St Philips Care Limited

Pine Trees Care Centre

Inspection report

15 Horsepool Road
Connor Downs
Hayle
Cornwall
TR27 5DZ

Tel: 01736753249
Website: www.stphilipscare.com

Date of inspection visit:
01 February 2017
02 February 2017
06 February 2017

Date of publication:
02 June 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
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

Pine Trees Care Centre is a care home which provides accommodation for up to 35 older people who require personal care. At the time of the inspection 34 people were using the service. Some of the people who lived at the service needed care and support due to dementia, sensory and /or physical disabilities.

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

We inspected Pine Trees Care Centre on 1, 2 and 6 February 2017. The inspection was unannounced. The service was last inspected in April 2016 when it was found to be not meeting the regulations in respect of how medicines were managed.

People told us they felt safe at the service and with the staff who supported them. We had concerns that a statutory requirement issued in April 2016 about the operation of the medicines system had not been complied with. We found a significant number of errors with the operation of the medicines system for example medicines being given but not signed for, and medicines being signed for but not given. We were also concerned about whether prescribed creams were being applied as necessary, and whether records of prescribed creams were being suitably kept.

We were concerned whether staffing levels was satisfactory to meet people's needs. Staff were observed as being very busy. This was particularly the case in the mornings when call bells were constantly sounding. We received concerns that people could have to wait up to 20 minutes for call bells to be answered, and this caused some people anxiety. There were some concerns whether people received their meals, or support with eating, due to the staffing available at the service. Some staff members told us meeting people's needs could be difficult, particularly in the mornings, and particularly if there was staff sickness.

Staff recruitment checks were not always completed as required. For example some new staff lacked two written references. One person did not have a Disclosure and Barring Service check, on their file, which is seen as necessary as evidence the person is fit to work with vulnerable adults.

People viewed staff themselves positively. Comments received included staff were "Excellent", and "Very kind." Relatives were also positive about the attitudes of most staff.

The environment was clean and well maintained. Health and safety checks were all completed appropriately, although the upgrading of the service's electrical circuit has been deemed as 'unsatisfactory'. We have been told this matter will be addressed shortly.

The service had suitable policies and procedures in place to ensure new staff received comprehensive

induction, training, supervision and appraisal. However records showed there were gaps in the delivery of this training and support, for example, staff did not receive training to obtain the Care Certificate (A nationally recognised industry standard) within 12 weeks of employment.

People were happy with their meals. For example, comments we received included food was, "Very Good," "Lovely," and "Excellent." The meal time we observed was a pleasant occasion. We did receive some concerns about people not receiving meals, and people not receiving timely and appropriate support with eating.

People said they had access to relevant health professionals. Records showed, the sample of people we assessed, had seen a GP, district nurse, optician and a dentist.

People and their relatives mostly viewed staff as caring. For example, comments we received included, "All nice…I could not want anything better" and "The home is very good." Staff were observed working in a kind, professional and caring manner. People said their privacy and dignity was respected, and they could see visitors when they liked.

We were concerned about how some complaints had been handled. Two complainants told us they were not satisfied how the matters they had raised had been dealt with. CQC has referred these matters, for investigation, to the registered provider. We were concerned that all complaints were not recorded in the service's complaints record. We were also concerned the frequency of complaints had risen since the beginning of 2017, and we have requested a copies of investigations of these complaints due to the concerning nature of the issues raised.

People all had a care plan, these were comprehensive and regularly reviewed.

The service had a comprehensive range of activities. An activities co-ordinator was employed five days a week. Activities on offer included bingo, quizzes, gardening and baking. There were some external entertainers who visited the service. Some trips were organised using the service's minibus.

We were concerned about how the quality of the service was monitored. Although there were comprehensive systems of quality assurance in place, we were concerned about their effectiveness in picking up some of the issues which were readily apparent, and raised by people, with us.

We were concerned that at least one matter which should have been reported to CQC by law was not reported to us. It is important matters such as safeguarding issues are reported to CQC so we can check, as necessary, that suitable action has taken place to ensure people are safe.

Management of the service was generally viewed positively, although some people thought the manager should be more visible. There was a positive culture in the team, and suitable ways for the team to communicate with each other. However some concerns were raised about staff sickness, and that information discussed at shift handovers could be more comprehensive.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Medicines were not suitably administered, managed and stored securely so there was a risk of people not receiving their medicines safely.

