Care Quality Commission

Bupa Care Homes (CFHCare) Limited

Crawfords Walk Nursing Home

Inspection report

Lightfoot Street
Hoole
Chester
CH2 3AD
Tel: 01244 318567
Website: www.bupa.co.uk

Date of inspection visit: 21 and 22 September 2015
Date of publication: 23/11/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
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

This inspection was carried out on 21 and 22 September 2015 and the first visit was unannounced.

Crawford's Walk nursing home comprises of four purpose-built units in the Hoole area of Chester. The service is owned and operated by BUPA care homes.

Northgate is a unit for people with enduring mental health illness issues, Watergate and Eastgate are units for people living with dementia and Bridgegate unit provides care for those with physical health needs.

There was a registered manager that had oversight of the whole service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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. In addition there were unit managers and deputy unit managers with responsibility for each of the four separate units. Each unit has its own dedicated staff team.

At the last inspection on 2 and 3 March 2015 we found that there were a number of improvements needed in relation to: people being at risk of receiving inappropriate care, unsafe care and treatment due to a lack of information about people and risks associated with unsafe premises. We asked the registered provider to take action to make a number of improvements. After the inspection, the registered provider wrote to us to say what they would do to meet legal requirements. They informed us they would meet all the relevant legal requirements by the end of June 2015. However, on the 21 and 22 September 2015 we found that the registered provider has made some improvements, however, they had not fully met their own action plan. We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see the action we have told the provider to take at the end of the report.

People we spoke with said that they felt safe at the service and told us 'I couldn't feel safer, I am not just happy here I'm delighted – it's great'. Relatives informed us that they were reassured that when they left the service that their loved ones were in good hands and would be well looked after.

Staff understood what was meant by abuse, were aware of the different types of abuse and knew the process for reporting any concerns they had. Staff told us they would not hesitate to raise concerns and they felt confident that they would be dealt with appropriately. The provider had robust systems in place to ensure that safeguarding incidents and complaints are reported to the relevant authorities.

All of the people we spoke with said there were enough staff working in the home. However there were periods of time where the lounge on Watergate was left unsupervised. This meant people were at risk of potential harm

Staff showed an understanding of their responsibilities and processes of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Staff practice showed that people's consent was considered before any daily care or support was provided. However, the registered provider's policy, procedures and documentation did not reflect why and how complex decisions for people who may lack capacity had been made in their best interests. Where a person's liberty was being restricted or they were under continuous supervision, we found that the manager had made the appropriate application to the supervisory body under Deprivation of Liberty Safeguards. We have made a recommendation that the registered provider improves the procedures, documentation and recording systems in place to ensure that the Mental Capacity Act 2005 is fully implemented.

People who lived in Northgate, Eastgate and Bridgegate were treated with dignity and respect at the service. However we found that people on Watergate unit were not always supported or treated in a dignified manner.

The communication needs of people who did not speak English as their first language where not fully met by the service. This meant people were not always supported to communicate independently or effectively.

The provider had quality assurance systems in place to audit the services provided at the home but these were not always effective. Issues we found as part of our inspection had not been identified through the registered provider audit process.

The care plans, including risk assessments, did not always record people's needs accurately.

Records on all units were not personalised to reflect people's individual preferences or how they would like their care and support to be provided. People on one unit did not always have care plans in place for the management of wounds or catheter care.

The registered provider had made some improvements to make the environment safer for the people that lived there. We were informed that the service will have a full refurbishment completed within the next 12 months.

The registered provider reviewed accidents and incidents at the service appropriately and these were reported

Summary of findings

through the provider's quality assurance system. This meant the provider was monitoring incidents to identify risks and trends and to help ensure the care provided was safe and effective.

People received their care from people who were of suitable character and the registered provider has safe systems in place for recruitment of staff. Staff attend regular training sessions in areas such as moving and handling, first aid and safeguarding adults to update their knowledge and skills. Staff have regular team meetings and supervisions to discuss areas of improvement in their work. We have made a recommendation that the registered provider access training for staff in Dementia awareness and positive mealtime experience for people living with dementia.

