Heathbrock Limited

Chester Lodge Care Home

Inspection report

Brooke Street
Hoole
Chester
Cheshire
CH1 3BX
Tel: 01244 342259
Website: chesterlodgenursinghome.co.uk

Date of inspection visit: 29 October and 3 November 2015
Date of publication: 06/01/2016

Ratings

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

Overall summary

This inspection was carried out on 29 October and 3 November 2015. Both visits to the service were unannounced. We brought our inspection of this service forward following concerns raised to our attention around care and safety of people who used the service.

Chester Lodge care home is a privately owned residential and nursing care service located close to Chester city centre. The service is based over three floors, which provide accommodation and personal care for up to 40 people. Access to the upper floor is via a passenger lift or stairs. Local shops and other amenities are a short distance away from the service. At the time of our inspection there were 35 people living at the service.

The service has a registered manager. 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

Summary of findings

the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. In addition there was a lead nurse at the service who had responsibility for overseeing clinical practise and care.

During our visit we found a number of 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 know someone will help me when I need them'. Relatives informed us that the staff do their best to look after people and keep them safe from harm.

Risks to people's health and safety were not always identified or assessed. We identified the unsafe use of one person's bedrails during the visit. The registered provider took immediate action to remove the risk. However we also found that robust risk assessments were not in place for the use of bedrails which meant people could be left at risk of harm or injury.

One of the concerns raised prior to the inspection was in relation to the management of pressure sores by staff. During this visit we found that sufficient checks were not always made on pressure relieving equipment. We found two mattresses that were on the wrong setting and identified faults with equipment. This meant that people using the service were at risk of harm.

People did not always receive their medication as prescribed. People's medication administration records (MAR) had not been appropriately signed when medication was given. Care plan for PRN (as required) medication were not in place for staff guidance. Medication was not always stored in a safe and secure way.

Accident and incidents were not effectively monitored. Reviews did not identify risks or patterns to falls. There were no actions identified to ensure that people were kept safe.

The service was not clean. Several areas were dirty and in need of a deep clean. Unpleasant smells were detected in some parts of the building. The management of infection control was poor.

Fire safety management at the home required reviewing. We saw no evidence to support effective evacuation in the event of a fire. Flammable items were stored in rooms that had no fire detectors. We have requested the Fire authority to visit the service to complete an inspection.

Staff showed a limited understanding of their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered provider did not have policy and procedures in place with regards to the MCA. Staff practice showed that people's consent was considered before any daily care or support was provided. We found that the registered manager had made some applications to the supervisory body under Deprivation of Liberty Safeguards, but this was only in relation to people choosing to live at the service. Supporting documentation did not reflect how complex specific decisions for people who may lack capacity had been made in their best interests.

Staff attended annual training sessions in areas such as moving and handling, first aid and safeguarding adults to update their knowledge and skills.

The mealtime experience was disorganised and did not promote a positive experience for people. Undignified practice such as putting plastic aprons on everyone was observed. Staff did not always respect people's opinions and choices at mealtime. People were not always treated with dignity and respect. Some people told us that they felt staff spoke to them in a disrespectful manner at times. Others informed us that the staff were caring and did the best that they could to look after them.

Care plans did not always record people's needs accurately. Records were not personalised to reflect people's individual preferences about how they would like their care and support to be provided. Care plans did not always include accurate information for the management of wounds. Food and fluid charts were not always completed in detail to reflect what people had consumed on a daily basis. However, care plans identified what people's end of life care wishes were. Staff were familiar with decisions that had been made with the GP and the people who were supported. Appropriate referrals to health professionals were made when any concerns regarding people's health were identified.

The quality assurance system in place was not effective and did not monitor the quality of care and facilities

Summary of findings

provided to people who used the service. Issues we found as part of our inspection had not been identified or addressed through the provider quality assurance processes. The policy and procedures manual at the service required updating. Information contained within the documents was out of date and did not reflect changes to current practice, law and legislation.

The registered manager had a limited knowledge and understanding of the Health and Social care Act 2014 regulations and fundamental standards.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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

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

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?
The service was not safe

Risks to people were not always identified or assessed appropriately. This meant people were not always protected from harm.

Medication was not safely stored or managed within the service.

The service was not clean. Infection control was poorly managed.