There were not satisfactory numbers of suitably qualified staff on duty to keep people safe and meet their needs. Subsequently people did not always receive timely support when it was required.

Staff recruitment processes were not satisfactory and did not provide assurance that staff were fit to work with vulnerable people.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Is the service effective?

Requires Improvement

The service was not effective.

There was not satisfactory evidence that staff received suitable induction when they started work. There were some gaps in the delivery of training. There was not satisfactory evidence staff received regular supervision or annual appraisal.

People's capacity to consent to care and treatment was assessed in line with legislation and guidance. Not all staff were provided with
effective training to provide them with knowledge and skills about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff supported people to maintain a balanced diet appropriate to their dietary needs and preferences.

Is the service caring?

Good

The service was caring.

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

People's privacy was respected. People were encouraged to make choices about how they lived their lives.

Visitors told us they felt welcome and could visit at any time.

Is the service responsive?

Requires Improvement

The service was not responsive.

The service did not have an effective complaints procedure. We were not assured there was a comprehensive record of complaints kept at the service

People received personalised care and support responsive to their changing needs. Care plans were kept up to date.

There were suitable activities available to people who used the service.

Is the service well-led?

Requires Improvement

The service was not well-led.

Systems in place to monitor and improve the quality of the service were not effective.

The Care Quality Commission were not always notified of some incidents required by law.

Pine Trees Care Centre

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.

We visited Pine Trees Care Centre on 1, 2 and 6 February 2017. The inspection was carried out by one inspector. The inspection was unannounced.

Before visiting the service we reviewed information we held about the service such as notification of incidents. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern.

During the inspection we spoke with 16 people who used the service. We spoke with eight relatives and two external professionals (including GP's and other health and social care professionals who visited the service regularly.) We also spoke with the registered manager and five members of staff. We inspected the premises and observed care practices during our visit. We looked at four records which related to people's individual care. We also looked at nine staff files and other records in relation to the running of the service.

Inadequate

Is the service safe?

Our findings

People told us they felt safe. Comments included "Yes I am safe here".

At the inspection in April 2016 we judged the medicines system was not being effectively managed. We had concerns about the satisfactory completion of medicines administration records. For example, some medicines were signed for when the medicine remained in the monitored dosage system. There were other instances where we found medicines appeared to be given but were not signed for. Some people also expressed concern that prescribed creams were not always applied. Records for cream application were not always completed. Before this inspection we were provided with an action plan which stated suitable action had been taken to manage the medicines system.

At this inspection we inspected the medicines system, and medicines records for the period 16 January to 1 February 2017. Medicines were stored in locked cabinets, and trolleys. We checked the records for medicines administered. We found a high number of medicines which were not in blister packs, at least 33 dosages, but had not been signed to state they had been administered. We also found a high number of medicines which had been signed for to state they had been given to people, at least 23 dosages, but the tablets remained in the monitored dosage system. The medicines system operated a coding system, which staff were required to use if medicines were not given. For example, if someone refused their medicine or they were asleep. Some items were coded as 'G- see overleaf' but there was no note overleaf to state why the medicine was not given. This meant it was not clear why people had not received their medicines.

Within one of the medicine cupboards there was medicine cups containing dosages of medicines, a sealed envelope marked "Medication out of controlled cupboard", unlabelled plastic bags containing medicines which had either been found, or unidentified medicines which had not been given for an unknown reason. There were also bags containing medicines identified for specific people who had refused or been unable to take their medicines. In total there were at least 17 dosages of medicines which had been removed from their packaging, and not given. Where these were packaged and dated, most of these medicines were not from the period where records were readily available. This meant they had been in the cupboard for some time. We were able to check one labelled dosage which had not been administered. It was of concern that this had been signed for, as administered, on the current medicines' administration sheet.

We checked medicines which were required to be stored with additional security as they are seen as 'controlled medicines.' These medicines were all stored appropriately, and recorded in a separate bound book as is required by the regulations. They were signed for by two members of staff when administered. We checked that the total number of tablets stored corresponded with the total recorded in the bound book. Totals were correct apart from one item where the total of medicine kept was one less than what was recorded in the book. It was of concern that a new page was not started when the current page was completed, which was the probable reason why the totals did not tally.

