Prime Care (GB) Ltd

Leyland Rest Home

Inspection report

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Ratings

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

Overall summary

This unannounced inspection of Leyland Rest Home took place on 10 March 2015.

Leyland Rest Home was inspected on 2 September 2014 and found to be in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The breach of Regulation 10 related to inadequate processes to seek the views of people living at the home and the views of their families regarding changes to the service. In addition, managerial roles and responsibilities were not clear which was impacting on the decisions making arrangements. The Care Quality Commission (CQC) received an action plan from the provider to outline how improvements would be made. Satisfactory improvements had been made with respect to this breach.

Located close to Southport promenade and the town centre, Leyland Rest Home provides accommodation and care for up to 33 people. The building is a large Victorian house with gardens to the front and back. The home has three lounge areas, a dining room and lift access to all floors. Twenty seven people were living there at the time of the inspection.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality

Summary of findings

Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found the staffing levels were inadequate to ensure people's safety was maintained at all times. Three care staff were on duty during the day to provide care for people over three floors. Four people had high dependency needs and often required the support of two staff. Dependency assessments had been completed for each person to support with deciding on staffing levels but the assessments we looked at had not been reviewed since June 2014 so they may not have reflected people's current needs. You can see what action we told the provider to take at the back of the full version of this report.

People's individual risk assessments had not been reviewed in a timely way to take account of any new risks or incidents that had occurred. Risk assessments and associated care plans had not been completed for new people who had recently moved into the home. You can see what action we told the provider to take at the back of the full version of this report.

Not all staff were clear about what adult safeguarding meant. Less than half the staff team were up-to-date with adult safeguarding training. Frequent altercations between people living at the home were not being treated as, or reported as, a safeguarding concern. The safeguarding policy for the home was inaccurate as it made reference to staff using physical restraint. Staff confirmed they had not used physical restraint and were not trained in its use. You can see what action we told the provider to take at the back of the full version of this report.

Not all medicines were stored in a safe way. We observed prescribed topical medicines (creams) in people's bedrooms were not stored securely. A risk assessment had not taken place to confirm a person was able and safe to manage their own medicines. There were a number of missing staff signatures on medication administration records. The medication policy was last reviewed in May 2009 and was not in accordance with good practice national guidance for managing medicines in care homes. You can see what action we told the provider to take at the back of the full version of this report.

Safe and effective recruitment practices were in place. Staff training was not up-to-date and staff told us they had not received regular supervision and an annual appraisal. You can see what action we told the provider to take at the back of the full version of this report.

We found that areas of the home, including bedrooms and bathrooms, were unclean and unhygienic. For example, we observed black mould on bathroom tiles and taps despite the room having recently been prepared for a new person to move in. Wheelchairs and other equipment were dirty. Furniture in shared areas was unclean and upholstery was torn. You can see what action we told the provider to take at the back of the full version of this report.

Arrangements to check the risk associated with the equipment used, such as hoists and wheelchairs were not robust. For example, wheelchair risk assessments were unchanged since 2008. You can see what action we told the provider to take at the back of the full version of this report.

Arrangements to monitor the safety of the environment were not rigorous. For example, many areas of the building, including people's bedrooms were in a poor state of repair. The wallpaper and or paint were peeling from walls in some rooms. Not all of the hot water pipes in areas accessed by people living at the home were insulated. Some of the carpets had an unpleasant odour. Lighting was insufficient in some areas. You can see what action we told the provider to take at the back of the full version of this report.

People had access to health care when they needed it, including their GP, dentist, optician and chiropodist. A visiting healthcare professional told us staff responded promptly to people's changing health care needs.

The staff we spoke with had not received awareness training in relation to the Mental Capacity Act (2005) and had a limited understanding of how it applied in practice. Nobody living at the home was subject to a Deprivation of Liberty Safeguarding (DoLS) plan. Some people used

Summary of findings

bedrails and there was no record to indicate how people consented to the use of this equipment. We made a recommendation regarding consent and the Mental Capacity Act (2005).

Overall, people were satisfied with the meals and access to drinks. The dining room was not well staffed at lunch time so there was limited support to encourage people to eat and to monitor what people had actually eaten. We made a recommendation about this.

Staff were caring and kind in the way they supported people. They treated people with compassion and respect. They ensured people's privacy when supporting them with personal care activities. People had been given the opportunity to express their preferred gender of staff to provide support. People and/or their representative were not routinely involved in on-going care plan reviews.

