Bupa Care Homes (CFHCare) Limited

Crawfords Walk Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was carried out on 16 and 17 May 2016 and was unannounced on the first day.

During this inspection we focused on Watergate and Bridgegate units due to concerns that we had received following our last inspection. In addition we requested the support of a specialist advisor nurse who visited Watergate and Eastgate unit to review clinical practice at the service.

Crawford's Walk nursing home comprises of four purpose-built units in the Hoole area of Chester. The service is owned and operated by BUPA care homes. Northgate is a unit for people with enduring mental health illness issues, Watergate and Eastgate are units for people living with dementia and Bridgegate unit provides support for those with physical health needs.

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

At the last inspection on 21 and 22 September 2015 we found that a number of improvements were needed. These were in relation to people not being protected from risk when left unsupervised or due to unsafe care and treatment because there was a lack of information about their needs. People were not always supported or treated in a dignified way. We asked the registered provider to take action to address these areas.

After the inspection, the registered provider wrote to us to say what they would do to meet legal requirements in relation to the breaches identified. They informed us they would meet all the relevant legal requirements by the end of December 2015. However, whilst the registered provider had made improvements, they had not fully met their own action plan. We found a continued breach of the Health and Social Care Act 2008 (Regulated Activities) 2014 and also identified some additional concerns. You can see the action we have told the provider to take at the end of the report.

Quality assurance systems in place were not effectively used to assess and identify improvements needed to ensure the quality and safety of the care provided. Issues we raised during our inspection relating to care planning, documentation, and analysis of accidents and incidents had not been identified or fully addressed through the provider quality assurance processes. This was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as the provider did not effectively use systems and processes to assess, monitor and improve the quality and safety of care.

Records that we looked at were not always accurate, comprehensive and up to date. Care plans contained varied levels of information on each person and how their care and support was to be delivered. Daily records were not always completed in enough detail to reflect what care and support people had received

on a daily basis. Records did not always provide sufficient information to ensure that people who used the service received the necessary care and treatment. This meant that people were at risk of not receiving personalised care in line with their wishes, needs and preferences.

The registered manager had knowledge and understanding of the Mental Capacity Act 2005 and their role and responsibility in regards to this. However, staff had a varied understanding of their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People's care records did not contain information about their mental capacity, and mental capacity assessments had not been completed as required by the MCA. Furthermore there was no information outlining how decisions for people who lacked capacity had been made in their best interests.

People told us they felt safe and we found there were enough staff on duty to meet people's needs. Staff understood how to identify abuse and were aware of the action to take if abuse was suspected or reported. We saw safeguarding procedures had been followed when incidents had occurred. However, following our inspection concerns have been raised around the care of some people in the home. These are currently under investigation by the relevant authorities.

People were supported to eat their meals by care staff appropriately and sensitively and people told us they enjoyed their meals. Although we observed that people's nutritional and hydration needs were met, this was not always recorded accurately or in detail.

Staff attended regular training sessions in areas such as moving and handling, first aid and safeguarding adults to update their knowledge and skills. Where training in MCA and DoLS had not been effective the registered provider accessed coaching sessions for staff to enhance and develop their skills. Staff had access to regular supervisions to discuss matters that affected them and also to focus on aspects of their performance that were good or where improvement was required.

People received their medication as required. Nursing staff had completed competency training in the administration and management of medication. Medication administration records (MAR) were appropriately signed and coded when medication was given. However, we noted that care plans for PRN (as required) medication were not always in place for staff guidance.

Staff were caring and treated people with kindness and respect. Most people and relatives were happy with the overall care that they had received. Observations showed that staff were mindful of people's privacy and dignity and encouraged people to maintain their independence

Robust recruitment processes were followed and there were sufficient qualified, skilled and experienced staff on duty to meet people's needs. This meant people were cared for by staff that had been deemed of suitable character to work within the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

Accidents and incidents were reviewed on a regular basis but the registered provider did not always take appropriate actions to minimise risk.