We spoke with people about whether prescribed medicated creams were applied, and the people we were able to speak with said staff always did this. However we had concerns about the records kept for creams

prescribed for people's skin. Some of the creams were prescribed to be administered at least once a day, and others were prescribed to be given 'as required' (for example if the person had itchy skin.) The senior carer told us a daily written risk assessment form should be completed, for each person, which determined whether 'as required' creams needed to be applied. A 'Topical Medicines Application Record' (TMAR) was then subsequently completed when creams were applied. These records were kept in a file in people's bedrooms. From assessing both the risk assessments, and the TMAR we concluded risk assessments were not always completed on a daily basis, and there did not appear any documented reason why the TMAR was or was not filled out. There was also no record in people's care files, or in the central medicines records to determine whether creams should be applied or stopped. For example, for one person the TMAR was last completed on 20 January and there was no record anywhere why records had not been completed since this date. The person themselves was unable to communicate with us whether they felt the cream was required.

We were concerned that one person was prescribed to have cream applied, for pain relief, four times a day. However according to the TMAR the cream was not always applied each day, and was only applied, according to the TMAR, a maximum of twice a day. The central medicines' chart was also not signed to state the cream was administered as prescribed.

Creams were not always labelled when they were opened and should subsequently be disposed of. Although there was a record of all creams on forms in people's bedrooms, not all prescribed creams were recorded on centrally stored medicine administration records. The centrally stored medicine administration record only referred to the record in people's bedrooms. There was not a record of all creams in the centrally stored records.

This is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

A satisfactory system was in place to return and/or dispose of medicine. There was no excessive stock in cupboards. Medicines which required refrigeration were appropriately stored, and the temperature of the refrigerator was checked daily. Training records showed staff who administered medicine had received training, although records showed some staff had not fully completed on line training. Staff said they felt competent to carry out the administration of medicines. The pharmacist had checked the system, and their report said its operation was satisfactory.

There were not enough staff on duty to meet people's needs. Rotas showed there were five staff on duty in the morning, at least four staff on duty in the afternoon and evening, and three staff on waking night duty. One of these staff was a senior care assistant who had responsibility for co-ordinating the shift and also administering people their medicines. The rota showed from Monday to Friday there was an activities co-ordinator on duty during the day. In addition, the registered manager worked at the service during the day, from Monday to Friday. There was also an administrator who worked at the service from Monday to Friday. There was a deputy manager in post but this was currently vacant. The service employed other ancillary staff such as catering, housekeeping and maintenance staff.

We found that staffing levels were not able to meet people's needs at all times. We observed staff were constantly busy, without any break, attending to people's personal care needs. In the morning, during each day of the inspection, call bells were constantly sounding, alerting staff that a one or several people needed assistance. Staff seldom were seen in lounges, for example socialising with people, apart from when they had to attend to an individual's care needs or give people a drink. Staff told us it could take all morning to assist people to get up and get dressed. A senior carer told us eight people required two staff to assist them

with moving and handling, and personal care.

At lunchtime, on the first day of the inspection, we observed there were three members of staff to assist approximately 25 people. However these staff were also taking meals, answer call bells, and assisting people with meals in their bedrooms, which at times could leave only one or two staff. Although most people were able to feed themselves, some people did need some assistance. At one point, one person called out to a staff member "Can you sort this table out, this man is getting food everywhere apart from his mouth!"

Senior care assistants said they would help care assistants but this was not always possible due to their other responsibilities and duties such as administering medicines. Some people had severe dementia, physical disabilities or significant physical health problems which resulted in them needing one to one, or two to one (with manual handling) support with personal care, eating and drinking.

People told us staff did their best, were, "Excellent," and "Very kind." People had no complaints about their care or attitudes of staff. However, there were lots of concerns about the ability of staff to answer call bells promptly. For example. one person said they, "Wait a long time, up to 20 minutes," for staff to answer call bells, and "I worry I could be laying on the floor for 20 minutes before someone comes." Another person said staff "Have a lot to do." One person told us that when staff did not answer their call bell, they would telephone the reception desk, using a mobile phone, as this was the only way to get assistance. When asked if there was enough staff people had mixed views such as "Sometimes I wonder if they could do with a few more," although other people said staffing levels were satisfactory. We also received several concerns, including from a visiting professionals and relatives that call bells were not left in people's reach or at times were not plugged in. A staff member told us " We try to respond (to call bells) quickly but it can be difficult sometimes."

