Care Quality Commission

Smallwood Homes Limited

Cale Green Nursing Home

Inspection report

Adswood Lane West
Cale Green
Stockport
Greater Manchester
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Tel: 0161 477 1980

Date of inspection visit: 12 and 13 January 2016
Date of publication: 12/08/2016

Ratings

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

Overall summary

This inspection took place on 12 and 13 January 2016. Our visit on the 12 January was unannounced.

The service was previously inspected on 27 and 28 April 2015, when breaches of legal requirements were found.

When we visited the service there was a Registered manager in place. A Registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Cale Green Nursing Home is a nursing and residential home that is registered to provide care and support for up to 50 older people. The home is located in the Cale Green area of Stockport near Manchester.

At the time of our visit 44 people were living at Cale Green Nursing Home.

Summary of findings

The Care Quality Commission (CQC) carried out a comprehensive inspection at the location on 27 and 28 April 2015. At the time of the inspection we identified breaches of the following regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Person centred care, Safe care and treatment, Safeguarding people from abuse and improper treatment, Premises and equipment, Staffing, Fit and proper persons employed and Duty of candour. As a result the Care Quality Commission gave the provider an overall 'Inadequate' rating and the location was placed into 'Special Measures'.

The purpose of special measures is to ensure the provider makes significant improvement to become compliant with the Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made and provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration. Following our adult social care inspection methodology, services placed in special measures will be inspected again in six months from the date of the final report being sent to the provider.

We issued the provider with compliance actions to address the regulatory breaches. We also served two Warning Notices to the provider to address breaches in Regulation 12 Safe care and treatment and Regulation 19 Fit and proper persons employed. Warning notices notify a registered person that we consider they are not meeting a condition of registration, a requirement of the Health and Social Care Act 2008, a regulation, or any other legal requirement that we think is relevant. Compliance actions can be a precursor to enforcement action.

We gave the provider a clear timeframe within which to improve the quality of care they provide and we inspected the service again in January 2016 within six months of publishing the April 2015 final inspection report.

In May 2015 the Care Quality Commission received an application to cancel the manager's registration and the current manager became registered with the CQC in September 2015.

At this inspection we found eleven breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to person centred care, dignity and respect, need for consent, safe care and treatment, management of medicines safeguarding people from abuse, meeting nutritional and hydration needs, premises and equipment, staffing, safe care and treatment, and good governance. We are currently considering our options in relation to enforcement. We will update the section at the back of this report once any enforcement action has been concluded.

Not all care plans were written in a person centred way, were not responsive to people's needs and did not include the relevant health and safety concerns relating to their care and treatment. This placed people at risk of receiving unsafe or inappropriate care and exposed them to the risk of actual harm.

Two people, one of whom was nearing the end of life and receiving palliative care, had been provided with shared bedroom accommodation. There was no evidence of a best interests process having been followed in relation to the continued appropriateness of shared accommodation for either person. This indicated a lack of consideration of these people's dignity.

We saw that 16 people were offered treatment in "Kirton" chairs. there were no written records in place to show that the service had considered the person's consent to the use of the chair, sought the assessment of a physiotherapist, or considered other less restrictive options.

There was an overall lack of recorded risk assessments about the health, safety and welfare of people using the service. Where risk assessments were in place the instructions needed further clarity, so staff could make sure people received personalised care to meet their individual needs.

We looked at the systems in place to manage medicines in the home. Records in relation to the storage, administration, management, recording and disposal of medication showed medicines were not being managed safely.

Summary of findings

People using the service were at risk of cross infection because we saw staff barrier nursing a person without wearing appropriate protective clothing such as disposable gloves and aprons that would help to prevent cross infection.

Following the inspection the CQC made two safeguarding referrals to the local authority adult safeguarding team. The first referral was for a person at very high risk of their skin integrity being compromised. This person's skin integrity care plan had not been completed and was blank. The second referral related to potential risks associated with a person's diabetes and the lack of safe care and treatment provided in relation to the person's diabetic care and monitoring. Following our inspection, the provider informed us that on review of the referrals no further action was taken by the local safeguarding team.

Systems in place to regularly clean the kitchen were not being followed and despite there being a cleaning schedule outlining the method of cleaning for each item of equipment in the kitchen. We found the cleanliness of the kitchen was below the required standard. This exposed people to the risk of becoming ill from eating contaminated food prepared in a kitchen which presented a health risk to people. Two days after our inspection the local authority inspected and awarded the kitchen 5 stars.

Cleaning products were not stored safely and were stored in an unlocked store cupboard on the ground floor of the home. In several instances the storage cupboard door was left wide open.

A cracked window pane in the ground floor dining room was temporarily covered using gaff tape and had not been replaced following our last inspection at the location in April 2015. A further window in the dining room had no window restrictor, restricting how far the window could open, to prevent people from falling from the window.

Some policies and procedures in place did not ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Registered manager was not aware of relevant nationally recognised guidance or quality and safety standards that had changed over time. This meant care; treatment and support did not always meet current best practice.

The staff recruitment and selection policy and procedure in place were not followed to make sure that a registered nurse was suitably skilled and experienced with the necessary clinical competencies to look after people within the home.

People told us that they felt safe in the home and staff knew how to protect people from the risk of abuse.

Not all people's privacy and dignity were respected by staff despite staff members having received training in this topic.

We saw there were good relationships between individual staff and people who used the service and we saw that care was provided with kindness.

Where they were able to tell us about their experiences people who used the service told us staff were kind and caring. They told us they would feel able to raise any concerns they might have with staff or the Registered manager.

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 always safe.

Where risk assessments were in place the instructions required further clarity so staff could be clear about how to make sure people received personalised care to meet their individual needs.

Cleaning products were stored in an unlocked store cupboard on the ground floor exposing people to the risk of harm.

Records in relation to the storage, administration, management, recording and disposal of medication showed medicines were not being managed safely.

People were at risk of cross infection because staff did not wear appropriate protective clothing such as disposable gloves and aprons while barrier nursing.

Is the service effective?

Inadequate

The service was not always effective.

Although care staff demonstrated an understanding of people's needs we found the supervision they received needed to be improved to help make sure they were able to deliver more effective care.

16 people were restricted to act independently because they could not freely get themselves out of bucket chair if they wished to do so. Where people lacked capacity the restrictions amounted to a Deprivation of Liberty Safeguard (DoLS) which had not been authorised.

There was an overall offensive odour throughout the home. Systems in place to regularly clean the kitchen were not being followed and the cleanliness of the kitchen was below the required standard.

Is the service caring?

Requires improvement

The service was not always caring.