Assessments and person centred plans had not been completed for people who recently moved into the home. We found that staff had a limited knowledge of the backgrounds and needs of the new people. You can see what action we told the provider to take at the back of the full version of this report.

A complaints procedure was in place and displayed. People we spoke with and families were aware of how to raise concerns. The complaints process was not being used appropriately by staff. For example, some incidents and grievances were recorded as complaints. A complaint a visiting family member told us they made that had been dealt with effectively had not been recorded. We made a recommendation about this.

A system to audit the care records had been developed and each of the care records were being audited three monthly. Meetings were being held at the home for people living there to express their views about service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not always managed in a safe way.

Staffing levels were inadequate to ensure the safety of the people living at the home.

Arrangements to ensure people were safeguarded against the risk of abuse were not robust.

Effective arrangements were in place for the recruitment of staff.

We identified risks associated with the safety of the environment and equipment.

Appropriate standards of cleanliness were not being maintained.

Is the service effective?

Requires Improvement

The service was not always effective.

People had access to health care when they needed it, including their GP, dentist, optician and chiropodist. A visiting healthcare professional told us staff responded promptly to people's changing health care needs.

Staff we spoke with were not receiving regular supervision and their training was not up-to-date.

People were satisfied with the meals .There was insufficient staff support at lunch time to ensure people received support with their meal and had adequate to eat and drink.

Although staff sought consent from people before providing care, they were unclear about principles of the Mental Capacity Act (2005) and how it applied to their practice.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were caring and kind in the way they supported people. They treated people with dignity and respect. They ensured people's privacy when providing support with personal care activities.

People living at the home or their representative were not routinely involved in care plan reviews.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Summary of findings

Person centred plans were in place for people who had lived at the home for some time. They had not been developed for people who recently moved into the home.

Staff were unsure of the needs and background of people who had recently moved in.

Recreational activities were not taking place in line with the planned programme.

A complaints process was in place. A visiting family member told us about a complaint they had made that had been resolved to their satisfaction.

Is the service well-led?

Requires Improvement 

The service was not always well-led.

A Provider Information Return (PIR) had not been submitted even though CQC had requested this in November 2014.

Meetings for people living at the home had been put in place to seek the views of people about the service.

A range of audits were in place but these were not always robust or effective in driving improvements.

Leyland Rest Home

Detailed findings

Background to this inspection

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

This unannounced inspection of Leyland Rest Home took place on 10 March 2015.

The inspection team consisted of an adult social care inspector, a specialist advisor in health and safety and an expert by experience with expertise in services for older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home. A Provider Information Return (PIR) had been requested for the home in November 2014 but the Care Quality Commission (CQC) had not received it. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We looked at the notifications and other information the Care Quality Commission had received about the service. We contacted the commissioners of the service, the local environmental health team and the local infection prevention and control team to see if they had any updates about the service.

During the inspection we spent time with seven people who lived at the home and two family members who were visiting their relatives living at the home at the time of our inspection. We spoke with a visiting health care professional. We also spoke with the provider (owner), a senior member of staff, the maintenance person, the housekeeper, three care staff and the chef.

We looked at the care records for five people living at the home, three staff recruitment files and records relevant to the quality monitoring of the service. We looked round all areas of the home, including people's bedrooms, bathrooms, dining rooms and lounge areas.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at the home. A person told us, "I feel safe because I don't have to ring my daughter in the night." Another person said, "I don't know why but I just feel safe." One of the people said they felt safe because people could not enter the building without staff letting them in.

Equally, families who were visiting at the time of our inspection felt the home was a safe place for their relative to live. A family member said, "There tends to be someone [staff] around all the time. If she [their relative] was to go downstairs they would go with her. They even offered to help me with the wheelchair when I took her out." A family member told us they would speak with the manager if they had concerns about their relative's safety.

We asked people about the staffing levels and the feedback we got was mixed. People who were more independent thought there were enough staff and people who were more dependent on staff to meet their needs said there was not enough staff. One person said, "Most days [there are enough staff] but some days they might be short." Another person told us, "I think there are [enough staff]. They [staff] answer the bell pretty quickly." Yet another person said, "There are plenty of staff but my needs aren't great." Family members told us they thought there were enough staff on duty each day.