There were systems in place to manage medicines, including risk assessments for people to manage their own medicines. Medicines were administered safely and administration records were up to date.

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?

Requires improvement

The service was not always safe

People told us that they felt safe. Staff had attended safeguarding training and had an understanding of abuse and how to protect people.

People on Watergate were not always supervised. This meant people using the service were at risk of potential harm.

Medicines were administered safely and records were up to date.

Recruitment procedures were in place to ensure only people of suitable character and skill worked at the service.

Is the service effective?

Requires improvement

The service was not always effective

Records and procedures failed to demonstrate that people's rights had been fully considered when implementing the Mental Capacity Act 2005.

Applications had been made under Deprivation of Liberty Safeguards (DoLS) by the provider to ensure that any restrictions placed upon people were assessed

Staff had not received training in dementia. This meant that people using the service did not always receive good care.

Staff ensured people had access to healthcare professionals when they needed it.

Staff had access to regular supervision and meetings with the registered manager

Is the service caring?

Requires improvement

The service was not always caring

People were mostly treated with kindness and respect and staff encouraged people with their independence. However, on Watergate Unit people's dignity was not always maintained and people were not always treated with respect.

Communication needs of people whose first language was not English had not always been considered. This meant that people using the service were not supported to independently communicate with others.

Staff were respectful of people's choice and independence

Is the service responsive?

Requires improvement

The service was not always responsive.

Summary of findings

Care plans were not specific to each person's needs and there was not always clear guidance for staff to follow when providing support.

Supplementary charts were not completed in a timely manner and little detail was recorded as to what people ate and drank.

Records did not identify the correct settings for pressure mattresses and so there was a risk of harm

People were given information how to raise concerns or make a complaint and had confidence in doing so.

Is the service well-led?

Requires improvement

The service was not always well led.

A registered manager was in place, who had a good understanding of the improvements that were needed.

Quality assurance audits were carried by the registered provider but these were not always effective in highlighting areas of improvement.

Staff felt able to discuss the support and care provided with each other and the registered manager. Regular meetings are held to discuss service improvements.

Crawfords Walk 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on the 21 and 22 September 2015 and was unannounced on the first day. The inspection team consisted of four adult social care inspectors.

Before the inspection, we reviewed the information that the provider had given us following our last inspection. They had provided us with an action plan that gave details of how they were going to make improvements. They had indicated that all of the improvements were to be completed by July 2015. We looked at information provided by the local authority commissioning team, the safeguarding unit and Infection and Prevention control. We were informed that the service is working positively with these teams to make improvements to the service.

We also looked at information we hold about the service including previous reports, notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law.

As part of the inspection we spoke with 10 of the people living in the home, 13 relatives, 13 staff, and the registered manager. We observed staff supporting people and reviewed documents; we looked at 13 care plans, medication records, four staff files, training information and some policies and procedures in relation to the running of the home.

We spent time observing the support and interactions people received whilst in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

Requires improvement

Is the service safe?

Our findings

People supported said that they felt safe at the service and told us 'I couldn't feel safer, I am not just happy here I'm delighted – it's great'. Relatives commented 'I am here a lot and when I leave I have no worries because I know that the staff look after [my relative] and keep them safe'.

All of the people we spoke with said there were enough staff working in the home. One person told us 'I like to sit in my room as I like it and it is quieter there, but they always come and see me to make sure I am ok'. However there were periods of time where the lounge on Watergate was left unsupervised. We had to intervene when a person grabbed hold of an extension cable and starting walking with it pulling it from the wall. We discussed the lack of supervision on Watergate unit during our last visit with the registered provider. People were at risk of potential harm when left unsupervised.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as the registered provider had not ensured that staff are deployed in a manner that provides adequate supervision of people supported.

At our inspection in March 2015 we asked the registered provider to take action to ensure that the care provided was safe and that improvements were made to the living environment. We asked the registered provider to send us an action plan telling what action they had taken.