Two people, one of whom was nearing the end of life and receiving palliative care, had been provided with shared bedroom accommodation. There was no evidence to confirm the continued appropriateness of shared bedroom accommodation to ensure the dignity of the two people were respected and their needs had been taken into consideration at this private and sensitive time.

Although some people told us they considered staff were kind and caring, our observations showed some staff did not know the people they were caring for including their preferences and personal histories.

Summary of findings

Staff showed warmth and friendship to people using the service and they spoke to people in a kind, comforting and sensitive manner.

Is the service responsive?

Inadequate

The service was not always responsive.

Not all care plans were written in a person centred way to make sure people's views about their strengths, level of independence, health and quality of life were taken into account.

Care plans and care assessments were not responsive to people's needs and did not include the relevant health and safety concerns relating to their care and treatment.

Is the service well-led?

Inadequate

The service was not always well-led

The Registered manager, Clinical Nurse Lead and Quality Lead were not fully aware of relevant nationally recognised guidance or quality and safety standards that had changed over time to ensure care reflected current best practice.

Some policies and procedures and governance systems in place were not up to date and compliant with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This meant governance and clinical governance systems in place were not robust enough to assess, monitor and evaluate the quality of the service and drive continuous improvement.

A staff recruitment and selection policy and procedure in place was not followed to make sure that a registered nurse was suitably skilled and experienced with the necessary clinical competencies to look after people within the home.

The quality systems in place were not robust enough and had not identified the issues found during inspection.

Cale Green Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on12 and 13 January 2016. Our visit on the 12 January was unannounced.

The inspection was carried out over two days by five adult social care inspectors and a specialist advisor in older people's nursing care (SPA). SPA's provide specialist advice and input into the Care Quality Commission's (CQC) regulatory inspection and investigation activity to ensure that CQC's judgements are informed by up to date and clinical and professional knowledge and experience.

Before we visited the home we reviewed a range of information that we held about the service, the service provider and the care provided in the home. We also spoke with the local authority adult social care safeguarding and quality team, the local authority health protection nurse team and the local authority fire service department.

On this occasion we did not ask the provider to complete a provider information return (PIR) before our visit. A PIR is a document that asks the provider to give us some key information about the service, what the service does well and any improvements they are planning to make.

Some of the people living at the home were unable to give their verbal opinion about the care and support they received. Therefore we examined peoples care records and observed the care and support being provided to them in communal areas to capture their experience of living at Cale Green Nursing Home. During the inspection we saw how the staff interacted with people using the service.

We spoke with 14 people who used the service, six relatives, the cook, a kitchen assistant, a domestic, the laundry assistant, six care staff, a registered nurse, the maintenance person, a visiting social worker, the Registered manager, the Clinical Nurse Lead and the Quality Lead. We walked around the home and looked in fifteen bedrooms, all of the communal areas, the kitchen and communal toilets and bathrooms.

We reviewed a range of records about people's care which included the care plans for 10 people, the medicine records, the training and supervision records for eight staff members, and records relating to how the home was run.

Inadequate

Is the service safe?

Our findings

We found no risk assessments in place to support why 16 people who use the service were seated in Bucket (Kirton) chairs. When we asked the Registered manager, and Clinical Nurse Lead, if individual needs assessments and risk assessments had been carried out they advised us this had not been done. The provider told us bucket chairs were being used in the interests if people's safety. However, there was no evidence that potential risks to people's health and wellbeing through use of this equipment had been considered. The use of bucket chairs presents potential risks including risk of falling from the chair, a decline in sleep patterns. It disempowers individuals as they are totally reliant on others for any movement. There is also the potential for increased risks in relation to people developing muscle wastage, incontinence, poor tissue viability pressure sores, depression and cognitive decline. The service had taken no action to make sure people being seated in bucket chairs had undergone a needs assessment to determine whether they required the use of the chairs, or that their use was safe an met the individuals needs.

This is a breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

There was a policy in place to support the safe administration of medicines in the home. Medicines including Controlled Drugs (CDs) were stored in dedicated treatment rooms located on each floor of the home. CDs are medicines where strict controls apply in order to prevent them from being misused and causing harm. Medication was stored in a locked medication trolley in each locked treatment room to ensure only authorised people could access them. The home operated a Monitored Dosage System (MDS). This is a system where the dispensing pharmacist places medicines into a cassette containing separate compartments according to the time of day the medication is prescribed. Some medicines were not included in this system and were dispensed by the pharmacy into separate bottles or boxes.

We carried out a tablet count for eight boxed medicines and found balance inaccuracies in seven instances. We found excess stock of medication; for one person we found nine boxes of medication dating back to 18 August 2015 and seven boxes of medication dating back to November 2015 for another person. None of these medicines had been included on either person's Medication Administration Records (MAR). This meant peoples medicine records were not up to date and people were at risk of medicine errors because medicines were not managed safely.

We looked in the medicines fridge and found medicine belonging to a deceased person. We found a used swab dated 30 September 2015 that had not been sent for analysis. The senior carer on duty when asked, did not know what the swab was for or why it was still in the fridge. A prescribed skin cream dated 20 October 2015 was found in the fridge for a person who was no longer being prescribed the same skin cream. We found six medicines that should have been discarded 28 days after opening because they had a limited life span, were still being stored in the medicines fridge.

When we asked how the home stored and recorded medicines to be disposed of, a senior care assistant advised us they were not currently recording medicine that was to be disposed of because the medicines returns book had been missing for three weeks. We saw that some medicine for disposal was stored in the bottom of a cupboard in the treatment room on the ground floor and some were stored in a blue box with a removable lid. This meant that medicines for disposal were not being stored in line with recognised good practice as recommended by the National Institute for Care and Health Excellence. The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. It develops guidance, standards and information on high quality health and social care.

A system in place to record daily medicines fridge temperatures and daily temperature of the treatment room were not being followed and there were gaps in the recordings. In December 2015 there were 20 gaps and no recordings had been taken for January 2016. This meant that medicines may not have been stored at the correct temperature, which may compromise the stability of the medicines stored in the room which might put people at risk of harm.

Accurate records for the administration of prescribed skin creams were not maintained and there were no written instructions on MAR sheets to identify which part of a person's body the skin cream should be applied. This

meant there was a risk that people's prescribed creams might not be applied as intended by their GP, which could result in unnecessary discomfort and the risk of harm to the person.

Two staff members advised us that a deceased person's prescribed medication called 'Thick and Easy' was being used to thicken drinks for all people living at the home who required a thickening agent. Thickening agents play a vital role in reducing the risk of choking and is used when medical conditions cause people difficulty when swallowing. Prescribed medicines must only be used for the person who it is prescribed for.

