care plan. This meant that the care plans were not always directing staff appropriately.

Daily notes completed by care and nursing staff were not consistently completed. There were gaps of up to five days seen in some care staff and nursing staff records. This meant it was not possible to establish what care and support had been provided for people. This was a concern that had been previously highlighted by the Quality Assurance and Service Improvement team at Cornwall Council and was an outstanding item on their action plan.

Some people required to be re-positioned regularly when cared for in bed. Staff recorded when they provided this care. On the day of inspection we visited one person at 11.20 am in their room. The person was cared for in bed and did not have any care recorded in their file since 12.20 am earlier that morning. We asked the care staff if they had provided any care for this person, they said they had 'not been able to get to her yet.' We asked the manager about this person's care. We found this person had been provided with care by the night staff that morning but it had not been recorded. Staff told us they did not have sufficient time during their shifts to write up all the records.

Care plans were stored in the nurses office. The door to this room was open when we arrived in the morning of the inspection visit. There was a sign on the door stating that the door was to be kept closed when staff were not present. We closed the door on two occasions throughout the inspection visit and on each occasion we found it open again later and not occupied. Staff confirmed that the nurses office was, "Always open." This meant people's confidential information and care plans were not held securely. The service did not follow the guidance set out in the Data Protection Act 1998.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Some people had been assessed as requiring pressure relieving mattresses when cared for in bed. We checked the settings for four of these mattresses. One mattress was set for a person weighing 150kgs and a red alarm light was showing. There was no weight recorded in this person's care file for staff to use as a guide to set the mattress correctly. Another mattress was set at 3 ½, the nurse told us this represented approximately 30 – 40 kgs of a person's weight. The person using this mattress weighed 52.5 kgs. A third mattress was set for a person who weighed 90 – 115 kgs. This person's last recorded weight in June 2016 was 42.9 kgs. These mattresses were not regularly checked to ensure they were correctly set for each person. There was no information in people's care files for staff regarding the appropriate setting for each person's mattress. Regular audits were carried out on these mattresses. The member of staff who carried out these audits told us they checked the mattress was turned on and working, they did not check the pressure was correct. This meant people were not always protected from the risks associated with pressure damage to their skin.

Families were concerned that there was not enough for people to do during the day. We had concerns about this issue at our previous two inspections. People did not have access to a range of activities within the service or outside. An activities co-ordinator was not employed at the time of this inspection. We were told the service was recruiting such a person and interviews were taking place in the near future. Care staff tried to provide activities when they had time. This had been difficult in the recent past due to staff shortages. There was no planned programme of meaningful activities. Since the new manager had arrived at the service there had been some improvement in the amount of activities which took place. For example, the courtyard had been improved with planting and people were able to access this secured area as they chose independently. People had been involved in the planting of this area. Staff reported playing some games with people occasionally. A tea party was planned along with a Garden Party in the coming weeks. Records showed some people had been to the hairdresser, sat in the lounge or watched TV, this had been recorded as an activity. The manager told us this was, 'Work in progress.' One staff member commented, "If we have time we usually try and play some group games or do manicures. There aren't really any entertainers."

Some people chose not to take part in organised activities and therefore were at risk of becoming isolated. During the inspection we saw some people either chose to remain in their rooms or were confined to bed because of their health needs. Staff checked on people regularly however there were no records of them having been engaged in any activities. One care file stated, "Ensure librarian delivers large print." We checked this person's books, they were not in large print. We remained concerned at the lack of meaningful activity provided for people.

This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014

People and their families comments included, "Staff are lovely, things have improved recently since the new manager has arrived although there are still things to be done" and "They (staff) don't do enough with people to stimulate them, they get left to their own devices a lot which leads to a lot of sleeping."

People who wished to move into the service had their needs assessed to ensure the service was able to meet their needs and expectations. The manager was knowledgeable about people's needs.

People were supported to maintain relationships with family and friends. Visitors were always made welcome and were able to visit at any time. Staff and management were seen talking with visitors and discussing both their social care and support requirements

People received care and support to meet their basic needs because staff had a good knowledge of the people who lived at the home. Staff were able to tell us information about people's backgrounds and life history from information gathered from families and friends.

There was a staff handover meeting at each shift change. During this meeting staff shared information about changes to people's individual needs, any information provided by professionals and details of how people had chosen to spend their day. This sharing of information helped ensure there was a consistent approach between different staff and that people's needs were met in an agreed way each time care was given. Nurses shared information regarding the management of people's wounds and their dressing requirements.

People and families were provided with information on how to raise any concerns they might have. Details of the complaints procedure were contained in the pack provided upon admission to the service. Where concerns had been raised with the manager they had been responded to appropriately.

Is the service well-led?

Our findings

The service is required to have a registered manager in post. At the time of our inspection there was not a registered manager in post. No application for this post had been received by the Care Quality Commission. A new manager had been in post since April 2016.