Staff we spoke with demonstrated a good understanding of how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents

Medicines were stored and administered by suitably trained staff. However, care plans for PRN (as required) medication were not always in place for staff guidance.

Is the service effective?

Requires Improvement

The service was not always effective

Records to evidence that consent to care and treatment and best interest's decisions made were not in line with the requirements of the Mental Capacity Act 2005.

Staff received regular supervision and training to support them with their roles. However, it was clear that not all the training was effective as staff had a varied understanding of the principles of mental capacity or DoLS requirements.

The mealtime experience was relaxed and pleasant. People told us how much they enjoyed the food and they were offered choices at mealtimes.

Is the service caring?

Requires Improvement

The service was not consistently caring

Staff on Bridgegate did not always treat people with dignity. People's personal appearance was not always maintained.

We saw people being acknowledged and their privacy being respected as staff were discreet in asking if people needed help.

Staff understood the importance of providing dignified and respectful end of life care to people.

Is the service responsive?

Requires Improvement

The service was not always responsive

Care plans did not accurately reflect the care and support that people required. Daily records were not completed in a timely manner or in full detail.

Supplementary charts or daily records were not checked or monitored in order to analyse and utilise the information recorded.

People and their relatives knew how to complain and were confident their complaints would be resolved.

Is the service well-led?

Requires Improvement

The service was not always well led

The registered provider had a quality assurance system in place at the service but this was not used effectively.

The service was managed by a person registered with CQC. The registered manager was described as friendly and polite.

Crawfords Walk Nursing Home

Detailed findings

Background to this inspection

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

We visited the service on the 16 and 17 May 2016. Our inspection was unannounced on the first day and the inspection team consisted of two adult social care inspectors and a specialist advisor. The specialist advisor was a Nurse who also had professional experience in End of Life care.

As part of the inspection we spoke with nine of the people living in the service, nine family members, two visiting health professionals and thirteen staff. We also spent time with the registered manager and area manager. We observed staff supporting people and reviewed documents at the service. We looked at fourteen peoples care records, medication records, four staff files, training information and quality assurance processes in relation to the running of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed care and support in communal areas and staff interaction with people during a mealtime.

Before our inspection we reviewed the information we held about the service including notifications of incidents that the provider had sent us since the last inspection, complaints and safeguarding. We also contacted local commissioners of the service and the local authority safeguarding team to obtain their views. Concerns were raised about the service in relation to care planning and the safe use of the call bell alarm system.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe using the service. Comments included, "The care staff come when I need them and they are usually pretty quick" and "They look after me well and make sure that I don't come to any harm". Family members told us "The staff act on their initiative and "I feel that [my relative] is very safe when I leave here".

When we inspected the home in September 2015, we observed that there were periods of time where people were left unsupervised on Watergate unit and identified a safety risk to people who used the service. This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. We issued a requirement notice and asked the registered provider to take action to ensure the adequate supervision of people supported. On this inspection, we found that the registered provider had made some improvements to ensure that people were safe.

A staff member on Watergate unit was always available to supervise people in the lounge area and completed regular checks to ensure people were not at risk. Staff told us "One of us makes sure we stay in here now when people are here. That way we can ensure no one comes to any harm or if someone needs some help they know we are here" and "We recognise how important it is not to leave the room without staff. It takes a split second for something to happen and we don't want anyone here to be vulnerable". It was clear that staff had improved practice and they had an awareness of the importance of ensuring people were not left unsupervised.