When we inspected the home in March 2015, we identified concerns that there was furniture that was in poor condition such as seats with ripped fabric and broken furniture in bedrooms. This was identified as both an infection and safety risk to people who used the service. This was a breach of Regulation 15 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Premises and equipment and we issued a requirement notice.

The registered provider had made some improvements to make the environment safer for the people that lived there. The registered provider had replaced the carpet in the hallways with cushion flooring to try to minimise any unpleasant odours and a number of different products which were being trialled within Watergate Unit. However, we noted that upon entering that unit there was a strong smell of urine on both days. All other areas within the service were free from unpleasant odours. Damaged furniture had been removed from communal areas and bedrooms on Watergate and replaced. This has reduced the risk of harm to people who were supported in those areas.

Cleaning schedules were in place and these were regularly checked to ensure they were effective. There was a good stock of personal protective equipment (PPE) such as disposable gloves and aprons and staff were seen to use them. The service has been visited by the Infection prevention control (IPC) team from Cheshire and Wirral Partnership. IPC has stated that the service has made good progress in the refurbishment of some of the bedrooms; however there was still work to be undertaken. We concurred with the finding that there are areas of the home that require redecorating due to damage to the paintwork and decoration looking tired and in need of replacing. On Watergate a sofa was heavily stained and would benefit from being replaced. The Area manager and registered manager informed us that the service will have a full refurbishment completed within the next 12 months.

Previously we had concerns about the way medicines were managed. Following our visit in March 2015, we made a recommendation to the registered provider to follow the correct guidance in the administration of medicines such as NICE Managing medicines in Care Homes March 2014. On this inspection, we found that improvements had been made and we identified no concerns about the management of medicines.

The registered provider had implemented safe practise procedures in relation to the use of the prescribed agent 'thick and easy'. There were individual picture cards for each person which identified the correct amount of thickener within a specific cup size. This meant that people were receiving their fluids at the right consistency which reduced the risk of choking. Each person had their own identified tub of 'thick and easy' for personal use with the correct dispensing labels. People's medication was safely stored and administered by suitably trained staff.

The medication for each unit is managed and administered by the Registered Nurse. They told us that they had annual competency checks undertaken to ensure they managed medication correctly and records that confirmed this.

Medication administration record sheets (MARs) were properly completed and staff had used signatures and appropriate codes when completing them. A recent

Requires improvement

Is the service safe?

photograph of the person was in place which helped staff identify the person prior to administering medication. Staff had access to policies and procedures and codes of practice in relation to the management of medicines. Important information about people's medication, including what the medication was for and any possible side effects was kept within the medication records. Procedures were in place for the use of controlled drugs and appropriate records were kept of these medicines.

Staff told us they had completed safeguarding adults training and records confirmed this. Staff knew what abuse meant; they described the different types of abuse and knew how to report concerns they had about people's safety. They had a good awareness of the registered provider's and local authority safeguarding procedures. Records showed that safeguarding concerns had been addressed in partnership with the local authority.

People's needs were assessed and where risks were identified risk management plans were in place. Assessments included risks associated with, pressure care, nutrition and hydration, diabetes, falls and choking. On Watergate unit, three people's care plans identified that they were at risk of pressure damage due to poor mobility and their risk assessment identified they required pressure relieving equipment and/or repositioning every two to four hours when in bed. People had the required equipment in place and our observations confirmed that people were being repositioned.

The registered provider had safe procedures in place for recruiting staff. We viewed recruitment records for four staff and saw that a range of checks had been carried out to assess the suitability of applicants prior to them being offered a position. This included completion of an application form which required the applicant to provide details of their skills, experience and previous employment.

References were obtained from an applicant's previous employer and a Disclosure and Barring Service (DBS) check obtained prior to applicants starting work at the service. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. This ensured staff were suitable to work with vulnerable people.

We viewed accident and incident reports and these raised no concerns with us. Accidents and incidents at the service were recorded appropriately and were reported through the provider's quality assurance system. This meant the provider was monitoring incidents to identify risks and trends and to help ensure the care provided was safe and effective.