We examined the controlled drug (CD) register and carried out a CD stock check, we found tablets counted corresponded with the balances recorded in the register. We reviewed the home's medication policy, which stated that a complete audit of all controlled drugs (CD's) must be carried out every Friday and the details should be recorded in red ink as 'CD audit complete.' We saw that an audit had not been undertaken every Friday and where the audit had been undertaken the details had not always been recorded in red ink.

We looked at the homes medication self-administration policy and saw this had not been followed for a person self-administering their medication. A risk assessment had not been undertaken to ensure the person was able to self-administer their own medicine safely. Checks to ensure medicines had been administered appropriately and safely had not been undertaken and there was no evidence to show the medication was being kept in a lockable storage area in line with the homes policy.

The above examples demonstrate multiple breaches of Regulation 12 (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe the proper and safe management of medicines.

Cleaning products were not stored safely and were stored in an unlocked cupboard on the ground floor of the home. In several instances the store cupboard door was left wide open during the inspection. This exposed people to the risk of serious harm such as skin burns, poisoning and possible death if a person had swallowed any of the cleaning products and chemicals.

This is a breach of Regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

We asked to see the home's cleaning schedule and were provided with copies of the daily, weekly and monthly cleaning schedules for the domestic staff to complete. We found that records relating to the weekly cleaning schedule were not being kept. We saw an internal 'infection prevention and control audit' dated 16 November 2015 and 23 December 2015 had been completed.

As we walked around the home on the first day of the inspection, we noted a person using the service was being barrier nursed to prevent the risk of cross infection. We saw there was a notice on this person's bedroom door requesting all staff to wear aprons and gloves on entering the room. We saw there was no antibacterial hand gel for staff to use on leaving this person's room. We observed two staff members on two occasions entering this person's room without wearing the necessary protective clothing. When we asked why they were not wearing protective clothing they told us they had not touched anything. Evidence on the staff training matrix showed both staff had completed infection control training but on questioning neither of them could recall having had this training. This meant staff were not protecting themselves or other people from the potential risk of cross infection and acquiring infections.

We asked the Registered manager, if there was an infection control lead person for the home in line with best practice. The Department of Health (DOH) Code of Practice on the 'prevention and control of infections in care homes' states a person with appropriate knowledge and skills should become the infection prevention lead and take responsibility for infection prevention (including cleanliness) in the home. The Registered manager advised us there was no infection control lead person for the home.

We were provided with a copy of an infection control assessment undertaken by Stockport Metropolitan Borough Council's Health Protection and Control of Infection Unit (HPCI) at Cale Green Nursing Home, on 27 April 2015, where required improvements were identified. Following the assessment an action plan was submitted by the home on 31 May 2015 to the local authority HPCI. Despite our requests to the Registered manager for evidence of improvements made we did not receive this information.

When we visited the laundry room we found five bags of dirty and soiled laundry that required washing. The laundry staff had completed their duty shift at 17.00 and told us the

soiled laundry would not be done until 11.00 the following day. This practice is not in line with current DoH best practice which requires soiled linen to be processed as soon as possible, to prevent the risk of cross infection.

We examined audits in relation to the cleaning and maintenance of bed bumpers, pressure cushion's, mattresses and a catheter stand. Each audit was dated 17 November 2015. The homes infection control policy stated such audits should be undertaken on a monthly basis, we found no further monthly audit reports had been completed. The bed bumper audit identified bumpers in three bedrooms needed replacing. When we checked these rooms, we found the bumper in one bedroom had been replaced but was stained and needed cleaning and the bed bumper in another room still required replacing. This meant that although audits were being completed checks had not been carried out to make sure actions identified had been completed.

The above examples demonstrate multiple breaches of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

Systems in place to regularly clean the kitchen and kitchen equipment were not being followed. We looked in the kitchen and saw there was food debris on the kitchen surfaces, behind bins, under the fridges and freezers, underneath and behind all the kitchen units and the legs of all the kitchen units were dirty. We saw the floor was littered with food debris and required a thorough clean. The wheels on the food trolleys were dirty and each shelf on each food trolley was ingrained with stains and dirt.

The rim of the hot plate had a layer of brown grease underneath it. The handle of the heated food trolley and the electrical flex were stained with dried food. The electric plugs and sockets around the kitchen were greasy and the kitchen wall tiles were splashed with food and needed to be cleaned. The inside of the oven and hob, the oven doors and oven control knobs were stained with burnt on food and grease. The bottom of the oven was lined with tin foil which was full of remnants of old burnt food. The cook told us the tin foil should be change daily however they often ran out of foil, which meant the foil could not be changed as regularly as it should be. The deep fat fryer in the kitchen was full of dark coloured oil and there was a pool of oil on the surface behind it. The label on the fryer was peeling and the fryer temperature could not be read. We noted all of the kitchen fridges required a thorough cleaning. The door handles were dirty; there were spilt liquids in one fridge that had dried. The fridge shelves needed cleaning and the milk storage compartment in the fridge doors, were dirty.

There was a detailed cleaning schedule outlining the method of cleaning for each item in the kitchen and a cleaning rota was also in place. The cleaning rota was to be completed daily, however there were entry gaps in the record, for example; on 5 November 2015, 9 December 2015 and 24 December 2015. We saw the section to record the equipment deep cleansing that had taken place was largely blank. When we asked the cook to explain about the lack of cleanliness in the kitchen, the cook told us the kitchen needed deep cleaning and needed to be refurbished and they had informed the manager of this.

We saw raw chicken stored on the same shelf as double cream and because Bacteria can spread inside a fridge if the juices of raw meat or poultry, drip onto ready-to-eat food there was a risk of people becoming ill from eating cross-contaminated food. Plastic containers used to store breakfast cereal, biscuits and sugar either had no lids or the lids were cracked and dirt was embedded in the grooves where the lids should sit. It was apparent the containers had not been cleaned for some time and food had become wedged in between the plastic. We saw the kitchen skirting board paintwork in the food storage area, at the rear of the kitchen, was dirty and there were three mouse traps in the kitchen which were also dirty with food spillages and food debris covering them. This exposed people to the risk of becoming ill from eating contaminated food prepared in a kitchen which presented a serious health risk to people. When we asked the cook if they had been provided with a copy of the Food Standards Agency (FSA) document on Listeria and how to keep food safe they told us they were not aware of the document. This meant the home did not make sure there were good food hygiene and safety practices in place to prevent harmful bacteria from causing serious illness to people using the service.