Prior to our inspection, we received information from the local authority, that concerns had been raised with the registered provider regarding the use of call bells, at the service. We looked at the records of fourteen people across all of the units inspected and saw that an assessment for each individual had been completed to identify whether a call bell was necessary and/or required. Where people were deemed unable to use a call bell, the assessments did not provide clear guidance to how staff were to monitor people to ensure that they were safe or did not require assistance. Records did not always identify other means by which the person was monitored, such as implementing regular visits or checks. We also observed that not everyone was able to access their call bell. Call bells were accessible to people whilst they were in bed but the cords were not long enough to allow the bell to be placed next to the chair. However, observations showed that staff visited and checked on people on a regular basis to ensure that they were safe. We raised this with the registered manager and area manager who confirmed that records were under review on each of the units to ensure that they clearly identified how people were to be supported if they could not use the call bell alarm system independently.

Individual risk assessments were in place for people for areas such as moving and handling and use of bed rails. The registered provider also used a recognised risk assessment tool for the monitoring of malnutrition and skin integrity. Where an increase in risk was identified, we saw that appropriate action had been taken such as the provision of specialist equipment or referral to an external agency for advice. The registered provider had ensured that, where assessed as required, people had an air mattress to minimise the risk of developing a pressure ulcer. We saw that a number of people were on pressure relieving mattresses but not

all had an assessment to indicate what pressure setting was required and there no evidence that they were checked throughout the day to ensure they were working properly. This meant that people could be at further risk of developing skin problems if the settings were incorrect. Care plans did always not reflect the correct equipment being used for the person. We brought this to the attention of the registered manager on the first day of the inspection. When we returned on the second day, remedial action had been taken and all care plans reflected the equipment used and the required setting of any mattress.

Staff had an understanding of safeguarding. They were able to identify areas of abuse and/or poor care and had a good understanding of the reporting procedures used by the service. They told us "People trust us to make sure they are safe. I would not hesitate to raise any concerns either internally or externally if I wasn't happy with something". Staff directed the inspectors to posters that were displayed on the office walls which clearly outlined what actions they were required to take in the event of suspecting abuse or ill treatment of a person. In addition, staff were able to tell us about the BUPA help line "speak out". This created an opportunity for staff to speak to someone who did not work at the service if they felt concerned and not able to speak to the manager. Records we looked at showed that staff had attended training about safeguarding vulnerable people and that safeguarding concerns had been addressed in partnership with the local authority.

Staff were able to describe how they were required to record information about any accidents and incidents that occurred at the service. These included such things as slips, trips, falls, skin tears and medication errors. Accident records were completed and the registered manager reviewed and collated this information on a monthly basis.

There was a protocol in place for the ordering, storage, administration and disposal of medicines. We looked at ten medication administration records (MARS) and found them to accurately reflect the medication given and medication remaining in stock. These included controlled drugs. Medication was also stored securely in a locked storage facility or the refrigerator. Some people were prescribed medicines that needed to be taken only 'when required' (PRN) such as pain killers or sedatives. On Bridgegate unit, care plans were in place for some, but not all PRN medications. Where PRN care plans were in place, we found on Bridgegate unit, that they did not contain sufficient information to guide staff as to when and how these medicines should be given to people. This could result in people not receiving their medicines as required. We raised this with the registered manager who informed us that PRN care plans would be reviewed and updated.

The registered provider had robust recruitment and selection procedures in place. We looked at the recruitment files of four staff members and the information contained in the files demonstrated that appropriate checks had been carried out prior to the staff starting their employment. For example, we saw that an application form had been completed, evidence of formal identification had been sought and written references had been obtained. In addition a Disclosure and Barring Service (DBS) had been carried out. These checks were carried out to ensure that only staff of suitable character were employed by the registered provider.

Watergate unit was clean, hygienic and free from unpleasant odours. Cleaning schedules were in place and well maintained. However, we noted that on both Bridgegate and Eastgate units some areas were visibly unclean. Bed rail protectors were dirty and areas situated behind peoples beds were covered in dust and debris. We raised this with the registered manager. The area manager contacted us following the inspection to confirm that new bed rail protectors had been purchased and the cleaning concerns addressed. Staff had access to a good stock of personal protective equipment (PPE) such as hand gels, paper towels disposable gloves and aprons.