There were mixed views amongst the staff we spoke with regarding the staffing levels. Some thought there were enough staff. Others said more staff were needed in the morning as that was the busiest time. Three care staff were on duty in the morning to provide support across three floors to the 27 people who were living at the home at the time of our inspection. Staff told us that four people had high dependency needs and often required the support of two staff with personal care. One of these people was living at the home on a temporary basis (respite care). Staff told us that four people needed one-to-one support with their meals and two people needed to use a hoist to move. Although a programme of activities was displayed, care staff said they rarely had time to facilitate activities because they were busy.

Dependency assessments had been completed for people. These assessments are often used to make an informed decision to decide staffing levels. The care records we looked at showed the dependency assessments were last reviewed in June 2014. People's needs may have changed in the eight months since the last review, which meant the assessments we looked at may not have reflected people's current needs.

We spoke with a health care professional who was visiting the home at the time of our inspection. They told us the ground floor has on occasions been unsupervised by staff. They told us they often had to wait to leave the building as staff were not around. They said they once had to press the emergency bell because of the length of time they had been waiting to get out of the building. This meant people were in the shared areas on the ground floor unsupervised, which placed them at risk.

Not having sufficient numbers of suitably qualified staff at all times was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care records informed us that risk assessments had been completed for people living at the home. The frequency of when these assessments were reviewed was variable. Some had been reviewed each month and took account of any new risks or incidents that had occurred. However, a serious incident occurred for one person in February 2015 yet the most recently recorded review of the person's risk assessment was in July 2014. Staff were unable to locate a completed accident form regarding this incident. Furthermore, a person admitted to the home in January 2015 had displayed assaultive behaviour towards staff and other people living there. No risk assessment or associated care plan had been completed in order to guide staff in how to manage this behaviour. Some people used bedrails which can present a risk of entrapment. Care records for a person showed that a bedrail risk assessment was undertaken in June 2013 and was last reviewed in July 2014. This meant any changes to the person's risks in relation to the use of bedrails had not been reviewed for the last seven months.

Not taking proper steps to ensure people were protected against the risks of receiving unsafe care was a breach of Regulation 9(1)(a)(b)(ii) of the Health and Social Care Act

Is the service safe?

2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 12(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We explored with staff their understanding of adult safeguarding. The responses were mixed. Some staff had a good understanding and said they would raise any concerns with the manager. One member of staff said they if they got an unsatisfactory response from the manager they would contact the police or the Care Quality Commission. Other staff thought safeguarding was just about arguments between people living at the home, which they said they would report to the manager. The training matrix (monitoring record) we were provided with showed that more than half the staff team required training in adult safeguarding.

We looked at the adult safeguarding policy for the home. Some of the content was inaccurate. For example, the policy stated, 'There may be occasions when care staff need to restrain physically the behaviour of someone who poses a risk to their own safety and the safety of others.' Staff confirmed restraint had not been used at the home. None of the staff were trained in the use of restraint. We noted that staff, including recently recruited staff, had signed to say they had read this policy.

Staff told us that some of the people living at home did not get along very well. We overheard two altercations between people during the inspection, one of which involved a physical assault. Staff told us these altercations were regular occurrences. They were not considered a safeguarding matter as staff did not think they needed to be reported under local safeguarding arrangements. We observed an incident report dated 7 January 2015 that detailed a physical altercation between two people. This had not been treated as an adult safeguarding concern when it should have been in accordance with local safeguarding procedures.

Not making suitable arrangements to ensure people were safeguarded against the risk of abuse was a breach of Regulation 11(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A member of staff provided us with an overview of how medicines were managed within the home. The medication was held in a locked trolley in a dedicated lockable room. We looked at the medication administration records (MAR) currently in use and noted a large number of missing signatures where staff had failed to sign to say they had administered medication to people. A member of staff advised us that medication errors happen but they are not recorded as incidents. Rather, staff were asked to come in and correct their errors. This meant the extent and nature of medication errors at the home was not being monitored or analysed in order to identify themes and patterns.

Some people's photographs were missing from the MAR sheets. We noted a medicines audit in November 2014 and a further audit in January 2015 identified this issue and each audit provided a date that the photographs should be put in place by. This has not happened.

Medication requiring cold storage was kept in a dedicated medication fridge. At the time of the inspection there were no medicines in use that required refrigeration.

Facilities were in place for the safe management of controlled drugs. At the time of the inspection only one person living at the home was prescribed a controlled drug. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs legislation.

We observed prescribed creams for topical use in people's bedrooms. These had not been stored safely in each person's bedroom so could be accessed by anyone who walked into the room. A medication audit in June 2014 identified this issue and advised staff that topical creams should not be left out on show in people's bedrooms. We noted that prescribed fortified drinks were inappropriately stored on the floor in the medication room.