One person told us they would receive help to get undressed and go to bed at 6:30pm. The person told us they used to go to bed later but sometimes staff were not coming to assist them until 11pm. The person said they would subsequently rather go to bed early than have to wait until too late. The person said they would just lay in bed as the "TV was at the wrong angle" so they could not watch it in bed. The person told us they would not sleep but "just lay there." Staff would not help them, the next day, to get up until 9am to 10am "which felt like a long time" to be in bed.

Most relatives were complementary about the care staff provided, and staff attitudes, but we did receive some comments that for example, "Staff can be abit thin on the ground, (my relative) can be left waiting for the bathroom."

Staff had mixed views whether staffing levels were satisfactory. One staff member said, "There is a lot of sickness. When everyone is in, it is fine." Another member of staff said: "At the moment some people have high needs…it can be hard work…for example two people need assisting to eat." We were also told, "I would like to be in three places at one time. You can be run off your feet. When people want to get up you can't be everywhere. It can be pretty stressful…I wish there could be one or two more people on sometimes. Especially in the mornings." Lastly another member of staff said, "We are told five (staff) is enough but if managers did the shift they would know it was not. Some people are 'doubles' (needing two members of staff to help them), and the senior does the medication (and may not be around to help till lunch)."

Professionals told us, "They do their best (with the staffing levels) with what they have got," and "They do not have enough staff for the residents here…staffing levels are much to be desired." One professional alleged that, "One person was left waiting on the toilet for three hours," and "With more staff it would make a huge difference."

The registered manager completed a monthly assessment of the needs of people in the service. A staffing dependency tool calculated the staffing required for the service based upon these needs. Completed assessments showed the current staffing levels were satisfactory based upon the dependency tool used. However, based upon our observations, and the views of the various people we spoke with, we did not think staffing levels were satisfactory for the number of people accommodated, the range of needs which people had, and in terms of staff being able to respond to people in a timely manner.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

We were concerned about recruitment checks completed particularly for staff who had commenced employment in the last year. These did not always demonstrate that people employed had satisfactory skills and knowledge needed to care for people, or could be judged as safe to work with vulnerable people.

We inspected files for nine members of staff, all of whom had commenced employment since 2014, including six of whom had commenced employment at the service in 2016. Two of this group had no application forms on their file. Two people's forms were very poorly completed with limited information for manager's to assess the person's suitability and work history. One person had no references on their file, and another person only had one reference. One person had no Disclosure and Barring Service (DBS) check. Five people had no record of any orientation / induction when they commenced employment.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

The service had a satisfactory safeguarding adult's policy. The majority of staff had received training in safeguarding adults. Staff demonstrated they understood how to safeguard people against abuse. Staff told us they thought any allegations they reported would be fully investigated and satisfactory action taken to ensure people were safe. The registered manager informed us, during the feedback of the inspection, that they had made a safeguarding referral about a medicines error. CQC had no record of being informed of this, and should have been through our formal notifications procedure.

Risk assessments were in place for each person. For example, to prevent poor nutrition and hydration, skin integrity, falls and pressure sores. Risk assessments were reviewed monthly and updated as necessary, although we did have concerns about the use of risk assessments about applying skin creams as outlined above. From our observations, people were provided with safe moving and handling support where this was necessary. We did however receive one complaint about how one person was provided with moving and handling support, from the person and their relative, and this was referred by us to the registered provider. Staff said they had received training about moving and handling, and we were able to check this was the case from the records we inspected.

Incidents and accidents were recorded in people's records. These events were audited by the registered manager to identify any patterns or trends which could be addressed. Where necessary, action was taken to reduce any apparent risks.

The service kept monies on behalf of some people. This was for when people needed to purchase items such as toiletries and hairdressing. Suitable records were kept, and receipts were obtained for expenditure. We checked monies kept, and cash tallied with the totals recorded in records. Where necessary the registered manager said she would provide families with receipts and invoices for any expenditure. Staff within the organisation did not act as appointees for people's finances or Department of Work and

Pensions' benefits.

The environment was clean and well maintained. Appropriate cleaning schedules were used. Hand gel was available to assist in minimising the risk of cross infection. Staff wore uniforms and had aprons available to them to assist in preventing cross infection. The service was warm, and had sufficient light.

We were told the laundry service was efficient. We saw there were appropriate systems in place to deal with heavily soiled laundry. There were no offensive odours.