Inadequate

Is the service effective?
The service was not effective

The registered manager and staff had a lack of understanding of the principles of the MCA and DoLS. This meant that people's capacity was not always assessed or best interests taken into account to support decision making

Insufficient checks were completed on pressure relieving equipment.

Records were not accurately completed for food and fluid intake. The registered manager was unable to evidence what people had received.

Requires improvement

Is the service caring?
The service was not caring

People were not always treated with dignity and respect. People said that staff were sometimes rude in their manner.

The mealtime experience was disorganised and not well managed. People told staff that the food was not well presented. The use of undignified language such as 'assists' was used in front of people supported.

Staff promoted choice with people. People were asked what their preferred morning routine would be.

Requires improvement

Is the service responsive?
The service was not responsive

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

Care plan reviews did not reflect changes to care and support needs for people.

People were given information how to raise concerns or make a complaint.

Requires improvement

Is the service well-led?
The service was not well led

Inadequate

Summary of findings

The quality assurance system in place failed to monitor the care and services provided. These systems did not always identify areas of concern or where improvements were required.

Policies and procedures used at the service did not include up to date information to reflect changes in processes, law and legislation

The registered manager had limited knowledge and understanding of the Health and Social care Act 2014 regulations.

Regular staff team meetings were held. Discussions and reflection regarding improvements to practice were undertaken.

Chester Lodge Care Home

Detailed findings

Background to this inspection

'We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 29 October and 3 November 2015 and was unannounced on both days. The inspection team consisted of one adult social care inspector an inspection manager and a specialist advisor. The specialist advisor looked in detail at the management of Tissue Viability and pressure care support within the service.

Before the inspection, we received concerns regarding the provision of care at the service. We therefore decided to bring forward our inspection. We reviewed information provided by the local authority, safeguarding teams and Infection and Prevention control team before the visit. 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 five of the people who lived at the service, three relatives, seven staff, and the registered manager and registered provider. We observed staff supporting people and reviewed documents; we looked at five care plans, eight 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.

Inadequate

Is the service safe?

Our findings

People told us they felt safe at the service. One person commented, "There is always someone around when I need them". Another person said, "I've never had any reason to complain, they will eventually get to me when I need help".

Since we last inspected the service there has been a number of safeguarding alerts that have been raised in relation to the care and support that people received. The registered provider and registered manager were working with the local authority on an improvement plan for the service. During our inspection we identified concerns in relation to the safe care and treatment of people living at the service.

We found that risks to people were not always identified or assessed appropriately. For example, we saw that some people in the service had bed rails in place. On review of records we identified that two people had no care plans in place for bed rails and no regular review and assessment of safety of the bed rails used. We raised concerns during our visit to the registered provider and registered manager about the unsafe bed rails in place for one person supported. The registered manager took immediate action to remove the risk.

We found that medicines were not managed safely. We looked at six people's medication administration records (MAR). We found that there were errors in the way some staff recorded medicines administration. We noted that the registered provider did not have a signature sheet in place. A signature sheet allows the service to identify who is assessed as competent and responsible for signing for the administration of medication. We found gaps where signatures had not been completed to demonstrate that the person had been given their prescribed medication. An example of this was one tablet had been signed for by nursing staff as administered and was still within the dispensing package This could have had an impact on the person's health, placing them at risk.

A number of people using the service had PRN (as required) medication. The registered provider did not have care plans in place to direct staff as to in what situation these medications should be given and when. There was no information recorded and readily available for staff to ensure people were given medication safely and consistently with regard to their individual needs and preferences. Failing to administer medicines safely places the health and wellbeing of people living in the home at risk of harm. We saw that creams were not always stored correctly. We found creams stored in cupboards within the hallways. When staff were asked who they belonged to, we were informed that they had never heard of one person. Through further investigation the person no longer lived at the service. This meant that medication that was no longer required was not returned to the pharmacy as required. . A medication fridge was in place at the service. We noted that the temperature was not regulated and not always checked on a daily basis. Medicines stored at incorrect temperatures may alter their effectiveness. We saw poor practice in relation to single patient use syringes used for medicines given via percutaneous endoscopic gastrostomy (PEG) and orally being rinsed and used for an unknown number of times. Several syringes were stored in a plastic container within the clinical room alongside spoons that were dirty.