Requires improvement

Is the service effective?

Our findings

People were complimentary about the food. Comments included: “the food here is really good, you get plenty of choice and if you want something else, or more you just ask”, “I love the food, you never go hungry”.

Previously we had concerns the units for people living with dementia were not well designed to aid orientation, observation and independent living. We issued a recommendation to the registered provider to refer to best practise guidelines for the development of a dementia friendly environment.

On this inspection we found that the registered provider had introduced some changes to the environment on Watergate unit. Consideration had been given to places of interest within the hallways which offered people the opportunity for conversation and reminiscence. Handrails were contrasting in colour to the walls so they could be easily seen and there were a number of places to sit down and relax in the hallways. Dementia friendly signage which used both pictures and words had been put in place on toilet and bathroom doors. These doors were also a contrasting colour to help them to be easily recognised. Each person’s bedroom now had a personalised memory box outside of the door to support a person to recognise their bedroom and to promote wayfinding within the unit. The registered manager informed us that there was now a lead staff member responsible for developing the dementia friendly environment on Watergate unit and this was still work in progress. Further development of the environment will be looked at through the refurbishment programme of work.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the management team. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people’s best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

The registered manager had a good understanding of the Mental Capacity Act 2005 (MCA) and deprivation of liberty safeguards (DoLS). He knew what his responsibilities were for ensuring that the rights of people who were not able to make or to communicate their own decisions were protected. Records showed that staff had attended MCA and DoLS training. During our inspection we heard staff on all units asking people for their consent before carrying out any activities. It was clear through observations that staff had an understanding and awareness of the Act.

The registered provider has a number of polices in relation to the MCA requirements which offered instruction and guidance to staff as to how the Act should be implemented. Our observations showed that staff had a good understanding of the MCA. However, we found that policies, procedures and records did not contain all of the information required. For example, records failed to demonstrate or record information to support the four stage mental capacity assessment process. The MCA clearly states that before care and treatment is carried out it must be established whether or not the person has the capacity to consent to the care and treatment. If the person does not have the capacity to consent, any care or treatment decisions must be made in their best interests. We found that best interest decisions were not fully recorded.

We recommend that the provider improves the procedures, documentation and recording systems in place to ensure that the Mental Capacity Act 2005 is fully implemented.

The registered manager had made applications to the local authority on behalf of people in relation to Deprivation of Liberty Safeguard (DoLS) authorisations. We saw that one person on Bridgegate unit was distressed for long periods of time and continually said that they wanted to go home. We raised this with the registered manager who had not recognised this and he informed us he would address this situation immediately.

Staff told us that they had received regular training for their role to enable them to provide care and support to people in a safe way. The registered provider’s action plan had identified that dementia training was required at the service. This had not been completed. We were informed subsequent to the inspection this training was called 'Person First, Dementia Second' training. Through our observations on Watergate unit it was clear that staff had a lack of awareness and understanding of how condition’s such as dementia may impact upon an individual and their behaviours. We spoke with the training manager, registered

Is the service effective?

manager and area manager who informed us that due to changes within the training team the registered provider had focused on the basic training required for staff. We saw that staff had completed training in relation to moving and handling, first aid, infection control; fire safety; nutrition and hydration; health and safety and safeguarding.

The mealtime experience on Northgate, Eastgate and Bridgegate units promoted a positive experience for people supported. Choices of food and drink were offered and alternatives to the meal presented were accessed when people did not want what was on the menu. There was a calm and relaxing atmosphere within the dining rooms and people chose or were asked were they wanted to sit to eat their meals. For some people they preferred to sit in their own personal bedrooms. Food presented looked appetising and was served from a hot trolley. People's care plans contained details of individual dietary requirements and these were provided. For example, one person required a pureed diet. The person received a pureed meal at lunchtime and staff we spoke with knew the person required a pureed diet and the reason why.