A person who recently moved into the home was managing and administering their own medicines. A risk assessment and care plan were not in place to ensure the person was fully supported and any risks identified and minimized.

We looked at the home's medication policy. It was last reviewed in May 2009 and made reference to regulatory organisations no longer in existence. The policy did not capture all the guidance outlined in the NICE guidance for managing medicines in care homes, including guidance on reporting errors, medication reviews and staff training. NICE (National Institute for Health and Care Excellence) provides national guidance and advice to improve health and social care.

Inadequate

Is the service safe?

We looked at the monthly medication audits since June 2014. We noted that the August and December audits were not available and staff were unable to confirm whether they had been completed.

Not ensuring effective safeguards were in place for the safe management of medicines was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 12(f) & (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the personnel files for three recently recruited members of staff. We could see that all recruitment checks had been carried out to confirm the staff were suitable to work with vulnerable adults. Two references had been obtained for each member of staff.

We had a detailed look at all areas of the building and some rooms, including occupied bedrooms. We found the home environment to be in a poor state of repair. In some areas wallpaper and or paint was peeling. The access/exit ramp was not in good condition. Some rooms smelt strongly of urine. We identified numerous environmental risks and concerns with equipment. For example, many chairs in the lounge were in a poor state and the chair coverings were torn. Hot water pipes were not insulated in some areas, including bedrooms and bathrooms. Carpets were in a poor condition and very odorous. There were no thermometers in the bathrooms to check the water temperature prior to a person living at the home having a bath. Lighting was insufficient in some areas of the building. In other rooms, we found bare light bulbs with no shades in place. Two people were receiving oxygen in their bedrooms. We found the signage for oxygen was insufficient as there was no hazard warning sign. There was no guidance in place regarding the use and storage of oxygen in the bedrooms.

The repairs around a door frame had not been well completed and were a potential risk for splinters. The provider advised us that no refurbishment plan was in place but that it would be completed by the maintenance person shortly.

Arrangements to regularly assess the safety of the environment were not rigorous. Health and safety audits were identified for completion each month but the most recent audit we were provided with was completed in July 2014. After the inspection management confirmed that the last audit was undertaken in February 2015 but we were not provided with this during the inspection. A falls risk assessment was in place but it was the same risk assessment, identifying the same environmental hazards, since 2009. It did not identify risks we found, such as a lack of grab rails, loose fitting carpets, uneven flooring and narrow stairwells. A risk assessment was in place for the passenger lift but again we found the content of the assessment had not changed since 2009. The assessment did not take into account what to do in an emergency and failure of the lift when someone was in it. The lift was small and the assessment did not make reference as to how people who used wheelchairs should safely access and egress the lift. Some rooms were very hot with no temperature control. For example, the one of the windows in a bedroom on the ground floor could not be opened which reduced ventilation in the room. A person in another bedroom complained to us that the room was not well ventilated and was extremely hot in the summer.

Some of the bedrooms were not suitable to the needs of the people who were accommodated in them. For example, a person who recently moved into the home had a narrow en-suite toilet. The light switch was located half way into the toilet which meant the person the person could not switch on the light before entering the room. Because of the narrow space and the person's mobility needs, they had to reverse into the toilet. The location of the light switch and the person entering the toilet backwards meant they were at risk to falling, particularly in the dark at night.

The fire risk assessment for people living at the home was dated March 2012. One of the staff confirmed that the assessment was not up-to-date as some people were no longer living at the home. We asked a number of staff how many people were currently living at the home and we received various answers before it was confirmed 27 people were living there. It was concerning that staff did not know the correct number of people should the building need to be evacuated in the event of a fire.

Weekly checks were carried out for emergency lighting, fire equipment and exit routes. The evidence we were provided with showed that monthly smoke detector checks had not been completed since June 2011. A fire policy was in place and up-to-date but we observed there were a number of different fire policies in circulation and an out-of-date fire policy was displayed in the back lounge.

Inadequate

Is the service safe?

Not protecting people against the risks associated with the environment was a breach of Regulation 15(1)(c)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 12(1)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Arrangements to regularly assess the risks associated with equipment used at the home were not robust. For example, the content of the risk assessments for the hoists had not changed since 2010. The assessments did not take account of the different hoist slings, the weight of people and the support required. Wheelchair risk assessments were unchanged since June 2008. The assessment did not identify the checks that should take place to ensure wheelchairs were safe. Although records informed us wheelchairs were last checked in December 2014, they were very dirty and it was evident they had not been cleaned for some time. The fridges and freezer were old and rusting.