Records relating to the safety and maintenance of the service were in place and up to date. Equipment used at the service such as hoists and bath chairs had been regularly tested to ensure their safety and safety checks on gas and electrical equipment were conducted by external specialists. The service had contingency plans in place to deal with emergencies such as a fire, flood, gas leak and loss of power to the home.

Requires Improvement

Is the service effective?

Our findings

People told us that they were supported to access the GP or other health professionals when needed. One person told us, "My leg was a bit sore, so I told them and the doctor came out quite quickly". Family members felt relatively confident that the service would access health professionals for people when needed. Comments included, "They let me know of any changes to [my relatives] health straight away and tell me what they have done about it" and "[My relative] had a pressure ulcer when they came here. The nurses have involved the tissue viability nurse and it's now healed perfectly. I am confident in their ability".

At the last inspection, we had concerns about staff understanding and application of the Mental Capacity Act 2005. We made a recommendation to the registered provider that staff needed to improve practice in this area. We found that the required improvements had not been achieved.

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. Policies and procedures were in place to guide staff in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

Not all of the people who used the service were able to make complex decisions for themselves, such as where to live, whether to take medication or how to keep themselves safe. We found that there was little evidence of any 'decision specific' mental capacity assessments in regards to support tasks such as medication, use of call bells or the use of restrictive equipment. For example, where people did not have call bells in place we found no mental capacity assessment in place to explain how the decision had been reached that the person was unable to use it. Comments such as 'cannot use call bells as mentally impaired' were recorded in care plans. Where bed rails were in place, there was no evidence that informed consent had been sought from the person. Although there were basic risk assessments in place to demonstrate why they were deemed necessary, there was no evidence that least restrictive options had been considered. Records in place showed that staff had not carried out a mental capacity assessment or recorded a best interest decision meeting.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider had failed to ensure that effective procedures, documentation and recording systems were in place to ensure that the Mental Capacity Act 2005 was fully implemented.

The registered manager had submitted applications under DoLS to the local authority for a number of

people who used the service. These were for people they believed could not make a decision, due to mental capacity, as to where they should reside or the use of other restrictions in place such as the use of bedrails.

We spoke with the registered manager who confirmed that this was an ongoing area of development at the service. We noted that some staff had attended MCA and DoLS training with Cheshire West and Chester local authority since our last inspection. The registered manager told us "We know that some people are still struggling with this and we are trying to get the help that they need. This is not going to be fixed overnight. We want to invest time and training to get it completely right moving forward". The registered provider had arranged for a quality assurance lead to regularly attend the service from May 2016 to undertake coaching and training sessions with the staff on MCA and DoLS.

We raised concerns during our last inspection regarding the mealtime experience on Watergate unit. We made a recommendation to the registered provider to ensure that staff completed dementia awareness training and promoted a positive mealtime experience for people with dementia. We found that significant improvements had been made.

People told us that the food was good at the service. One person who lived on Bridgegate said "The chef does special pasta and jelly for me as I am diabetic. It is nicer than my daughters so that is saying something". Family members told us "The food is good, [my relative] eats like a horse and has put weight on since living here" and "The food is fantastic. [My relative] always has lots to eat and drink and there are always snacks available".

The mealtimes across all three units promoted a positive experience for people. People were relaxed, happy and staff were organised in their approach. The registered provider had introduced a hostess role at mealtimes which enabled staff to focus on ensuring that each person received their meal, dessert and drinks as required. People were offered choices of where they would like to sit. Some people chose to sit at the dining room tables and others chose to sit in their chair with over tables or in the privacy of their own rooms.

It was clear that lunchtime experience for people on Watergate unit was greatly improved. Tables were set in a timely manner and appropriate equipment and condiments were available for people to use. Where support was required, staff sat with people and helped them to eat their meal. Support was provided sensitively and staff gave people sufficient time to enjoy their food. Family members were welcomed into the dining area to support their relatives with their meal. One person we observed had a number of their personal items with them at the dining table such as magazines and dolls whilst eating their meal. Staff were respectful of this and recognised the importance of the person having these items with them. Staff provided clear explanations and visual choices were appropriate. Meals looked balanced and healthy and people were given their choice of meals at the table or alternatives were made available if they did not like the options presented.