The boiler, gas appliances and water supply had been tested to ensure they were safe to use. Portable electrical appliances had been tested and were safe. A current gas safety certificate was in place. The electrical circuit had been tested and was deemed as 'unsatisfactory'. The registered manager told us the registered provider was arranging appropriate remedial action to shortly be completed. Records showed manual handling equipment had been serviced. There was a risk assessment to minimise the risk of Legionnaires' disease, and systems were in place to take action to minimise the risks identified. There was a system of health and safety risk assessment in place. There were smoke detectors and fire extinguishers on each floor. Fire alarms, emergency lighting and fire extinguishers were checked by staff, the fire authority and external contractors, to ensure they worked.

Requires Improvement

Is the service effective?

Our findings

The staff we spoke with said they had received an induction to introduce them to their role. The staff we spoke with said when they started to work at the service a senior member of staff spent time with them to explain people's needs, the organisation's ways of working, and policies and procedures. New staff also worked alongside more experienced staff before being expected to complete shifts unsupervised.

The registered manager said she was aware of the need for staff, who were new to the care industry, to undertake the Care Certificate. The Care Certificate is an identified set of national standards that health and social care workers should follow when starting work in care. The Care Certificate ensures all care staff have the same introductory skills, knowledge and behaviours to provide necessary care and support.

There were limited records available to confirm what induction new staff had received. Of the nine files assessed, there was an orientation checklist for four staff members. However, for the other five staff there was no list on staff files confirming they had received an initial orientation at the service, when shadow shifts had been completed, and when basic instruction had been given about policies and procedures, people's needs and so on. One member of staff told us, "The maintenance man showed me around and showed me the fire system, I completed 13 modules of on line training, and did at least three shadow shifts." We did see an induction portfolio for one member of staff, but this was incomplete, and portfolios were not available for other staff whose files we assessed. The registered manager said the portfolios were either with the staff members, or yet to be completed. We were told four staff had completed the Care Certificate. One of the seniors told us they had recently attended training so they could deliver training about the Care Certificate to new staff. We were told some of the staff who commenced employment since 2016 still needed to complete this, even though some of them had not worked in the care sector previously. Four of these staff had recently been allocated to start completion of this training. However, these staff had all worked at the service for a significantly longer period than the 12 weeks, from the date of employment, when the Care Certificate should be completed by.

We checked training records to see if staff had received appropriate training to carry out their jobs. There were no training certificates on staff files to confirm they had received training. Confirmation staff had received training was only available through data entry on the organisation's computer system. The majority of training staff received was via computer based training, although practical face to face training was received for manual handling, first aid, and medicines management. Records showed that staff had all received training about dementia awareness, fire awareness and first aid. The majority of staff had received up to date training in manual handling, health and safety, infection control, knowledge of the Mental Capacity Act, safeguarding, the administration of medicines, and food handling. The records we were presented with showed a minority of staff had not completed these courses, or required an update in training. The majority of staff also had completed a diploma or a National Vocational Qualification (NVQ's) in care.

Staff told us they felt supported in their roles by colleagues and senior staff. For example, staff said they could go to a senior member of staff or a manager if they needed assistance with a problem. However, there

were records of supervision for only one of the nine people for whom we assessed staff files. The staff we spoke with said the registered manager. "Had an open door" and they could speak with her when they needed to. However, we were told, "I have not had any supervision since I started but I can approach senior staff and they will help," and "I have had nothing since last April but I can approach (the manager) as necessary." We did not see any evidence staff had received an appraisal.

Deficiencies in induction, training and supervision are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

People told us they did not feel restricted. However, due to some people having dementia, and the high level of vulnerability of everyone, the front door was locked for security reasons and to maintain people's safety. People could however leave the home if they knew the code to the key pad. People told us they felt there were no restrictions imposed upon them living at the service. People said they felt involved in making choices about how they wanted to live their lives and spend their time. For example, people told us staff involved them in decisions about how their personal care was given and they were able to choose when they got up and went to bed.

People's capacity to consent to care and treatment was assessed in line with legislation and guidance. 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 people lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

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.

The registered manager said, where necessary, applications had been submitted to the local authority to assess people who may lack mental capacity to make decisions for themselves. Within some people's files there was an assessment of the individual's mental capacity, but this assessment was not on every person's file. Where an application to deprive someone of their liberty, under the Mental Capacity Act, had been submitted, or a Deprivation of Liberty Safeguard had been granted these were on people's files. The staff we spoke with had varying knowledge of the legislation. One member of staff we spoke with had no understanding of the act, although information we were provided with said they had received training on this matter in 2016.