During our visit we found that the medication room was left unlocked on three occasions. This caused concern that the medication room was accessible to all staff and visitors to the service. We also observed that the medicine trolley was left unattended for 15 minutes by the nurse in charge in the middle of the hallway. Although the trolley was locked, when unsupervised it should be kept in a locked room.

Procedures were in place for the use of controlled drugs which included regular checks on stocks. Staff had access to the service policies and procedures in relation to the management of medicines.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as the provider did not have proper and safe management of medicines in place.

We viewed accident and incident reports during our visit. Accidents and incidents at the service were recorded through the use of the accident book and reviewed on a monthly basis by the registered manager. We viewed records that identified six incidents of falls since September 2015. Falls risk assessments were in place, but were not updated when a person fell to determine whether there was a change in need. There was no evidence of appropriate referrals to the falls prevention team or to support what actions had been taken to minimise the risks to people supported. Monthly reviews did not identify risks,

Inadequate

Is the service safe?

trends or actions taken to ensure that care provided to people was safe and effective this meant the registered manager was not monitoring accidents and incidents effectively.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have effective systems in place to identify and assess risk to the health and safety of people using the service.

We found issues in relation to the management of Infection prevention control (IPC) that required action. The home was visibly unclean in a number of areas. On both days of our visit the home had a strong smell of urine within the foyer area and in six people's bedrooms. The registered manager informed us during our visit that two new bedroom carpets had been ordered. Tables and chairs within two of the lounge areas were dirty and covered in dust and particles of food. We found rubbish lodged behind furniture that had not been noticed by staff .Thick dust covered pipework, skirting boards and edges on wardrobes. Equipment such as wheelchairs and commodes within people's bedrooms had not been cleaned appropriately. One bed had been made and when we pulled back the covers there was faeces on the sheet. We saw that bathrooms contained bins which did not store waste safely. One bin was overflowing with personal protective equipment such as gloves and aprons that had been used. We checked the sluice rooms and found that one did not have a lock on the door. Within the room we found a dirty mop placed downwards in a bucket containing dirty water. On the side of the bucket we found both dirty cloths and clean cloths hanging side by side. This meant that there was a risk of cross contamination in the service. Items such as toilet cleaner, air freshener and polish used for cleaning were stored in a bucket next to each other. The décor within the service was visibly in need of repair. There was damage to paintwork, broken and chipped tiles in the bathrooms and heavily scuffed skirting boards. The service was at risk of harbouring bacteria due to the poor management of infection control.

We found that the medication room carpet was heavily stained and the desk that was used by the nursing team was marked and damaged. The registered provider informed us that new flooring had been purchased to replace the carpet in the room and that they would address the use of the damaged desk immediately.

This was a breach of Regulation 12 and Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not being protected against identifiable risks of acquiring an infection.

During our visit we noticed a number of areas of concern in relation to the management of fire safety prevention at the service. This included storage of flammable items such as cardboard boxes and mattresses in bathrooms which are not required to have a fire detector. Documentation did not provide robust evidence to support effective evacuation of people who lived at the home in the event of a fire. There were fire doors that did not close properly and had damaged or no seals in place. This meant that an outbreak of fire may not be contained effectively and could spread within the service. Exit routes from the service were used to store a large number of items such as wheelchairs, bed rails and notice boards. We contacted the Fire officer to inform them of our findings and they agreed to visit and inspect the service.

We saw certificates to show that there had been routine servicing and inspections carried out on items such as hoists, the lift and electrical and gas installation.

Staffing rotas showed that each day people were supported by a team of nurses, senior care assistants and care assistants. Adequate recruitment checks for staff were in place to protect people. We noted that one member of staff did not have the required references in place at the time of our inspection. The registered provider has sent a copy of the reference since our visit.

Requires improvement

Is the service effective?

Our findings

People told us that they saw their GP when needed and that the staff always ensured that appointments were made as soon as possible. One person told us, "I needed new glasses and they arranged for the optician to come and see me here".

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 them 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 limited understanding of the Mental Capacity Act 2005 (MCA) and deprivation of liberty safeguards (DoLS). She knew some of her responsibilities for ensuring that the rights of people who were not able to make or to communicate their own decisions were protected. Records showed that support staff had not attended MCA and DoLS training. It was clear through observations and discussions with nursing and care staff that there was a limited understanding of the principles of the MCA.