Staff were knowledgeable about the care and support people needed. Staff explained their role and responsibilities and how they would report any concerns they had about a person's health or wellbeing. Appropriate referrals for people were made to other health and social care services. Staff identified people who required specialist input from external health care services, such as speech and language therapists and tissue viability nurses and where appropriate staff obtained advice and support.

Staff received regular training and they were provided with the knowledge and skills required to support people who lived at the service. Where training had been provided, the registered provider had tested out its effectiveness. Where staff had not achieved the correct level of understanding then additional training and

coaching support had been put into place. The registered manager informed us that since the last inspection, dementia awareness had now become part of the induction programme for all new staff who joined the service. Staff we spoke with were complimentary about the induction process and told us, "It was far better than the one I had at my last job in the hospital" and "It's been a good mix of classroom, practical and e-learning". We saw that staff had completed training in line with the registered provider's programme of training. Training sessions attended included moving and handling, first aid, fire safety, health and safety and safeguarding. The registered provider had processes in place that enabled the registered manager to update training records and identify what training staff required.

As well as training staff received supervision. This was done on a one to one and a group basis throughout the year. Staff confirmed that they regularly had the opportunity to spend time with senior members of staff to discuss issues of a personal and professional nature. Staff files held records of supervisions and we saw that the nursing staff had access to regular clinical supervision. Clinical supervision is a formal process of professional support and learning that addresses nurse's developmental needs in a non-judgemental way. The registered manager conducted 'heads of department' meetings on a regular basis to ensure that unit managers were kept up to date with relevant information or any changes to the service.

Requires Improvement

Is the service caring?

Our findings

People told us that overall they were happy with the service they received. They told us, "One word to describe this place, Brilliant" and "I'm very happy here. I couldn't wish for better people to look after me". Family members on Watergate commented "I visit every day and sit with [my relative] at lunchtime. They are very loved by the staff and they are affectionate with [my relative] which is important" and "The staff actually care about people, they take their time to get to know people and always talk to [my relative]. They never talk over them, everything is with them". Family members on Bridgegate had a mixed view and commented "I have never had an issue with my friends care and they always seems quite happy" whist another said "It is up and down. Some days here are better than others".

When we inspected the home in September 2015, we identified concerns that people living on Watergate unit were not always supported or treated in a dignified manner. This was a breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Dignity and respect and we issued a requirement notice. We asked the registered provider to take action to make improvements and that they had done so. The registered manager told us that following the previous inspection a lot of work and training had been completed with staff to ensure that people were always treated in a dignified way.

Family members told us "[My relative] is safe, cared for and relaxed with the staff. They have got to know [my relative] very well and respect their routines and choices". Relationships between people living on Watergate unit and staff appeared calm and we observed staff speaking with people in a respectful, compassionate and kind manner. Staff demonstrated a good knowledge of people such as their likes and dislikes and we observed staff encouraging people to maintain their independence where possible. Staff were able to describe how they would encourage people to make decisions relating to everyday activities such as, choosing what to wear, where they would like to spend their time, who with and for how long. Staff promoted different choices for activity and engagement throughout the course of the day and they spent time sitting and chatting with people.

We observed that people on Watergate and Eastgate units were cared for with dignity and respect. They were assisted to use the bathroom as they needed to and staff were discrete in their approach. People were dressed in clean clothes and had been assisted with their personal appearance. One family member told us "[My relative] is always nicely dressed and well looked after. Their appearance was hugely important to them all of their life. The staff have recognised this and make sure everything is just how they would like it to be".