Not protecting people against the risks associated with the use of unsafe equipment was a breach of Regulation 16 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 12(1)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two housekeeping staff were employed at the home providing seven hours of cleaning each day. Further cleaning was carried out by the care staff on night duty. A rolling programme was in place for cleaning and the housekeeper told us they tried to "gut" one bedroom each day. We noted dirty bedding on a bed in a person's bedroom and enquired about the frequency of bedding changes. We were told beds were changed when needed or once a week. A record of bed changes was not maintained.

The housekeeper was aware of the colour coding for mops and advised us that mops were changed once a week. We observed that mops were stored incorrectly. Not all clinical waste bins were pedal operated.

Infection control policies were not bespoke to the home as they included information about the use of an autoclave, aseptic techniques and invasive devices; none of which were used at the home. Infection control audits had been completed in October 2014, November 2014 and February 2015. The audits for the intervening months were not available. We found there was a significant difference between the generally positive findings of the audits and what we saw on the day of the inspection.

We could see that some areas of the home, including bedrooms were very unclean. For example, we observed black mould on bathroom tiles and taps despite the room having been prepared for a person who had just moved in. Toilet brushes were located in toilets but there was no evidence these were washed or regularly changed. We observed spillages on the floor of a shower room and the shower curtain had patches of excrement on it. Equally, we noted excrement on a very dirty shower chair. Used razors had been left in the shower room. Waste pipes had not been boxed in in one of the bathrooms and the radiator in the same bathroom was dirty and dusty. Furniture was dirty in shared areas with spillages and a general build-up of grease.

Not maintaining appropriate standards of cleanliness and hygiene was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 15(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

People living at the home told us the staff looked after their health care needs and arranged for them to see a doctor, nurse or other health care professional if they needed it. A person said to us, "I think I had the flu jab last year." Another person told us, "Someone comes from the hospital to check my blood. I get weighed about every two weeks."

We spoke with a health care professional who was visiting the home at the time of our inspection. They told us the staff were proactive when it came to people's health care. They said the staff made contact with them if they needed advice or needed a person's health care needs to be checked. Records were kept in individual care records of any visits from or to health care professionals. We could see from people's records that a range of health care professionals had been contacted depending on people's needs. These included chiropody, speech and language therapy and the diabetic eye screening service.

We asked people their views of the food and access to drinks throughout the day. Some people told us they were asked what they would like for each meal but others could not recall being asked. Overall, people were satisfied with the food. A person told us, "The chef's very good. He makes sure the food is cooked through. I get enough to eat and drink but if you want a snack you can have one." Another person said, "It's excellent, lovely homemade things. They make sure we get plenty of vegetables. We get fruit like we did at home." However, when speaking to another person they said. "The food is reasonable. I get enough to eat but we don't get fresh fruit." The chef told us a bowl of fresh fruit was available on the counter in the foyer each day. We observed a bowl of fruit there in the afternoon but some people said they had not seen fruit there before.

The chef told us people could have a cooked breakfast on request and that a hot meal was provided at lunchtime and teatime. Supper consisted of teacakes, crumpets and sandwiches. The chef told us he made cake four times a week.

One of the inspection team had lunch with the people living at the home. The main course was barely warm and the people we were sat at the table with commented on this. We observed that the food was served from a hot plate located next to an open window which could account for the tepidness of the food once served. There were periods of time when staff were not in the dining room during lunch. We observed that many people left quite a lot of the main course. When staff were in the dining room we did not see them encouraging people to eat, checking why they were not eating the meal or offering an alternative if they did not like the food.

Staff informed us that people's weight was monitored on a monthly basis to check for any fluctuation. We noted from the care records that people had been referred to the appropriate health professional if changes in their weight merited it. We observed there were gaps in the weight records as not everyone was weighed each month. No reason was recorded as to why the person was not weighed. We noted a person had been weighed two days before the inspection and registered a weight loss since the previous month of almost a stone. We asked that the person be reweighed and staff did so. The recording in the care record had been error and the person had actually put two pounds in weight on.

The staff we spoke with told us they had not received supervision since they started. Most had been in post less than 12 months. The staff who were in post over 12 months said they had not received an annual appraisal. The training matrix (monitoring record) we were provided with identified that 21 staff, including management, care and ancillary staff were employed to work at the home. The training staff were required to complete in order to undertake their role was not current in accordance with the home's policy on training. Some of the new staff had not yet completed the required training. For example, more than half the staff team were not up-to-date with training in adult safeguarding, infection control, dementia care, mental capacity and basic first aid.