People were happy with their meals. People told us food was, "Very good," "Lovely," "Nice" and "Excellent." At lunchtime we observed that everybody had enough to eat and drink. We were told a member of staff would walk around each morning and speak with people to ask them what they wanted to eat for lunch and supper. People were regularly offered cups of tea, coffee or a cold drink.

We observed the lunch time on the first day of the inspection. Meals were brought to people by table so people would eat their meals together, and people were not kept waiting too long for food to arrive. Most people sitting in the dining room did not require assistance. We were concerned about one incident, as outlined earlier in the report, where one person had to summon staff to assist another person who could not appropriately support themselves. Although support was then provided, the member of staff stood, rather

than sat with the person, to assist them to eat, and there was very limited verbal communication with the person throughout the time when they were assisted. Support for other people varied as there could be between one and three staff in the dining room, for about 25 people, due to staff having to leave the room to attend to other people throughout the service. People were however given suitable support to and from the dining room. If people said they did not want what was ordered they were offered a range of alternatives to encourage them to eat something. Tables had table cloths and people were provided with condiments such as salt, pepper and vinegar. People were provided with a cold drink with their meal and a cup of tea or coffee after their meal. However, people were provided with tea cups with no saucers which looked a bit shoddy.

Some people who were very vulnerable due to their age and illness needed to have what they ate and drank monitored to prevent the risk of malnutrition and dehydration. These people had up to date and accurate risk assessments about these risks in their care files. Fluid and food charts appeared to be regularly completed.

One relative expressed a concern that meals were sometimes not delivered to a person's bedroom, and the person would subsequently not have anything to eat. We were also told the person was not provided with specialist cutlery and crockery which made it difficult for the person to eat. We were told the person did not receive appropriate help to cut food, and on one occasion this had resulted in food slipping on to the person's body and burning them. We have referred this matter to the registered provider for investigation and asked them to feed back about their findings, report to adult safeguarding as necessary, and take any other suitable action.

People told us they could see a GP if requested. We were also told that other medical practitioners such as a chiropodist, dentist or an optician visited the service. Records about medical consultations showed that people saw, where appropriate, GP's, and district nurses regularly. There were records when people saw an optician and dentist.

We were able to speak with two district nurses, on two separate occasions, about the care received at the service. They both had concerns about care. Both nurses told us staff needed to be regularly reminded about ensuring pressure relieving mattresses being kept at the correct pressure and ensuring vulnerable skin areas were kept clean and dry. We were told there had been some instances where pressure relieving equipment had not been used when it had been prescribed. One of the nurses said care records, for example about the application of medicated creams, were often not up to date. One of the nurses said she had found call bells left unplugged. One nurse said there had been concerns about the numbers of people with redness on their skin, and people with pressure areas, but this had "Reduced a lot."

The home had appropriate aids and adaptations for people with physical disabilities such as bath chairs to assist people in and out of the bath, a specialist bath, and a walk in shower. All accommodation was on one floor which made it easier for people to move around the building. The home's environment was maintained to a good standard. All areas were well decorated, with clean and comfortable furnishings and fittings. The home was clean and tidy, and there were no offensive odours. One relative described the service as "Warm, comfortable with lots of space." The call bell had a very loud siren situated over the door of one person's bedroom. It was also situated in the main lounge. This must have been very unpleasant for the bedroom occupant, and also for people in the lounge particularly in the mornings when the call bell was constantly ringing, and the activities co-ordinator was facilitating group activities. We have previously raised this matter but no action has been taken. People said they liked their bedrooms and found the service warm and comfortable

Good

Is the service caring?

Our findings

People and their relatives were mostly positive about the care people received from staff. People told us "I am happy enough here," "All nice..oh yes I could not want anything better," and "It is absolutely fine, anything I want I ask for. I am very happy here." Relatives told us "The home is very good," "Care is excellent," "My relative is fitter here than when they were at home," and "Nothing is too much trouble." Members of staff described care as for example "Ideal,"

We observed staff working in a kind, professional and caring manner. Staff were however constantly very busy and there appeared very little time for staff to sit and spend any time with people. There was however an activities coordinator who worked 6 hours per day, Monday to Friday. They provided people who spent their time in the lounge with a central focus, and also helped people to have drinks and attend to other smaller care needs. The staff we saw were judged to be patient, calm, and did not rush people. People were generally very positive about the support they received from care staff. For example one person said "I do not have a single word to say about them. All have been fantastic to me." Staff provided personal care discreetly. The people we met were all well dressed and looked well cared for. People's bedroom doors were always shut when care was being provided.