At 10.30 on the first day of the inspection we saw gravy in the food bain-marie and the cook advised us the gravy had been in the bain-marie since 9.30am that morning and it would be reheated at 11.30am before lunch was served. There was no written guidance regarding how long food could be stored in the hot trolley although the cook told us it was two hours. A record to show the food probe being

used to test the temperature of food served had been calibrated were not being kept. The food probe should be calibrated regularly to make sure it is effective in reading food temperatures accurately. When we observed the probe being used to check the temperature of food being served, the readings fluctuated from sixty-eight degrees to eighty degrees Celsius. The home was unable to show consistently that food was being cooked thoroughly to 75 degrees Celsius or hotter to kill food poisoning bacteria. This meant people were at risk of food poisoning because it was unclear if food was being served at the correct safe temperature to prevent harmful bacteria from causing serious illness.

From the four fridges and two freezers in the kitchen the temperature of only one fridge was being recorded because there were no digital thermometers available for the other three fridges. Signed notes on the fridge and freezer records to confirm the fridge and freezer temperatures had been taken, were illegible, not kept in chronological order and there were gaps in recordings. For example temperatures were recorded on 16-18 November 2015, 23-25 October 2015 and 5 November 2015. We noted some fridge temperature readings were higher than the recommended five degrees Celsius for example; on 21 December 2015 the reading was 6.2ºC, on 22 December 2015 the reading was 5.2ºC, on 23 December 2015 the reading was 5.3ºC and 12 January 2016 the reading was 8ºC. We also noted the freezer readings were higher than the recommended minus eighteen degrees Celsius. On 17 December 2015 the reading recorded was 17.5ºC at 8.30am and 21.5ºC at 2pm.

The cook told us it was procedure to inform the Registered manager when the fridge or freezer temperature readings were of concern but the cook was not aware they had to make a record of these themselves. We looked into both freezers and saw they both required defrosting as there was evidence of ice build-up. In one freezer there was a large vacuum packed raw beef joint that felt soft to touch. The cook told us this had been in the freezer since the day before and was not sure what to do now it had semi defrosted. There was no date on the raw beef joint to remind the cook of the delivery date or the date on which it was frozen.

We asked the cook how they knew the date on which fresh meats had been frozen and the cook told us she relied on memory. This meant the home did not make sure the freezer temperature recording practices in place were completed regularly to prevent harmful bacteria developing in food which could cause serious illness to people using the service.

The above examples demonstrate multiple breaches of Regulation 12 (1) (2) (a) (b) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment

We found a window in the dining room had no window restrictor, which meant the window could be opened wide enough for people to either fall our climb out. This did not comply with health and safety regulations.

This was a breach of Regulation 12 (1) (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we reported our concerns about the risks associated with the lack of kitchen hygiene to the local authority environmental health department. Following our inspection the provider informed us, and we confirmed, that the local authority environmental health department had visited Cale Green shortly after our inspection on 15 January 2016. the home received a five star rating, which means it was assessed as being "very good". This indicated the home had been able to make improvements following our inspection.

There was a safeguarding procedure in place which was in line with the local authority 'safeguarding adults at risk multi agency policy' and staff spoken with knew how to access the policy which was located in the manager's office. We looked at records that showed the provider had procedures in place that helped to ensure any concerns about a person's safety was reported to the appropriate authorities such as the local authority or the Care Quality Commission. All of the staff we spoke with showed they understood how to keep people safe and had a clear understanding of the safeguarding procedure and they were confident in describing to us the different forms of abuse.

During the inspection we told the Clinical Nurse Lead to make safeguarding referrals to the local authority adult safeguarding team for two people because we found evidence to show the risks to their care and treatment was not being minimised. The first referral was for a person whose risk assessment stated they were at very high risk of their skin integrity being compromised and at risk of

developing a pressure ulcer. This person's skin integrity care plan had not been completed and was blank. The second referral related to potential risks associated with another person's unstable diabetic state and the lack of safe care and treatment provided in relation to the person's diabetic care and monitoring, which might have caused the person to become hyperglycaemic.

Following the inspection we returned to the home to provide the Registered manager with inspection feedback. During the meeting we asked the Registered manager if they had made the safeguarding referrals as instructed by us. The Registered manager told us this had not been done. Following the feedback meeting the CQC immediately alerted the local authority safeguarding team to our concerns about both people, because the Registered manager had failed to make the referrals in a timely way, which placed both people at further risk of receiving unsafe and inappropriate care. This is a breach of Regulation 13(4)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 significantly disregards the needs of the service user for care or treatment.

There was a recruitment and selection procedure in place. We looked at three staff recruitment files and found a registered nurse was recruited to work at the home despite there being only one character reference obtained prior to offering the nurse a position at the home. A reference from the nurse's most recent employer had not been obtained and gaps in the nurse's employment history had not been checked by the Registered manager. A recent photograph of the nurse and two types of proof of identification had not been obtained from the nurse before they started work at the home and were not available at the time of the inspection. Other pre- employment checks such as an enhanced disclosure and barring service check (DBS) and checks to ensure the nurse's personal registered with the Nursing and Midwifery Council (NMC) were valid had been carried out. Checking and recording details of any gaps in a person's employment and employment continuity prior to the person attending for interview would help the Registered manager to understand the chronology of the persons work history, reliability and potential risks to people who use the service.

When we told the Registered manager about our findings they said they would ask the nurse to bring to work the necessary records. This meant people were not protected against the potential risks associated with employing unsuitable people to work in the home. These checks help the Registered manager and provider to make informed decisions about a person's suitability to be employed in any role working with vulnerable people. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. The NMC is the regulator for all nurses and midwives in the UK. When a trained nurse registers with the NMC, they will give them a personal identification number PIN which is renewed annually.

When we examined the interview notes taken by the Registered manager, during the nurses job interview we found insufficient information had been gathered to assess and check the nurse had the competence, skills and experience required to undertake the role of a registered nurse at the home. It was clear from the lack of written detail in the interview notes that the Registered manager did not assess the accuracy of the detail of the application which meant they were unable to fully evidence the nurse's suitability for the role. When we asked the Registered manager if they had measured the nurses knowledge and skill against the job specifications and job description during the interview, the Registered manager told us that they hadn't done that. They said, "It didn't occur to me to do that; but I will do that next time we interview". This meant people were exposed to the potential risk of receiving unsafe or inappropriate care because the home's recruitment process and relevant records to demonstrate fit and proper people were recruited was not followed.

The above examples demonstrate a breach of Regulation 19(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Recruitment procedures must be established and operated effectively.