During our inspection we heard a small number of care staff asking people for their consent before carrying out any activities. Peoples care planning documents failed to demonstrate their ability to be involved or make specific decisions. Information relating to consent was not recorded in care plans we reviewed and where appropriate details of relevant others, who needed to be consulted about specific decisions on behalf of people, were also not recorded.

The registered provider did not have a MCA and DoLS policy and procedure in place. There were no records that offered instruction and guidance to staff as to how the Act should be implemented. The registered manager informed us that pocket guidance cards with the principles of the MCA had been sought for staff but had not yet been shared.

The registered manager demonstrated that eight applications had been made to the local authority on behalf of people in relation to Deprivation of Liberty Safeguard (DoLS) authorisations. However through discussions with the manager applications had only been made in relation to the Cheshire West high court ruling and for no other reasons. There was no evidence that capacity assessments or best interests meetings had been completed to validate the applications made. It was clear that the registered manager's knowledge in relation to DoLS required updating. This meant that the registered provider failed to apply the law when making decisions on behalf of people who lacked capacity.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as the provider had not ensured that care and treatment was provided with the consent of the relevant person.

Changes to the condition of people's health were not always identified and recorded within the service. An example of this was that the management of wound care for a number of people supported was undertaken by the District Nursing team. Staff told us that notes in relation to changes in care and support were held on the district nursing team's IPad. However, there were no care plans in place to identify what care the person required in between the nurse's visits and what action to take should the dressings fall off or become dislodged. There was no guidance in place for staff on what action to take if this occurs. This meant the person was at risk of not receiving safe care. Care plan records did not record when changes to care had been made. Staff did not have up to date information relating to what support people required to maintain their health. This meant that the safe monitoring and management of wound care at the service was at risk.

We found that insufficient checks were carried out on pressure relieving equipment. We identified three pressure relieving mattresses within the service that were not monitored effectively. Two mattresses we viewed were on the incorrect setting and one mattress showed a fault. This had not been identified by staff during our visit. People were at risk of not being protected from the risk of developing pressure ulcers.

Requires improvement

Is the service effective?

This was a breach of regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulation 2014 as the provider did not review health and safety risks or provide care and treatment in a safe way to people.

Staff told us that they had received training for their role to enable them to provide care and support to people in a safe way. We saw that staff had completed training in relation to moving and handling, fire safety, safeguarding adults, first aid and food hygiene. Due to the recent safeguarding issues that had been raised the service was working in partnership with the local authority to access Tissue Viability training for all staff. The registered manager informed us that new staff spent time with senior team members when starting employment. However, there were no records to show what was discussed or undertaken with new staff or evidence of competency being assessed prior to supporting people.

Records to assist staff in monitoring food and fluid intake for people were inaccurate or not completed. We saw records with only three entries recorded within a 24 hour period. A total of 21 entries for food and fluid intake over a period of seven days. Entries documented included '¼ bowl of porridge taken' or '70mls of water taken'. People who had significant weight loss had insufficient information recorded. Staff were asked if there were any other records held at the service which recorded food and fluid intake. We were informed that records were kept in the dining room on the first floor. These were not in place. There was no daily review of records completed by staff on duty to ensure that people had eaten and drunk sufficient amounts. This meant people were not safely protected from risks of dehydration and inadequate nutrition.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not protected from the risks of inadequate nutrition and dehydration.

Before the inspection we were informed that some people who used the service were not always referred to health care professionals as needed. However, we found that appropriate referrals for people were made to other health and social care services. Staff had identified people who required specialist input from external health care services, such as district nurses. GP visits were held on a weekly basis at the service to review the health needs of people supported.

Requires improvement

Is the service caring?

Our findings

People we spoke with told us that staff were helpful and the manager comes around to see people on a daily basis. People's comments included "The staff are caring", "I can make my own choices and staff respect that". One visiting relative told us "The staff are always friendly and they do their best". Another relative said, "It has its ups and downs. There are days when the care that is provided to my [relative] is better than others. It can depend who the staff are on shift".