However the mealtime experience on Watergate unit was disorganised for people living with dementia. The tables for the lunchtime meal were set at 11:40am and the meal did not arrive until 12:40 midday. This led to three people being sat at the table for an hour waiting for lunch to be served. Once the main trolley arrived staff served meals to a number of people both in the dining room and lounge area. Staff had difficulty in supporting one person to sit and eat his meal. They did not immediately recognise that another person had nothing in front of him to eat and this was why he kept leaving the table. People who required assistance did not always get the level of support they needed as there was an inconsistent approach from staff. Meals that were pureed for people who have difficulty with swallowing lacked presentation and colour to stimulate appetite.

We recommend that the registered provider undertakes dementia awareness training with all staff and refers to best practice guidance on positive mealtime experience for people with dementia

Records showed that regular staff meetings had taken place. In addition, staff had access to regular opportunities to meet with their line manager and discuss their role. Staff told us "my induction was really good and it included shadowing a senior carer until I was happy to work alone", "I feel very supported here, there is always lots of training taking place", "Supervisions are better now, they are taking place more frequently. Records we reviewed confirmed this.

Staff on Eastgate, Bridgegate and Northgate units were knowledgeable about the care and support people needed. Staff explained their role and responsibilities and how they would report any concerns they had about a person's health or wellbeing. Appropriate referrals for people were made to other health and social care services. Staff identified people who required specialist input from external health care services, such as GP's and speech and language therapists and where appropriate staff obtained advice and support. Records confirmed that people had been supported to attend routine healthcare appointments to keep them healthy.

Requires improvement

Is the service caring?

Our findings

People told us they received good care and that the staff were respectful and polite. People's comments included "The staff are very kind", "I do like it here, the staff on the whole are great – some are better than others". One visiting relative told us that they had been to visit three other care homes but this one was the only one that "felt" caring. They told us that all the staff had introduced themselves and go away feeling that their relative will "be safe, loved and cared for". Another relative who spoke with us said "this is the best place ever for [relative] the staff are wonderful and they always have a smile for [relative]".

When we inspected the home in March 2015, we identified concerns that the registered person had not ensured that the needs of individuals were being met and that their welfare and safety was not being compromised. This was identified as a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Person Centred Care. On this inspection, we found that improvements had been made by the registered provider.

People told us that "if any carers come into my bedroom they will always knock before they come in", "the staff took time to get to know me when I first came here, I was nervous as I didn't know what to expect, they went at my pace". One relative told us "my [relative] is loved and cared for and they always involve her in her care, she is very independent and it's important she doesn't lose that". The registered manager has worked with the staff teams through supervision and team meetings to discuss person centred care for the people supported. Records we viewed confirmed this

Staff on all of the units had a good understanding of how the majority of people wanted their care to be provided. Consent was sought where possible before peoples care needs were attended to and staff were respectful of people's choice and independence.

There was a contrast across the units in regards to people being treated with dignity and respect. On Watergate unit we observed four people walking around with stained clothing. One person had trousers that were too big and dragging on the floor as they did not have a belt on. This placed them at greater risk of falls. Two people had food on their face for a period of over two hours after their meal had been eaten and staff did not attempt to help them with personal care. Staff used of undignified language such as 'they are a feed', 'wanderer' or 'pleasantly confused' a number of times in front of people. One person supported asked us "why do [staff] say that about me?" It was clear from our observations that people were disrespected by the use of this language. Staff did not always treat a person with dignity. One person who used the service stood up from their chair in the lounge and a passing staff member pointed their finger directly at them and said 'no' in a direct manner. The person immediately sat back down in the chair and appeared alarmed. The staff member did not attempt to engage with the person to see if they required help or wanted to go somewhere else.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as the registered provider had not ensured that people were supported or treated with dignity and respect.