Observations on Bridgegate showed that staff took time to engage with people when providing care and support. An example of this was when one person required eye drops and we saw the nurse taking time to explain what they were for and how best to administer them. Staff were observed supporting a person in a hoist and time was spent with the person to ensure they understood what staff were going to do. Staff told them that they were going to place straps over and then to lift the person up. Staff encouraged the person and praised them for cooperating. It was clear from the person's reaction that they felt reassured by the calm approach. However, we received feedback from family members of less dignified care. Comments shared included, "The staff are OK but I am not confident that they would give [my relative] lots to drink if I

was not here". I am not convinced that they change their clothes every day as sometimes they are in the same things" and "I had to have [my relatives] hair cut short. They were not brushing it properly, just doing the front. It was rubbing against the pillow and so it was all matted". We raised these concerns with the registered manager who informed us that they would look into these matters immediately.

Following our inspection concerns have been raised around the care of some people in the home. These are currently under investigation by the relevant authorities.

Staff on Eastgate told us about their experiences in supporting people at the end stages of life. They told us "This is a difficult time and we try to ensure people have a pain free and dignified death". The registered provider had commenced the six step training with staff. The six step programme has been developed in the North West of England, to enhance and support organisational change, and develop staff working in care homes, in end of life care. The programme ensures that staff support the wishes, preferences and choices of people at this stage of care. Nursing staff told us "Our training is provided by a local hospice and we also attend the end of life care conference to make sure we are up to date with any changes in practice nationally". The registered provider had recently received written feedback from a family member which stated, "[My relative] saw all of you as an extended family and told us about many instances of your kind, caring manner. Thank you for all the support you gave right through to the end of their life".

Throughout the day we observed staff knocking on bedroom doors prior to entering to ensure people had privacy. Staff understood the importance of ensuring people's privacy was respected and were confident in describing how they protected people's dignity as far as possible in the way that they carried out personal care and support. Each person had their own bedroom which they had personalised with items such as photographs and ornaments. One family member told us "We spend time in here when I visit looking at all the pictures of our life. I have popped in for an unannounced for a visit and heard the staff talking to [my relative] about them too. It makes [my relative] and me very happy".

Visitors told us they were welcome at the service. One visiting relative said "I can visit [my relative] when I want too. I also call every evening to speak with [my relative] on the telephone before bed time. The staff know how important that is to me and try to help them to understand it's me calling".

Requires Improvement

Is the service responsive?

Our findings

People told us that if they were unhappy with the service they knew who to raise their concerns with. Comments included, "I have no concerns here and never have had" and "I tell the staff if I don't like something, they are pretty good at sorting stuff out for me". Family members across the units told us, "If I have a complaint they deal with it on the unit. I have never needed to go to the manager, but I know where to find them if I needed too" and "I raised some concerns when [my relative] first moved here. They were dealt with quickly and sorted by the staff. Staff are very approachable".

At the last inspection, we had concerns regarding the lack of accurate and complete records in respect of people who used the service. This was a breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. We issued a requirement notice to the registered provider and asked them to take action to make improvements. On this inspection, we found that whilst some improvements to care plans had been made, accurate records were still not always held in respect of each person.

Care plans across all three units were not of a consistent standard. Some lacked in detail about a person's wishes and preferences whilst others contained information that would allow staff to provide a more individualised level of support. Through discussions, we found that staff had a good understanding and awareness of the support required for people. We saw that the registered provider had started to review care plans at the service, however written records were not always accurate or fully completed.

Since our last inspection, the registered provider had taken a decision to remove some supplementary documentation. These records had been used to demonstrate what support and monitoring had taken place; for example in the monitoring of pressure relief or food and fluid intake. There was an expectation that staff would complete a comprehensive daily record of what care had been offered, delivered and how a person had been on that day. However, we found that the daily records did not always reflect the support provided. Information required to evidence that a person had been repositioned to aid pressure relief was inconsistent across all units. Daily records did not always include information as to how often people had been repositioned or to which side. Staff told us that they made a note of this information in their pocket notes to aid them to remember but that this was not always transferred into the daily records. This meant that staff could not be accountable for care and support offered, refused or provided to people at the service. Audits that we viewed showed that compliance with recording had not been monitored by the registered manager.