Care plans we inspected contained enough detailed information so staff were able to understand people's needs, likes and dislikes. There was a 'life story book' document in the majority of people's files with information about people's background, and life before to moving into the home. This information is useful to staff to help to get to know the person when they move into the home. The registered manager said where possible care plans were completed and explained to, people and their representatives.

People said their privacy was respected. For example, we were told staff always knocked on their doors before entering. To help people feel at home their bedrooms had been personalised with their own belongings, such as furniture, photographs and ornaments. The people we were able to speak with all said they found their bedrooms warm and comfortable.

Family members told us they were made welcome and could visit at any time for example we were told "I visit day or night it is never a problem." People could go to their bedrooms, and also to one of the lounges, or dining room, if they wanted to meet with visitors.

Requires Improvement

Is the service responsive?

Our findings

People said if they had any concerns or complaints they would feel confident discussing these with staff members or management, or they would ask their relative to resolve the problem. People said they felt confident appropriate action would be taken if they raised a concern.

The registered manager kept a record of complaints. This included the complaint, and what action had been taken to resolve the matter. We were concerned there had been a high number of complaints raised since January 2017. In 2016 there were seven recorded complaints, but since the beginning of January 2017 there had already been four complaints all of which were about significant matters. These included multiple concerns about issues such as poor pressure sore care, poor catheter management, beds not being made until the afternoon, call bells not being plugged in and people not receiving meals in a timely manner. As a consequence CQC has requested the registered manager to provide us with details of the investigations and what action will be taken about the matters raised since the beginning of the year.

We also received two sets of concerns, from two different relatives, who both said they were not satisfied that their concerns had been satisfactorily resolved when they had made a complaint. As a consequence we have referred these matters to a senior manager within the company and have asked these matters to be investigated. It was of concern there did not appear to be a record of either of the complaints, in the complaints record, which was kept by the registered manager.

Not having an effective complaints procedure and full record of complaints made is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

The majority of people and their relatives were positive about the care they received from staff and we observed staff acting in a kind and considerate manner. For example people told us "It is first class," "I like it here it is lovely," and "It is much better here than at the previous home I was at." A relative told us "It is an excellent home, a very friendly home."

Before moving into the home the registered manager told us she went out to assess people to check the service could meet the person's needs. People, and/or their relatives, were also able to visit the service before admission. Copies of pre admission assessments on people's files were comprehensive and helped staff to develop a care plan for the person.

Each person had a care plan. Care plans contained appropriate information to help staff provide the person with individual care. Care plans also contained appropriate assessments for example about the person's abilities in regard to eating and drinking, going to toilet, mobility and falls, personal hygiene, medicines, sleeping and so on. Subsequently care plans were developed where people needed assistance in these areas. There was a record that care plans had been reviewed in January 2017. Care plans were updated to show any changes in the person's needs. Care plans were stored securely but were accessible to staff members. All staff we spoke with were aware of each individual's care plan, and told us they could read care files at any time.

The service arranged organised activities for people. Activities were organised by an Activities Co-ordinator who worked at the service for six hours a day Monday to Friday. The majority of activities took place in the lounge or the dining room. We saw people participating in quizzes, singing, a baking session, and a bingo session. For the bingo session the activities organiser ensured there was a range of prizes for people, and people said they liked the opportunity to win something. Records showed other activities which took place included art, knitting, gardening and celebration of cultural events such as Burns Night and Pancake Day. There were also external entertainers and visitors such as singers and musicians, pet therapy and people from the local chapel who read Bible stories. There was also some trips out in the service's minibus for example to coastal resorts. The Activities Co-ordinator also said he would see those people in their bedrooms who did not join in with group activities.

Requires Improvement

Is the service well-led?