Not providing staff with appropriate training, supervision and appraisal was a breach of Regulation 23(1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout the inspection we heard staff seek people's consent before providing care. For example, we heard staff ask people if they wished to take their medication or use the bathroom. We noted from the care records that consent was sought from people or their representative to take photographs of the person, share information related to their care and for staff to administer their medication.

Requires Improvement

Is the service effective?

Some people we spoke with clearly had capacity to make decisions about their care needs. We could see that other people most likely lacked mental capacity to make significant decisions. We looked to see if the service was working within the legal framework of the Mental Capacity Act (2005) for the people who lacked capacity. This is legislation to protect and empower people who may not be able to make their own decisions, particularly about their health care, welfare or finances.

Mental capacity assessments were in each of the care records we looked at but the quality was variable. Some assessments contained more detail than others and described the decisions people had the capacity to make and the decisions they would need support with making. Other mental capacity assessments were merely generic in nature and did not clarify the decision that was being assessed.

Each person had a person centred plan in place. 'Person centred' means the individual needs of the person and their wishes and preferences are at the centre of how the service is delivered. Some of the plans contained a description of the person's mental capacity and we could see these were reviewed on a regular basis. However, not all the person centred plans contained any information about the person's capacity.

Some people used bedrails to keep them safe at night. Although a bedrail risk assessment had been completed, a mental capacity assessment had not been completed to determine if the person had the capacity to agree to the use of this equipment that can be considered a form of restriction.

We asked staff what they understood about the Mental Capacity Act. Staff said they had not received training in this area and their understanding was limited. Training records informed us that very few of the staff team had completed training in the Mental Capacity Act (2005).

None of the people living at the home was subject to a Deprivation of Liberty Safeguard (DoLS) authorisation. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. We observed people leaving the building throughout the day. People who were able went out on their own. Others went out with family members. Staff told us people who would be unsafe outdoors on their showed no interest in going out on their own. They said if a person insisted on going out then a member of staff would go with them.

We recommend that the provider considers current guidance in relation to the Mental Capacity Act (2005) and takes action to update its practice accordingly.

We recommend that the provider considers current best practice guidance on nutritional care for older people living in care homes.

Requires Improvement

Is the service caring?

Our findings

People living at the home were satisfied with the way staff treated them and said they were supported in a dignified way and their privacy was respected. A person told us, "The staff are great; very friendly. They come and chat if they are quiet." Another person said, "The staff are pretty good. If you ask for something they get it for you." People said staff were attentive and listened to them. A person told us, "If I didn't like it [here] I wouldn't stop here."

People told us they could have visitors at any time. They said they could go with a relative or visitor whenever they wished. We observed many family members visiting during the inspection and saw that people went out with their relatives.

We asked people if they could choose the gender of staff to provide personal care. They told us they could and a person said, "I can choose male or female to bath me." The care records we looked at showed that people or their representative had been asked their preferred gender of staff to provide support when they first moved to the home. The care records included a picture of the person and the preferred name they would like to be called.

Throughout the inspection we heard staff calling people by their preferred name and supporting people in a caring, respectful and dignified way. There observed positive and warm interactions between people and staff. Most people said they did not have to wait long if they needed support

We observed staff take the time to listen when people were expressing their needs. We heard staff explaining to people what was happening prior to providing care or support. From our conversations with staff they had a good understanding of the likes/dislikes and preferred routines of the people who had lived at the home for some time. However, staff had a very limited knowledge about the background, preferences and needs of people who recently moved into the home.

We looked at the communication book which the staff used to share information with the wider staff team. Some of the language used about people did not seem caring. For example, we saw recorded about a person, '….kicking off in the morning.' We also noted a person was referred to as 'naughty'.

Not everyone could recall if they were involved in the planning of their care. One person said, "They [staff] come to my home [bedroom] and chat to me." A family member we spoke with at the time of the inspection said they had been involved in the planning of care prior to their relative moving into the home. However, the family member said their questions were not always answered and they were not always kept informed of their relative's changing needs. There were signatures in the care records to indicate the person or their representative was involved in the initial care planning when the person first moved to the home. However, there was no real evidence in the care to suggest the person or their representative had been involved in on-going care reviews.

Requires Improvement

Is the service responsive?