In contrast, where 1:1 support was in place for people, staff were engaging with people whilst respectful of their privacy. Staff on Bridgegate supported a person to wipe their eyes and nose and to pull their clothes down in a very discreet manner. Staff there also helped people to maintain their personal appearance "[person] likes to wear petticoats under her dresses" and "[person] likes to have their handbag with her at all times as this makes her feel secure". Staff on Bridgegate were encouraging with people during our visit "come on you can do it", "well done that was hard but you did it". Staff supported people to be as independent as possible and gave clear instructions to people when needed. We observed staff on Northgate calling people by their preferred name and listening to what people wanted. One person told us "I know I can trust and speak to staff and they will respect my privacy".

On all of the units staff knocked on people's bedroom doors before entering which meant that their privacy was maintained. People who were supported in their own rooms were regularly visited by staff to ensure that they had everything that they needed.

The service supports three people whose first language is not English. On review of records we found that care plans did not embrace this difference. One care plan stated that "staff are to prompt [person] to speak in English as staff cannot understand [person]". No documentation was available in different languages. We discussed this with the registered manager who informed us that there is a

Requires improvement

Is the service caring?

method that can be used on a SMART phone for translation; however they then told us that staff are not allowed phones on duty. The registered manager confirmed that he would review and implement other ways of supporting staff to understand and meet the communication needs of people for whom spoken English is not a first language.

Requires improvement

Is the service responsive?

Our findings

People told us they received the care and support needed and this met their individual needs and preferences. On Northgate people said that they could make choices about their daily lives and that staff respected their decisions. One person said, "I have choice. They [the staff] come and ask me if I'm OK. I don't always want help and so they let me do things for myself". Another person said, "I chose to be in this room [bedroom]. I like to sit in my room because it's quiet and I like to have time on my own". People told us that they go out most days into the community and they are happy with that.

When we inspected the home in March 2015, we identified concerns that the registered provider had failed to ensure that people were protected from the risks of unsafe or inappropriate care and there was not an accurate records held in respect of each person. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014: Good governance. On this inspection, we found that some improvements had been made by the registered provider, however accurate records were still not always held in respect of each person.

We looked at people's care records and found that people's needs were assessed prior to them moving into the service which ensured that their needs could be met. The assessment process also sought the views of people's relatives or their representatives. However, information recorded in some care plans did not reflect the care the person required. For example we found from one person's daily notes that they used a catheter but there was no catheter care plan in place. Their toilet care plan did not indicate if the person could self-manage their catheter or what the required frequency of catheter change was. There was a blank continence assessment form in the person's notes. Wound care plans were not always in place for people. However through discussions we found that staff had an understanding and awareness of the support requirements for people. We viewed written records that were not accurate or fully completed.

We found across all four units, that there were no records to indicate what the correct pressure levels of mattresses should be set at or if they were reviewed or checked regularly. This meant that people were at risk of harm. The registered manager confirmed that he would take immediate action to ensure staff were aware of the correct settings .Records were not always completed to identify when and how often people had been repositioned.

We reviewed a number of care records on all units which showed that there was inconsistent practice in place for the monitoring of weight loss and gain. We noted that the registered provider had given due consideration and action when people had lost weight within the service, but not when people had gained weight. We looked at two people's care records on Bridgegate and identified a significant increase in weight over a short period of time. Records did not evidence any review of medical, care and support needs based on this information. One person's waterlow assessment had been completed incorrectly and did not reflect their correct current Body Mass Index (BMI).

Supplementary charts used to records food and fluid intake for people were not always completed in a timely manner. Staff completed records up to 4 hours after lunch had taken place. Staff had to ask each other what people had eaten as they may not have supported that person at lunchtime. It was clear from discussions with staff that the accuracy of what was recorded was dependent on recollection. The records did not clearly identify the amount of food and fluid that we observed people had eaten or drank. The comment 'all' was written on the food intake diary in the section asking for 'amount actually consumed'. We spoke to three staff and asked if they were aware of the recommended daily fluid intake for people and they advised us that this would be written in people's personal care plans. Care plans did not contain this information. This meant that an accurate record of food and fluid intake was not always maintained for people.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as the registered provider had continued to fail to ensure that people were protected from the risks of unsafe or inappropriate care as there was not an accurate records held in respect of each person

We viewed thirteen care plans that had information about people and their physical health needs and staff were able to discuss people's preferred way of being supported. However, records were not always personalised and did not always take into account how people would like to be supported, preferences, their likes and dislikes. The

Requires improvement

Is the service responsive?

registered manager informed us that the plans of care were currently in the process of being transferred to new documentation that had been introduced by the registered provider. We saw that a completion date for updating care files had been set for the 30th September 2015 in the monthly provider action plan.