The Registered manager told us there were enough staff on duty to meet peoples assessed needs. There was a cook and a kitchen assistant working in addition to care staff over the meal times. The cook advised us there was no additional staff to serve meals. We saw that this resulted in some people's meals going cold in the kitchen when care staff could not support mean service as they were engaged in tasks such as supporting people to the bathroom. When we spoke with three staff about the staffing levels at the

Is the service safe?

home all of them told us that the regular staff rota consisted of four care staff on the first floor, three care staff on the ground floor and one nurse responsible for the 25 nursing residents over both floors.

During both inspection days we saw the staffing numbers and skill mix as described by the Registered manager. Staff we spoke with told us that the daily care staff levels never exceeded seven and whilst they had appropriate skills and knowledge to carry out their role, most of the time there were not enough staff. Inspectors observed the call buzzers continually sounding and people had to wait for long periods before their call buzzer was answered. Inspectors observed long periods where people were left in the lounge without carers, e.g. during the bingo activity observed, the activities co-ordinator had to sit with an anxious resident, providing reassurance, whilst a visitor called out the numbers. No care staff assisted, or entered the lounge for 30 minutes. A relative who we spoke with said, "If they could get the staffing right it would be good". The lack of sufficient numbers of staff deployed meant people's care and treatment needs were compromised, exposing them to the risk of receiving inappropriate or unsafe care and treatment. This was in breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found a number of toilets at the home out of use. When we spoke with the Registered manager about this, he confirmed that four out of 10 communal toilets were not working and people were unable to use them. We found a sign on the ground floor sluice room to say that it was out of order; we asked the Clinical Nurse Lead if they knew the exact date when the sluice had broken down. The Clinical Nurse Lead told us that although they knew the date was recorded they were unable to locate the information and said, "It was recorded, probably verbally and probably on 28th December 2015; it would normally be added to the maintenance list but both managers were on bank holiday that day".

We examined the home's maintenance policy and procedure which made reference to a plan of maintenance being prepared on an annual basis. We asked to see a copy of the annual maintenance log but the manager told us there wasn't one. The Registered manager told us there was a "maintenance jobs list," which recorded the maintenance issue, and the jobs list was reviewed by the registered manger on a weekly basis and work was prioritised. We reviewed the maintenance jobs list from August 2015 to Dec 2015. We identified a "missing handle and crack on window in dining room" job remained unresolved. The cracked window pane in the ground floor dining room had been covered with gaff tape and had been identified during our previous inspection in April 2015. A risk assessment identifying any risk to the cracked glass was not in place to help make sure people were protected from the risk of harm.

The above examples demonstrate a breach of Regulation 15 (1) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked one of the care assistants their thoughts on the maintenance and repairs system in place and they said, "it's rubbish," we asked the care assistant what they meant by this and they said this was in relation to "things don't get fixed, for example toilets out of order and a leak that had taken three to four days to sort out". One person told us that damage to the floor covering in their room had been there, "for as long as I can remember".

Inadequate

Is the service effective?

Our findings

Staff induction records showed that new staff completed a 12 week induction, during which they shadowed a senior staff member before they were allowed to work unsupervised. New employees received a staff handbook which contained the relevant information to support and guide the person through their initial induction period. The staff records we looked at confirmed this.

We spoke with three members of staff about the quality and type of training received; they told us they had undertaken a lot of training including safeguarding awareness, National Vocational qualification (NVQ) level two and three in health and social care, fire safety, infection control, basic food hygiene, and pressure ulcer training. This was confirmed when we looked at the staff training and development plan.

However, one member of staff we spoke with shared concerns in relation to staff training and support. They told us they had received training on moving and handling but questioned the quality of this training. They also told us that for other areas of training the practice was for staff to be given sheets of multiple choice questions to complete, but then staff did not get any feedback or get to know their score so it was hard to know if their knowledge was adequate.

We asked the cook about their training and they told us they had completed Health and Safety and Care of Substances Hazardous to Health (COSHH) in 2015, but had received no formal kitchen training, food hygiene training or food preparation training. They told us they had been quickly trained by the previous cook. The provider confirmed the former cook left the service in November 2015, and had provided training to the current cook over a two week period. Staff should receive appropriate support, training and professional development to ensure they have the skills and competencies needed to carry out the duties of the role they have been employed to undertake.

There was a staff supervision procedure in place. Supervision meetings support and help staff to discuss their progress at work and also discuss any learning and development needs they may have. We looked at the supervision records for three members of staff and saw that supervision had taken place infrequently. The Registered manager said that some staff, such as a nurse, had received additional individual supervision from the Clinical Nurse Lead, as part of their induction process, which enabled them to carry out their duties more effectively.

From the staff records we looked at we saw staff had not received a comprehensive annual appraisal and the Registered manager told us that he was planning staff annual appraisals to take place in 2016. Staff members we spoke with told us the Registered manager had given them a completed sheet with areas for improvement to be signed and returned, there had been no discussion or 1:1 conversation with the Registered manager prior to or after receiving the notes. A member of staff we spoke with told us that they felt this was not a good way to conduct appraisals and this method had not prepared them to work more effectively with people who use the service. The Clinical Nurse Lead told us whilst staff members on day shift had received more frequent supervision, the night staff had not. The above examples demonstrate multiple breaches of Regulation 18(2) (a) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform

When we looked at the staff training and development plan and saw all of the staff team had undertaken Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training. Staff we spoke with were aware of the MCA and were clear of their duties when these restrictions were in place. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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.

We looked at the arrangements the service had in place to ensure that people who use the service were protected and their freedom supported and respected. We found the care records of a person diagnosed with dementia showed they had not undergone a mental capacity assessment to determine if they could make decisions or give consent about their care. We also found where people lacked capacity to agree to be seated in a Bucket (Kirton) chair the restrictions of the chair were a Deprivation of Liberty Safeguard as they prevented people from getting up out of the chair freely. When we asked the Registered manager if DoLS had been completed for each of the 16 people prior to them being seated in a bucket (Kirton) chair, we were advised these people were protected by a DoLS, although the DoLs did not specify the use of bucket chairs. The Registered manager acknowledged there had been no best interest meetings around any of the people using such chairs and told us that he was not aware of any consent being sought from each person or their relatives. We told the Registered manager people's best interests must be considered and the local authority adult social care department should be contacted to carry out the appropriate assessments.

The above examples demonstrate breaches of Regulation 11(1) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Care and treatment of people must only be provided with the consent of the relevant person.

We observed the lunchtime period on the first day of our inspection, observing activity in the kitchen and how meals were served to people. Meals were plated before they left the kitchen; this meant the people had no choice about what vegetables they wanted and likewise no choice about gravy which was poured over the food before it left the kitchen. On both inspection days we saw no menus displayed prominently in the home for people to read. In the downstairs dining room there were no condiments on one of the three dining room tables and there were no jugs of water or juice on each table for people to access if they wanted to season their meal or have a drink with their meal.