Our findings

People told us staff supported them in a way they preferred and responded to specific requests they made. A person said, "Yes, everything is alright but I try to look after myself." Another person said, "They [staff] let me do as much as I can. I don't like eating at 5.00pm so they make me something to eat at 7.00pm. One person was not satisfied with just having two baths a week and they told us they would like a bath each day. We discussed this with staff who said they would talk with the person about this.

People told us staff encouraged them to be as independent as possible. A person told us, "I do as much as I can for myself." Another person said, "I go out for a walk if the weather is okay." Staff told us there was no pressure for people to get up at specific times in the morning and that people went to bed when it suited them.

Person centred plans had been developed for people who had been living at the home for some time. Most of these were comprehensive plans that included details about each person's background, likes/dislikes and preferred routines. They indicated people's preferred day and night routine. This showed that the person or their representative had been involved in the initial development of the care plan in order to provide this information. Care plans were reviewed as people's needs changed. This was particularly evident for a person whose needs had altered significantly and would see the plan had been amended to reflect this change.

'Grab' sheets were in place for people should they need to go to hospital. The purpose of these was to ensure hospital staff had some information about the person. They included a copy of the person medication record. We noted from the care records that some of these had not been reviewed since August 2014. This meant if people's needs had altered and medication changed then hospital staff would receive information about the person that was inaccurate.

We looked at the care record for a person who moved into the home mid-January 2015. A pre-admission assessment had been completed and signed by the person's relative. However, no further assessments had been undertaken and there was no person centred plan or alternative care plans in place. This meant staff did not have care plans to follow to guide them in how to support the person in a consistent way. We spoke with staff about other people who had recently moved into the home. Staff were unsure of the background and needs of another person who recently moved into the home.

Not developing care plans for people was a breach of Regulation 9(1)(a)(b)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 9(b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people living at the home how they spent their day. We received mixed views regarding activities on a day-to-day basis. Some people were content with their own company, chatting with other people or organising their own activities. A person said, "It varies. I read the paper; I chat with people or go out for a walk. In the afternoon I watch television." Another person said, "I wander around all day and have a natter with people. Most of the people staying here are quiet pleasant." Other people told us there was not much to do and felt they could do with more activities. One of the people said, "There isn't much you can do. If [relative] comes we will go out for a meal." Another person told us, "There is not a lot to do. I watch television and then I'll go downstairs and have a potter about."

Family members we spoke with were unsure if any activities took place and a family member said to us, "That's one thing I would like to know. I would like a list of what they [people living at the home] do."

We observed two activity programmes displayed on the ground floor. The two programmes did not match so we asked staff which was the current activities programme in use. Staff told us neither programme was adhered to as they did not often have time to facilitate activities. A member of staff said, "We play skittles and bingo but if it's a busy day it doesn't happen." Another member of staff told us, "There is just no time for activities."

We observed little in the way of activities on the day of the inspection despite an additional member of care staff on duty that day. We saw people reading the paper and a there was a visit from the local church. The activities listed for the day on the two activity programmes displayed did not happen whilst we were there.

We asked people how responsive the manager was to any complaints they may have. The views were mixed. For example, a person said, "I don't bother complaining" but

Requires Improvement

Is the service responsive?

then clarified that they did not have any complaints. Another person said, "I complain but they don't seem to take any notice." The person did not elaborate on the complaints they had made. A family member told us they had made a complaint and that the provider had acted upon it to their satisfaction.

A complaints process was established at the home but it was confusing in that staff appeared to use the complaints process to report incidents. Rather than use the grievance process, they were also using the process to complain about other members of staff. Once we segregated out the incidents and grievances, we could see that the home had received very few complaints since the last inspection. These mainly related to missing clothing. We were not confident all complaints had been logged and managed in accordance with the complaints procedure because the complaint a family member had told us about was not recorded.

We recommend that the provider considers current guidance in relation to the management of complaints in care homes and reviews its practice accordingly.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post but they were not in work at the time of our inspection. We explored the leadership and quality management of the home with the provider and senior members of staff.

CQC requested the Provider Information Return (PIR) in November 2014. The request was sent to the registered manager's email address listed with CQC. An acknowledgement that a PIR had been requested was sent to the provider's email address listed with CQC. CQC did not receive a PIR. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We asked people living at the home their views of how the home was managed. People spoke positively about the manager of the home. A person said, "There is a lady who runs the place. She is out and about." Another person said, "She [manager] is very nice. Everything is running okay while she is off."