We saw that care staff on all floors had an understanding of how people wanted their care to be provided. Staff described how people had a choice in the morning to have a lie in if they wanted too. People we spoke with confirmed this. However we found that people were not always treated with dignity and respect. We were told, "The staff talk about me in front of me, I feel like a piece of meat when they do that" and "I've never known anyone to be so rude to an older person".

We observed staff practice that showed that consent was sought where possible before some people's care needs were attended too. One staff member asked politely and discreetly if a person would like to use the bathroom. However, we found that staff were not always respectful of people's choice and independence. Some people chose not to eat their meal at lunchtime and informed staff, "would you eat this it looks a mess". Staff response to this comment was "it's not in the appearance, it's in the tasting, you should just try it". Relatives told us, "they will cook whatever my [relative] wants to eat. Last week they made a jacket potato with cheese and my [relative] loved it".

The meal time experience did not promote a positive experience for people. Staff were disorganised in their approach with people which led to one person becoming frustrated. People were sat waiting for their meal at the dining table for up to 15 minutes before food arrived. We noted that eight people were sat at the table in their wheelchairs and everyone wore a plastic apron to protect their clothing. We did not observe staff asking people's consent to wear aprons. The use of undignified language such as 'assists' was used a number of times by staff in front of people sitting at the dining table. This was used to describe people who required support to eat their meals. It was clear from our observations that people felt disrespected by the use of this language. This was poor practice. Once the food was prepared different staff began serving meals to a number of people. This led to confusion as to what people had eaten, wanted or didn't want to eat. One person was told on four occasions by four different staff that they needed to eat their lunch. On each occasion the person informed the staff that they didn't feel like eating what was in front of them. One staff member offered an alternative on the fifth occasion of the person refusing the meal. Food presented did not look appetising. Comments were made by people about the poor presentation of the food. We observed only cold drinks being offered throughout the mealtime.

Staff on all floors knocked on people's bedroom doors if they were closed before entering. People who were supported in their own rooms were visited during our visit. However, we observed a number of bedroom doors left open with people who were partially dressed or in their night wear within view of others walking in the hallways. This may lead to people feeling vulnerable or uncomfortable within their own home. We spoke with the registered manager about consideration to privacy, dignity and respect for all people who live within the service. We were informed that this practice would be discussed with staff and addressed immediately. We saw three people who wore stained clothing and had dirty blankets and towels within their personal rooms. Staff informed us that this was people's personal choice.

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 with dignity and respect.

We saw that people had care plans in place that considered their end of life wishes. The service supports a number of people who had a 'Do not attempt resuscitation' (DNACPR) form in place. Capacity assessments were undertaken by the GP and were appropriate with the person or relevant others. Staff were aware of people's wishes and information was recorded in their care plans.

Requires improvement

Is the service responsive?

Our findings

Relatives informed us that any concerns or complaints were promptly responded to by the manager. People knew how to make a complaint and were confident about approaching the registered manager or other staff with any complaints they had. Relatives had raised concerns in areas such as poor cleanliness and low staffing levels. We reviewed response letters to complaints and found that these were issued within a reasonable timescale. The provider had a complaints policy at the service. Information contained within the policy did not reflect current processes for people to raise a complaint outside of the service.

Before the inspection we were made aware of concerns about the care of people's pressure areas and the development of pressure ulcers. In some instances we were informed that the records did not accurately reflect the person's condition.

People's needs were not always assessed. Where a specific need was identified there was not always a care plan in place. For example one person who was assessed as being at risk of developing pressure ulcers did not have a care plan in place for skin integrity. Care plans we reviewed lacked detail and were not personalised about how to meet the person's needs. On review of records we found documents that had not been accurately completed for people. Wound care plans and wound care charts were stored in a separate file that was held in the clinical room. Photographs of wounds were not regularly taken and did not document the person's name, date or orientation of the picture. Staff had not recorded in care plan notes when wounds had healed or when care plans were no longer required. There was a lack of understanding from staff when recording information relating to pressure ulcers. One entry described the location of a pressure ulcer as being on a person's 'knicker line'. The correct term would be a pressure ulcer on the 'sitting bone'. It was clear through discussions with staff that there was a limited understanding about the management of pressure ulcers within the service.

Regular reviews of risk assessments and care plans were completed on a monthly basis. However, there was no evidence to show that changes to people's care and support needs, for example, new risks, had been appropriately recorded. Comments such as 'no change' or 'continue' were consistently noted over a period of 12 months. This was despite a range of changing needs that were highlighted within daily records. Records had not been signed or dated by staff.