The cook told us there was a lack of communication between the care staff and kitchen staff. For example two people were admitted to the home on the first day of the inspection and the cook was unaware of one of the new admissions. The cook told us for the past two months menus were in the process of being reviewed. When we asked how people who use the service could choose their meals the cook told us they checked food stocks at the start of their shift and decided from that what meals to prepare. The care staff would then ask people to choose a meal and they would relay the information back to the kitchen. On the first day of our inspection it was 11.15am before the cook received any information about people's dietary requirements therefore they had to guess quantities and portion size of each meal. We were advised by the cook this was the usual practice. This meant that whilst people would receive a meal, it was not guaranteed they would receive a meal of their choice.

The cook advised us of a recent incident where they were not told a person using the service was a diabetic which resulted in the person being served a normal diet for seven days which had a serious impact on the service user's blood sugar levels. This was in breach of Regulation 9(1) (a) (b) (c) (Regulated Activities) Regulations 2014 the care and treatment of people must be appropriate, meet their needs and reflect their preferences.

We looked at the care records of a person with diabetes and noted their blood sugar readings consistently fluctuated at the same time each day. We spoke with two care assistants about the person's dietary requirements. The first care assistant told the inspector that the service user was being served digestive biscuits each morning. The second care assistant told the inspector that staff had to 'watch' the person's food intake because the person was a diabetic and they knew the person could have a plain biscuit but was unsure of how many they could actually have at any one time. This meant that the service user was not properly supported to maintain a balanced diet and their care did not follow recommended good practice guidelines. This was in breach of Regulation 14(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 The nutritional and hydration needs of people must be met.

Inadequate

Is the service effective?

One person we spoke with told us there was quite a good chef at the home and confirmed they were given meal choices daily. Another person told us there had been a problem with the temperature of the food being too cold but that this had improved over the last two months.

The home's environment was spacious with wide corridors and handrails, which help to support people to mobilise independently throughout the home. The premises were accessible for people using a wheelchair or mobility aids, which further promoted people's independence. Shared bathrooms and toilets were spacious enough to manoeuvre wheelchairs and hoists. Raised toilet seats, handrails and non-slip flooring were in place to help promote and maintain people's independence and wellbeing. On entering the home on the first day of our inspection and walking through the home we noted there was a strong odour of stale urine. The odour was also apparent in the ground floor lounge and along the ground floor corridor. A staff member said about the malodour, "sometimes the smell is so strong, it stings your eyes". When we told the Registered manager, about the unpleasant odour, they told us they had not noticed the odour and said, "that's a shame, I haven't noticed the odour and we have spent a lot of time trying to make the home smell fresher". We noted on the second day of inspection, the home's reception area had been cleaned and the malodour was not as apparent as the previous day.

Requires improvement

Is the service caring?

Our findings

An end of life policy and procedure and a privacy policy was in place. The policy would help guide members of staff in supporting people nearing the end of life and staff had received appropriate training in this topic.

We examined the care plan of a person using the service who was nearing end of life, and noted that it set out the person's needs so that staff could support them to remain in the home and be comfortable as possible. The Registered manager discussed with us the resources available to the person, such as specialist care and increased district nurse and GP visits to monitor the person's wellbeing. When we visited this person in their room we saw they were sharing their room with another person who used the service. We found no evidence that consent to a "shared room," had been sought from either person. There was no evidence of a best interest process having been followed in relation to the continued appropriateness of shared bedroom accommodation, to ensure the dignity of the person nearing end stages of life was respected and that the dignity and needs of the second person sharing the room had also been taken into consideration at this private and sensitive time. This did not reflect good practice as recommended by the National Institute for Care and Health Excellence. The provider did not ensure people's privacy and dignity and did not make every reasonable effort to make sure both people personal preferences were addressed and respected. This was in breach of Regulation 10 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw some staff showed warmth and friendship to people using the service and they spoke to people in a kind, comforting and sensitive manner. People were supported by staff to eat their meals in their rooms if they didn't want to use the dining rooms and we observed staff assisting some people to eat their meal where they were unable to support themselves. We observed staff verbal "hand-overs" at a shift change was effective to fall in line with the care workers every day routines and systems.

Although some people told us they considered staff were kind and caring, our observations showed some staff did not know the people they were caring for including their preferences and personal histories. Whilst a care staff member was able to tell us the basic needs of some of the people they supported, they were unable to describe any of their likes or dislikes or provide any information about the person's life history admitting they had not read the peoples care plan. This meant positive caring relationships were not always developed with people using the service which would not promote people's wellbeing.

We observed a person being admitted to the home on the first day of the inspection. They were initially supported into the home by the ambulance workers via a wheelchair. As the ambulance workers helped the person out of the wheelchair, the activities coordinator and a care staff member brought a chair behind the person and helped them to sit down. The chair was facing away from the main room and the activity coordinator and care staff member made no attempt to assist the person to adjust to their new surroundings by turning the chair around to improve their view or asking them where they preferred to sit. The care staff member then left the person with the activities co-ordinator, who made some attempts to make her comfortable, and asked the person about their hobbies and interests in a gentle and encouraging way.

Another person was admitted to the home during the lunch period. We noted they were upset and anxious and a care staff member showed comfort and reassurance to the person. This person was asked if they would like a pasty for lunch and we saw the activities coordinator ask the cook if the person could have a pasty, to be told there were none left. The cook commented they had not been told the person was being admitted. It was apparent that none of the staff members knew anything about the person being admitted. Staff checked this person could have a 'normal' diet, and they were given lunch. We later saw this person sitting alone; they had not been introduced to the home, staff or any other people who used the service.

The above examples demonstrate a breach of Regulation 9(3) (b) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 designing care or treatment with a view to achieving peoples' preferences and ensuring their needs are met.

On the second inspection day we saw a service user watching TV whilst sat in a bucket chair. We saw two care staff members enter the lounge and approach the service user from behind without attracting the service user's attention. One of the staff members pulled the chair back and wheeled it out of the room whilst the service user was sitting in the chair. This was done without any communication to advise the person of their intention to

Requires improvement

Is the service caring?

manoeuvre the chair. It was clear by the person's facial expression they were startled by this intervention because requesting the person's consent was not treated as a process that continued throughout the duration of their care and treatment. This was in breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we walked around the home we noted constant call buzzers sounding and televisions and radios playing at high volume from different rooms. The reception telephone bell was on loudspeaker throughout the day and people's bedroom doors were left wedged open whilst people were in bed, which showed people's privacy was not always respected.