We asked people how management involved them in sharing their views about how the service could be improved. A person said, "I can't say I have been [involved]." Another person told us, "They have residents meetings every so often but I stopped going to them last year. It was a waste of time. Nothing was ever done."

We asked family members we spoke with about the management of the home and how they were involved in providing their view on how the home was run. A family member told us they were disappointed that they had not been provided with any written information about the home when their relative first moved in. They said, "The owner did mention there is going to be a resident's meeting soon." The family member had concerns about how their relative's clothes were handled and felt it could be addressed in this meeting.

We looked at the feedback survey for people living at the home. Twelve questionnaires had been completed and most were signed by the person. The majority of the questionnaires suggested that improvements needed to be made around activities and choices of food.

We asked staff their views about the management of the home and some of the feedback we received was mixed. For example a member of staff said the management was, "Spot on". Another member of staff said, "Their hearts are in the right place but they need guidance and help."

The care records informed us that people's care plans were regularly reviewed to ensure they reflected people's current needs. We observed an audit form at the front of each person's care record and staff confirmed each record was audited every three months. Actions identified from each audit were acted upon. Medication audits were also completed. They had identified the concerns that we similarly found but the same issues were continuing. For example, staff not always signing to say they had administered medication. Infection control audits were routinely being completed but the mainly positive findings of the audits were significantly different from what we found during the inspection.

Staff told us communication was good and they had a handover at staff team changeovers. They advised us that there was a communication book that was used to remind staff of appointments people had and jobs that needed to be done. We looked at the entries in the communication for January 2015 and could see that staff were advised to read the care records for a new person who had moved into the home. The book also provided a brief overview on the needs for the new person. Furthermore, staff were advised via the communication book to read any revised care plans.

Staff told us that the aim was to hold 'resident's meetings' on a monthly basis. We had a look at the meeting minutes and the most recent meetings recorded were held in July 2014 and November 2014 which indicated to us that the home was not achieving its aim of holding meetings each month. We could see from the minutes that social activities, menus, refurbishment and a feedback survey had been discussed. A newsletter for people living at the home was produced in December 2014 and it provided feedback on actions taken from the 'resident's meeting' held the previous month. We were advised by a senior member of staff that the newsletter would be produced on a monthly basis in the future.

We asked staff about how they received feedback and updates on the service. We were advised that periodic staff meetings were held. A member of staff said, "They are supposed to be held every two months. We had one two

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Is the service well-led?

months ago but I don't know if there are any more planned." Regarding the staff meetings another member of staff told us, "They are a total waste of time. No way will I attend another. The member of staff did not elaborate further on their view. We were provided with the most recently held staff meeting minutes from January 2015, September 2014 and June 2014. These were not being held two monthly as staff had suggested. We could see at the most recent meeting that topics such as, the management structure, new CQC inspection process, staff training and the keyworker system was discussed. We also noted that staff were informed that signatures were missing from the medication administration records. Staff were also reminded about good practice regarding cleanliness. Our findings highlighted concerns with these last two issues.

Staff told us they felt valued by management and that there was an open and transparent culture within the home. They told us they would feel comfortable questioning practice. The majority of staff we spoke with understood what whistle blowing was and said they would not hesitate to whistle blow if they were concerned about something. However, some members of staff were unclear about what whistle blowing was and one member of staff said they did not know what whistle blowing was at all.

We asked staff how they learned from the outcomes of investigations into incidents and complaints. A member of staff told us, "We don't hear about complaints." Another member of staff suggested they would not be informed and said, "I think it would be confidential."

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	Regulation 18 HSCA (RA) Regulations 2014 Staffing **There were insufficient numbers of suitably qualified staff on duty at all times to effectively meet people's needs and keep them safe. Regulation 18(1).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People living at the home were not protected against the risks of receiving unsafe care because risk assessments were either not completed for known risks or not reviewed in a timely way. Regulation 12(1)(a)(b).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **People living at the home were not safeguarded against the risk of abuse. Regulation 13.**

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Effective safeguards were not in place for the safe management of medicines. Regulation 12(f) & (g).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Action we have told the provider to take

People living at the home were not protected from risks associated with the environment. Regulation 12(1)(d).

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People living at the home were not protected against the risks associated with the use of unsafe equipment. Regulation 12(1)(e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Appropriate standards of cleanliness and hygiene were not being maintained at the home. Regulation 12(2)(h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff had not been provided with appropriate training, supervision and appraisal. Regulation 18(2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care plans had not been developed for all of the people living at the home. Regulation 9(3)(b)-(h).