Our findings

The registered manager monitored the quality of the service by completing regular audits of for example care plans, staffing, medicines, infection control, health and safety, and meals and nutrition. We were told a survey of relatives to find out their views was to be completed shortly. We asked for a copy of the results of the previous relative's survey but were told this had not been provided to the service. We have requested this be sent to CQC following this inspection. We were concerned that although the system of audit seemed comprehensive it was not effective. For example, the last three medicines audits completed by the registered manager in August and September 2016, and on 27 January 2017 picked up similar concerns about medicine errors as we have outlined earlier in the report. However, based upon our inspection no satisfactory action has been taken to ensure such errors are not regularly and repeatedly occurring. Similarly although dependency level audits were completed and these determined staffing levels, these audits were not effective at preventing the concerns readily raised with us and documented in this report. The registered manager said the area manager visited the service regularly. Part of the visit was to check standards at the service. We asked for copies of any reports of these visits, but the registered manager said they were not available. CQC requested that copies of the area manager's reports were sent to us after the inspection.

Not having an effective quality assurance system is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

The registered manager was registered with the CQC in 2013. We were concerned that CQC were not notified of at least one incident, outlined in the 'Safe' section of this report, which was also required to be reported to CQC. To our knowledge the registered persons have ensured other CQC registration requirements, including the submission of other notifications, such as deaths, have been complied with.

Not notifying CQC of appropriate matters is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People and staff had confidence in the registered persons (owners and manager of the service.) Comments received about the management included: "They are approachable," "Will sit and listen," "Has an open door" "Very good, very pleasant and helpful." and "The manager is lovely." Some concerns however were expressed about the effectiveness of management by some relatives. "Management do as they please….they do not see people very often…We are promised things will change but they do not." "It would be nice to see the manager spend some time with residents, she will say hello and deal with problems but it would be nice to see her out of the office."

Relatives were generally positive about the culture of the service. Comments received included: "I have no concerns, fears, and worries. Staff are very respectful."

Staff were positive about the culture of the team. Comments received included "(Staff) practice is all good. Some staff definitely care a lot." However staff also told us "Sickness of staff lets things down, and brings us down as a team," and "A couple of carers 'don't care' but otherwise it is a lovely team." None of the staff we

spoke with had ever witnessed any poor practice, and all said if they had they were confident this would be immediately addressed by management. Staff told us that if they had any minor concerns they felt confident addressing these with their colleagues. They said major concerns were addressed appropriately by the registered manager.

The registered manager worked in the service full time. The registered manager said she was on call when she was not at the service. We were concerned that one of the senior carers, (who was in charge of the service as the registered manager was on annual leave) did not know who they could contact in an emergency. We were told staff would either contact the emergency services, or another senior member of staff who worked at the care home, even if they were on annual leave. It was only after some assistance we were told the area manager or the head office could be contacted.

Several relatives confirmed communication between staff and families was good, and they were informed of any concerns staff had about people's health and welfare.

There were formal handovers between shifts although one member of staff said "These could be more detailed. It is important to know if someone was ill or had a fall as these will have knock on effects on people's care." Another member of staff said "Night staff need to tell us who needs to have breakfast and at handover we need to decide who (staff members) is going to do what."

There were records that there were meetings held for the staff group, senior staff and kitchen staff. In 2016 we saw copies of four staff meetings, and two meetings for kitchen staff. We saw the minutes of one senior carers meeting which was held in January 2017. We were told residents meetings occurred, but we were not provided with minutes of any meetings. CQC requested that copies of residents meetings be sent to us after the inspection.

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 18 Registration Regulations 2009 Notifications of other incidents The registered persons were not always notifying the Care Quality Commission of matters which they are legally required to.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The complaints procedure, and processes in place for recording concerns and complaints was not effective. This meant people and their representatives were at risk of not having their concerns and complaints satisfactorily resolved.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not have an effective system of audit and quality assurance. This meant that people were at risk of receiving a service which was of unsatisfactory quality, and an inability to satisfactorily self assess and improve itself without external oversight.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment checks were not satisfactory. This put people at risk because staff who worked

with them were not robustly checked which may mean that they were not suitable to work with vulnerable people.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The medicines system is not well managed. This puts people who use the service at risk of not receiving their medicines, and their medicines not being looked after safely.

The enforcement action we took:

CQC issued the registered persons with a Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were insufficient. This put people at risk of inappropriate care Procedures in place to induct, train, supervise and appraise staff were not satisfactory. This put people at risk of being cared for by staff who did not have the knowledge, skills, support and guidance to carry out their roles.

The enforcement action we took:

CQC issued the registered persons with a warning notice