Staff told us they could approach the manager or deputy manager for support. Comments included, "They (the manager and deputy) are very approachable and supportive" and "It is work in progress. Things have improved although there are still things to be addressed." Staff meetings took place. These were an opportunity to keep staff informed of any operational changes and for staff to voice their opinions or concerns. However, staff did not feel that issues that they raised at meetings and at supervision had been addressed. For example, staffing level issues and concerns about the quality of the food.

Audits were carried out over a range of areas, for example, care plans and medicines management. The premises were checked weekly by the deputy manager for any issues that needed addressing. However, these audits had not been effective in identifying and addressing the concerns found at this inspection. For example, gaps in care records and handwritten entries on to medicine records which had not been signed by two staff.

The service had a resident maintenance person until July 2016. Up until then checks were regularly carried out and recorded of the emergency lighting, fire doors and staff drills. There was no record of these weekly tasks being done since July 2016. The maintenance of the service was the responsibility of the maintenance team that worked within the Morleigh group of homes. The manager told us the unalarmed fire exit doors had been reported some time before this inspection but this had not been addressed.

Equipment such as moving and handling aids were serviced to ensure they were safe to use. We were sent the records relating to these service visits. A stand-aid had been serviced in June 2016 requiring a part. Staff told us at this inspection that the stand-aid did not work correctly and they had to insert a writing pen into the equipment to make it work. One bath hoist and the passenger lift were out of order. The upper floor of the service was not being used at the time of this inspection. There were other bathrooms available for people to use on the ground floor.

There were no processes in place to monitor the quality of the service provided. Residents and families meetings were not held. In the entrance hall of the service there were family and staff questionnaires available for people to fill in. Families told us they had completed these forms in the past. We asked the manager about any recent quality assurance surveys. We were told there was no information available regarding the views of people and their families about the service. No residents meetings had taken place. This meant that the service was not effectively seeking people's views and experiences of the service provided and taking any action that may be needed to improve the service.

People's personal confidential information was not always held securely. Nurses and care staff records contained gaps. This meant it was not possible to always ensure people's care needs had been met.

The manager and the deputy manager had difficulty in finding some of the information requested by inspectors. The service had recently had a change of IT provider. The manager told us they were unable to produce some information to the inspectors as it had been 'lost' when the IT systems were changed recently. Information regarding the maintenance and servicing of equipment was held at head office and was forwarded to us following the inspection.

This contributed to the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People, relatives and staff told us the new manager was approachable and friendly. Comments included, "Things are improving," "They (management) work on the floor with us but it shouldn't be like that" and "The manager is very good, but there is a lot to do still. I wish the staff would wear name badges, it is so difficult to know who everyone is and their names."

There were clear lines of accountability and responsibility both within the service and at provider level. The manager had been supported by a deputy manager since June 2016. Both the manager and the deputy manager regularly worked alongside nurses and care staff providing care to people. This meant they were aware of the culture of the service at all times.

The manager was supported through supervision with the Head of operations and regular meetings took place with the managers of the other services in the Morleigh group.

The boiler, electrics, gas appliances and water supply had been tested to ensure they were safe to use. Such records were held centrally and were not always available at the service. Fire alarms and evacuation procedures were checked by staff, the fire authority and external contractors, to ensure they worked. There was a record of regular fire drills although these had not been recorded recently.

The service's policies and procedures had all been recently reviewed and updated to help ensure staff were provided with accurate and current guidance.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People's care and treatment was not designed to meet their needs and preferences in relation to their social and emotional needs. Regulation 9 (1) & (3) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Care and treatment must be provided in a safe way for service users including the proper and safe management of medicines and assessing the risks to the health and safety of service users of receiving the care or treatment. Staff should be appropriately supervised during induction and assessed as competent. 12 (1) (2) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	A variety of nutritious, appetising food should be available to meet people's needs. Nutritional and hydration intake should be monitored and recorded to prevent unnecessary dehydration, weight loss or weight gain. Systems must be in place to make sure that people using the service receive their prescribed dietary supplements at specified times. 14 (4)(a)(b)

Regulated activity	Regulation
<p>Accommodation for persons who require nursing or personal care</p> <p>Treatment of disease, disorder or injury</p>	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Effective systems and processes must be operated to make sure they assess and monitor the service to enable to the provider to identify where quality and/or safety are being compromised. Providers should seek the views of people who use the service, their families and visiting professionals. Records relating to the care and treatment of each person using the service must be complete, accurate, contemporaneous and held securely.</p> <p>17 (2) (c) (d)</p>
Regulated activity	Regulation
<p>Accommodation for persons who require nursing or personal care</p> <p>Treatment of disease, disorder or injury</p>	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>There must be sufficient numbers of suitably qualified and competent staff deployed to meet people's needs. Staff should receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out their duties. 18 (1) (2)(a)</p>