MUST (malnutrition universal screening tool) assessments were in place, however, where risks had been identified or there had been a change in need, actions required to support the person had not always been completed. We saw records that identified that one person as a medium risk of malnutrition and the instructions in the care plan were to 'observe' only. We asked staff what the rationale was for this action and they could not explain why.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as the provider did not have safe systems and processes in place to assess, monitor and improve the quality and safety of care.

Care plans were accessible to the relevant staff and they told us they shared important information about people during each shift handover. A new system had been introduced to ensure that information relating to changes in people's skin integrity was reported on a daily basis with the nursing team. This was to ensure that immediate action was taken to prevent pressure ulcers developing.

We saw some activities taking place during our visit which included people having a movie afternoon. Three people enjoyed listening to music in their bedrooms and a number of people sat reading. People told us that the service ensured that they get their daily magazine or paper. A relative informed us that they went daily to place a bet at the local booking shop for someone who liked a 'flutter on the horses'.

Inadequate

Is the service well-led?

Our findings

The service was managed by a person registered with CQC since October 2010. The registered manager is also the nominated individual at the service. People supported, relatives and staff we spoke with were positive about the manager. Staff said they felt supported by her.

There were limited systems in place to assess and monitor the quality of the service; they were not always effective. The registered manager and nominated individual was responsible for the audits / checks at the home, including reviewing falls and cleaning. We noted that there were other staff nominated to take the lead in areas such as Health and Safety and infection prevention control. Records we saw showed that issues with the premises such as cleanliness, cross infection and contamination and safety hazards had not been identified. There was a lack of evidence to demonstrate where improvements were required in response to shortfalls in these areas. We noted that audits were not completed on a regular basis and were not always completed. The medication audit was last undertaken by the local authority in March 2015. We asked the registered manager what measures they took to ensure that the management of medication was audited effectively. We were informed that this was not a regular audit that they completed, but MAR sheets were looked at on a monthly basis.

Audits did not identify specific timescales for completion and we there were no action plans in place to demonstrate the improvements implemented by the registered provider. These systems did not ensure that people were protected against the risks of inappropriate or unsafe care and support. There was a lack of oversight by the registered provider to ensure the quality of care and facilities provided to people who used the service.

We reviewed the service policy and procedures manual. The registered manager and one of the directors of the company had undertaken a review of the manual in July 2015 and signed to say that the information was still relevant. Policies did not reflect current law and legislation. Information included in documents was out of date and inaccurate. An example of this was the missing resident's policy which indicated that the National Care Standards Commission which is an organisation that no longer exists should be informed. There was no policy and procedure in place to support the Mental Capacity Act (MCA) or Deprivation of Liberty safeguards (DoLS).

We asked the registered manager if she had a copy of the guidance for providers in meeting the regulations. We were showed an old copy of the Essential Standards. These are standards which no longer exist. She informed us that she accessed our website for information that was needed. It was clear through discussions that the registered manager was not familiar with the fundamental standards.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as the provider did not have systems and processes in place to assess, monitor and improve the quality and safety of care.

Staff attended team meetings on a monthly basis and we saw minutes of discussions held. The registered manager had spoken with staff about the recent concerns raised about the management of pressure wound care. Effective communication was discussed and new practices implemented to ensure up to date information was shared about people supported. The meetings provided an opportunity to reflect on poor practice as well as issues relating to staff at the service.

There was a service user guide in place. This included general information about the home including staffing levels, type of care provided and contact details. We noted that the address registered with companies' house was incorrect. The registered provider assured us that they would change this to reflect the correct information.

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 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 in a dignified and respectful manner. 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: Care and treatment was not provided with the consent of the relevant person. 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care 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 protected against identifiable risks of acquiring an infection. Care and treatment was not always provided in a safe way. 12(1)(2)(g)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met: People were not protected from the risks of inadequate nutrition and dehydration. 14(1)(2)(b)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: Management of infection control was poor. Premises and equipment were not maintained or kept clean. 15(1)(a)(e)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not have systems and processes in place to assess, monitor and improve the quality and safety of care. 17(1)(2)(a)(b)(c)(f)