Inadequate

Is the service responsive?

Our findings

Before people moved into Cale Green Nursing Home the Registered manager told us that care needs assessments were carried out to gather information about people and whether their needs could be met at the home. Records we looked at showed these assessments, including mental capacity assessments, had not been fully completed and some care plans did not contain enough information needed for staff to provide person centred care responsive to meet people's needs.

For example a service user diagnosed with dementia had not undergone a mental capacity assessment to determine if they could make a decision or give consent about their care. We also noted that information required to identify the service user and meet their needs such as an up to date photograph of the service user and associated clinical issues and their personal care needs, were not detailed in the care plan. This meant the lack of appropriate detailed information about the service user's care and treatment did not meet their needs and reflect their preferences and might place the service user at risk of receiving unsafe and inappropriate care. This was in breach of Regulation 9(3)(a) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 carrying out, collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user.

Some parts of people's care plans were written in a person centred way. For example, it was recorded what time people liked to go to bed at night and get up in the morning. However we found peoples agreed care aims and outcomes and their agreed support requirements were unclear because the record did not state what the expected outcome was for the person and how any outcomes identified would be achieved. We noted that people's care plans had been written by different members of staff and the care instructions in some care plans were less person centred than the care instructions written in others. This meant that staff might find care pathways difficult to follow which would place people at risk of receiving unsafe or inappropriate care.

Whilst a care staff member was able to tell us the basic needs of some of the people, they were unable to describe any of their likes or dislikes or life histories. They told us they had not read the person's care plan. Recorded details in relation to the care and treatment of another person, admitted to the home during the inspection were insufficient to provide person centred and responsive care. Following this person's admission a pre admission assessment form consisting of a tick list was completed. However a section about the person's mental health was not completed. A more comprehensive care plan was developed after we pointed out the lack of detail in the record.

When we looked at the care plan of a person who had a visual impairment, we saw the occupational therapist had recommended for them to have their meals served on a coloured plate. We noted at lunch time this did not happen. When we asked the cook why this had not happened they told us they were unaware of this and the information had not been shared with them.

We examined the care plan of another person and saw a dependency assessment that was to be completed monthly was last completed on 5 November 2015. A care plan review completed on 15 December 2015 identified a nutritional care plan was not in place and was needed. A nutritional care plan was not in place at the time of the inspection. A Waterlow skin integrity assessment to be completed monthly was last completed on 3 October 2015, a falls mobility risk assessment completed on 27 October 2015, a malnutrition universal screening tool (MUST) last completed on 23 November 2015 was partly completed and didn't indicate the overall MUST score. MUST is a screening tool to identify adults who are malnourished, at risk of malnutrition or obesity. It also provides management guidelines which can be used to develop a care plan. An unnamed piece of paper titled 'nursing needs was partially completed stating "reduced mobility, make sure staff are present when [person] is walking around the home; physio if [person] would like", other areas of the nursing needs record were blank. The person's life story had been condensed into 12 lines and their care plan formal audit and review form was last completed on 29 December 2015 and had identified areas for action. However an action completion date was not in place and there were no records to show any actions were completed.

During the inspection we were approached by a person mobilising with a Zimmer frame who required help to the bathroom to change their incontinence pad. They told us it had been on for about three hours and they felt it needed changing because they said they could feel the urine burning on their leg. Another care assistant supported the

service user to the bathroom promptly. Afterwards we asked the care assistant about how frequently people's incontinence pads were changed and they said, "it depends on the individual". We asked about the person's continence assessment carried out at the home and were told the care assistant had seen on admission the service user needed a blue pad [large] but added they could go to the toilet on their own. We asked the care assistant if prompted more frequently if it would it be more appropriate for the service user to use a smaller incontinence pad to encourage their independence promoting their comfort and wellbeing. The care assistant advised there would not always be enough staff to support the person in promoting their continence. This meant people's care and treatment was not person centred, personalised specifically for them and focused on them as individuals and they were exposed to the risk of receiving inappropriate care and treatment.

We reviewed the care plan for the same service user alongside the senior carer and found discrepancies in the service user's continence plan. For example in the activities of daily living section 'bladder' was ticked as 'continent-independent' whilst toilet was ticked as 'dependant on getting on/off/help with balance, paper. Pads used in daytime/night-urine'. A dependency level assessment carried out on 5 November 2015 gave the service user a score of 3 for toileting indicating they 'need physical help' whilst on 20 November 2015 the service assessment scored a 1 indicating they could 'manage alone'. The review of care on 20 January 2015 continence was ticked as 'still the same'.

The service user's detailed care plan records showed they wore pads for urine incontinence and needed assistance with toileting. There was no evidence of pad size being assessed, usage monitored or any reference to promoting their independence or maintaining their dignity with more regular toileting. There was no evidence that a continence nurse assessment had been requested.

We looked at another person's care plan we looked and found gaps in the personal information section. For example; purpose and reason for admission were blank as was the relationship of the next of kin. The do not attempt to resuscitate (DNAR) form had been completed in hospital and the person had been assessed as 'no review required'. However, this form should have been reviewed and repeated on admission to Cale Green and the service user involved as their Deprivation of Liberty Safeguards checklist deemed them as having capacity. There was no detail in the plan regarding daily care preferences, likes /dislikes and there was no photograph of the service user in two of the care plans we looked at.

We saw people were not encouraged by staff to get out of bed and utilise the shared facilities in the home and a large majority of people stayed on or in bed in their rooms. We spoke with three people about this. Whilst they told us it was their choice they also told us the activities on offer did not have wide appeal. One of the care assistants we spoke with told us there was a lack of activities that interested people.

When we spoke with the activities coordinator they told us they no longer planned activities but left it to the people to decide what to do. They told us they alternate between lounges, but we didn't see them on the first floor of the home during both inspection days and we saw no activities taking place during the inspection. Therefore people on the first floor of the home were left without stimulation and meaningful activity. This meant people's care and treatment was not person centred and focused on them as individuals and there was the potential risk that the practice of people spending most of their day isolated in their room might become a culture embedded in the day to day running of the home.

The above examples demonstrate multiple breaches of Regulation 9(3)(b) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 designing care or treatment with a view to achieving people' preferences and ensuring their needs are met.

One service user told us "I'd have more company at home" but added "staff are alright, they're great". One of the visitors we spoke with told us they weren't sure why their friend didn't get up and when asked about activities agreed there wasn't a lot going on to stimulate them to get up. We asked two of the people when they had last been out of the home. One of them told us they hadn't been out since their admission in August 2015 and the other service user told us they had been out at Christmas but prior to that could not recall the last time they had left the home to engage in any meaningful activity away from the home. A relative of a service user who was a new admission to the home told us they had visited the home to look round prior to their relative being admitted and were "happy so far".