People told us there were plenty of activities going on in the home. One person said "there is always something going on here, today people are dong craftwork". Relatives said that they would like to see the activities increased for with people living with dementia. On the day of our visit we were introduced to two new activity co-ordinators who had been employed to work on Watergate and Eastgate units. The registered manager informed us that they were undertaking a review of the activities across the home. He informed us that consideration had been given to the best type of activities for people with dementia and this area was work in progress.

The registered provider had erected a new smoking shelter on Northgate which removed the smell of cigarettes from the unit. People who lived on that unit were happy to use the shelter and have now got used to going outside to smoke.

People told us that they would talk to the staff or the provider if they had any concerns. One person said, "I talk to the manager and the other carers every day so I never have a problem" Another said, "I am able to speak to the staff and make suggestions." Relatives knew how to raise concerns and were aware of the registered provider's complaints procedure. The registered provider had systems in place to record complaints. Records showed the service had received complaints in the last 12 months and that they were dealt with appropriately and what action was taken as a result.

Requires improvement

Is the service well-led?

Our findings

People who used the service and relatives spoke positively about the open culture and communication at the service. One person using the service told us, "I can speak to the manager, I see him most days, he is always available". Another person told us, "I am able to speak to the staff and make suggestions." We also spoke with a number of relatives one of whom told us, "We see the manager a couple of times a week which is good, he always comes over for a chat".

The service was managed by a person registered with CQC since May 2014. The registered manager had a good understanding about their roles and responsibility and displayed a commitment to continued improvement and providing good quality care. Staff said that the registered manager was approachable and they felt well supported. Regular meetings took place where staff discussed their practises such as managing falls and managing people's risk of developing pressure sores. These meetings also ensured that staff were kept informed about the service and their responsibilities. They were used to identify where improvements were needed to drive up quality and helped staff to keep up to date with best practice. An example of this was a discussion with staff to improve their understanding about the safe use of thickening agents for people who are at risk of choking.

The registered provider had an in depth system to assess the quality of the service but this had not always been effective. One of the audits included a review of care plans and these were carried out at unit manager, registered manager and provider level. The issues that we raised as part of our inspection had not always been identified and actioned by the provider. For example care plans were not always in place where required or did not accurately reflect the person's needs. The audits in place needed were not effective in enabling the registered provider to identify actions required in response to people's needs. This meant that people were not assured of living in a home that was well managed where their care and safety were promoted.

An operational audit was completed monthly by the registered provider. This involved a senior manager visiting and completing a review of the service. The regional manager last completed this audit in September 2015 and we saw that areas of improvement such as the environment had been highlighted. The senior manager spoke about the progress the service was making towards improvements that were required and the support that had been requested from the registered provider and external stakeholders. The audit included a check on the progress made against the previous month's actions

The provider had an up to date whistleblowing policy and procedure in place. Through discussions we found that staff were familiar with the content of the policy and new where to access a copy if needed. Staff were aware of how to report any concerns they might have regarding the conduct of colleagues and were confident their concerns would be addressed.

The registered manager had informed the CQC of specific events that they are required, by law to notify us about. They had also reported incidents to other agencies when necessary in order to keep people safe and well.

The registered provider had displayed their ratings from the previous inspection in line with Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20A.

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 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: People were not always supported or treated in a dignified and respectful manner. 10 (1)

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 How the regulation was not being met: People were not protected of unsafe or inappropriate care or treatment arising from the lack of proper or accurate information about them. 17(2)(a)(b)(c)

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 How the regulation was not being met: People were not always protected from risk when left unsupervised. 12(1)(2)(b)