Inadequate

Is the service responsive?

Feedback from people about the service had been sought in Nov 2015 and the results were on display in the reception area of the home, including details of actions taken in response to the feedback received such as; the cook speaking to people regarding their food preferences and reviews to be undertaken for people who highlighted they felt a change in one or more of their needs.

We asked the Registered Manager for a copy of the home's Complaint's policy, and were provided with a copy of the Complaints and Compliments Policy and Procedure and a Complaints, Suggestions and Compliments Policy and Procedure. When we asked the Registered Manager about the two different policies they were unsure which was the most up to date. The Registered Manager maintained a log of complaints and compliments received.

Inadequate

Is the service well-led?

Our findings

The home had a manager registered with the Care Quality Commission (CQC), who was present for both days of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The Registered manager was supported in their role by a Registered nurse who held the role of Clinical Nurse Lead and a Quality Lead who completed quality audits at Cale Green Nursing Home and another home operated by the provider.

Since taking up the position of Registered manager at Cale Green Nursing Home in 2015, the Registered manager had produced regular "residents and relatives newsletters", to share information about the service. Visitor and relative's questionnaires had also been "left out" in the reception area of the home since November 2015. No formal written feedback had been provided although some families had verbally told the Registered manager things were better in the home. Whilst the Registered manager was unable to be more specific, he told us he tried to resolve any issues of concern as quickly as possible.

The Registered manager maintained a log of compliments, complaints, safeguarding alerts and outcomes. On review of these logs we were unable to identify if any analysis had been completed to highlight trends and triggers, so that actions could be taken to prevent reoccurrence.

When we asked the Registered manager and management team about the vision for the home, they told us they had not thought about it specifically as they had, "hit the ground running", following the CQC inspection in April 2015. They told us they continued to work with the staff team to reduce the number of complaints and safeguarding alerts and were in constant communication with the staff team. They initially identified any problems and resolved them through systems such as staff training and making sure people using the service "get what they need". The Registered manager told us that they wanted to deliver great care and for the home to be "a great place to work and live". A relative we spoke with said about the Registered manager, "things have got better; especially with the laundry".

The Registered manager told us he held weekly meetings with the Clinical Lead Nurse and Quality Lead, to discuss issues and results from audits completed at Cale Green Nursing Home and another home operated by the provider. Actions required for the week were agreed at the beginning of each week and reviewed at the end of the week to determine what had been completed.

We highlighted the dining room window pane was still unsafe and had been for eight months since the CQC inspection in April 2015. The Registered manager told us this had been reported to the provider but a repair date had not been discussed with them. We saw repairs were reported and recorded on the maintenance log and the Registered manager told us the four toilets out of use had also been reported to the provider. When we asked if there was an annual maintenance plan, the Registered manager confirmed there wasn't one. We were told, "tasks are prioritised at the weekly meeting but not recorded; just a conversation". These are then discussed with the maintenance person.

A discussion with the management team showed whilst the Registered manager had tried to meet the action plan points following the last inspection in April 2015, systems and processes had not been properly established and operated effectively to ensure compliance with the requirements made by CQC.

There was a lack of robust assessment and monitoring of the risks relating to the health, safety and welfare of people using service. We reviewed a quality audit check in relation to eight people's individual medicine stock quantities and found contemporaneous records were not maintained accurately of each person's medicines. For example; medicines were not carried over from the existing medication administration records (MAR) to a new MAR. Also a medicines stock check carried out on 23 December 2015 showed out of eight people, the medicine quantities for six people were not accurate and a person's paracetamol was noted as being, "unable to find".

Records in relation to the care and treatment provided to people were not accurate, complete and contemporaneous. A service user skin review undertaken

Inadequate

Is the service well-led?

by the Quality Lead on 15 November 2015 showed out of 42 people, seven people did not have a skin plan. A Waterlow skin assessment had not been carried out for two people, up to date information about people's skin condition had not been recorded on the skin plan for three people, a person's skin review had not been completed since July 2015 and a skin integrity form had not been completed for two people since November 2015. There was no evidence to confirm actions identified had been addressed and in some instances the same issues were reported in the following months audit check. When we reviewed people's care documentation on the 13 January 2016, we found that this information was still missing or incomplete.

Audit records given to us were presented as lists. Where shortfalls had been identified these lists did not identify any potential risk, or what action was needed to address the shortfall and who was responsible for addressing the shortfall to minimise the likelihood of risks to the health, safety and welfare of people using the service.

The above examples demonstrate multiple breaches of Regulation 17 (1) (2) (a) (b) (c) (f) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, operating effective governance systems to ensure the safety and of service provision.

Overall we saw care records were not up to date and systems and processes were not maintained to ensure the provider was able to meet other requirements in the Health and Social Care Act 2008. We reviewed a number of policies and procedures for example; recruitment and selection, the complaints, suggestions and compliments policy and procedure, consent to care and treatment, infection control, privacy, management of medicines and found they were last updated on 01/06/2012. The end of life care planning policy and procedure and the accident and incident reporting policy and procedure were last updated on 05/09/2013 and were written to meet the requirements in the Health and Social Care Act 2008 (Regulated Activities) regulations 2010.

These policies and procedures were not current and up to date to reflect the requirements in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which came into force on the 1 April 2015. This was in breach of Regulation 17(1) (a) (b) and 2(c) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance.

The Registered manager explained that the provider had introduced a new quality assurance system three weeks prior to our inspection, however there was no evidence to support the effectiveness of the new system as it was still in its infancy.

Through discussion with the Registered manager and management team and from the evidence we identified during the inspection we had significant concerns about the safe care and treatment of people living at the home. We had significant concerns about the skills, qualification(s), knowledge and experience of the Registered manager and management team to manage the regulated activity safely and to ensure the safe care and treatment of people living at the home. The above examples demonstrate a breach of regulation 7(2) (b) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 [a registered manager must have] the necessary qualifications, competence, skills and experience to manage the carrying on of the regulated activity.

From the evidence gathered during the inspection the Registered provider did not show they were aware of relevant nationally recognised guidance and best practice, and they had not taken steps to ensure practice at Cale Green Nursing Home reflected relevant national guidance and best practice. In addition to this organisational policies and procedures in place did not ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This meant the provider did not make sure people using the service were safe and not at risk of receiving unsafe and inappropriate care, treatment and support that met current best practice. This was in breach of regulation 5 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and proper persons: directors.