Some people living at the service required close monitoring of their diet and fluid intake. Records and conversations with visiting professionals showed that the service highlighted any people who required specialist support with their nutrition. One visiting professional told us "They are very good at flagging up problems whether major or minor. We are kept alerted to changes in people's weight on a weekly basis. The team are responsive in this area". However, we found that accurate records were not always kept to assist staff to monitor whether someone had adequate food or fluid intake even when there was an identified risk. Where records were in place, these were not always accurate or completed in full. We found on Bridgegate that one person's food and fluid intake chart indicated on the 13 May 2016 that they had only taken a small

amount of breakfast throughout the day. However, daily notes completed by staff indicated that "Diet and fluids were taken well". We found on Watergate unit that no food and fluid intake had been recorded for a period of 48 hours for one person who was known to be at risk of weight loss. We spoke with the person and staff who were confident that they had received regular food and drinks; however records had not been completed accurately to reflect this. Across all units we found that records did not provide an accurate reflection of what had been consumed by people. Comments such as "half a roast dinner" or "tea" were recorded and there was no suggestion as to how big the meal was or how much had been eaten. Daily records and supplementary charts were not checked or monitored in order to analyse and utilise the information to make informed decisions on care, support or medical needs of people supported.

We found at 4pm on the first day of our inspection that the daily interventions for two people on Bridgegate had not been recorded in the daily records since the previous day. For one person the last entry indicated that they had been assisted back to bed after dinner and the other person had been assisted back to bed at 2pm. This meant that there was no record of what care and support they had received for over a 24 hour period. Both these persons were found to be in bed wearing their days clothes, but records did not support whether they had received any personal care that day or whether they had, in fact, been left in the same clothes from the day before. We spoke with staff who informed us that both people had received personal care but it had not been recorded.

We found on all three units, that where records had been completed they did not always provide useful or constructive information as to what had occurred or what support had been provided over a given time period. Unit managers told us "This is an area of development for our staff. Some are better than others at writing good information in daily records. We recognise that there are gaps in information".

Since our visit we have been informed by the registered manager and area manager that supplementary records have been reintroduced as required at the service. Records will be reviewed on a regular basis to ensure they contain accurate and relevant information.

This was repeated breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as the registered provider had failed to ensure that accurate and contemporaneous records were held in respect of each person.

Since our previous visit the registered provider had introduced activities coordinators for each unit at the service. On Watergate unit we observed a number of interactions being undertaken with people which included reading magazines, listening to music and some people were actively watching a movie. After lunch an entertainer visited the unit and people were engaged in singing and dancing and staff encouraged people to be involved as much as they wished. Activities on Bridgegate were being reviewed as people presented with more complex needs. The activity team told us "We are trying to research new things to do all the time. We want to buy some more age appropriate books and crafts for people to use" and "We are spending a lot of time with people on a one to one basis here" and "We recognise how important it is to know about people's life histories. Some of our care plans are scant in this area so we are trying to meet with families to get some more information". It was clear that this was an area of continued development at the service.

The registered provider had a robust complaints and compliments procedure in place which gave details of who people could speak with if they had any concerns and what to do if they were unhappy with the registered provider's response. We saw a record of complaints that the registered provider had acted upon and successfully concluded. Compliments the service had received had also been recorded and comments included, "We cannot find the words to express how thankful we are for the great care and support [our

relative] received" and "Thank you for all your care, kindness and support".

Requires Improvement

Is the service well-led?

Our findings

People who used the service told us that they knew who the manager was and he regularly visited them throughout the day to see if everything was ok. One person commented, "He is always very friendly and polite, a cheery guy all round". We noted that throughout our visits the registered manager visited all the units to speak to people and to see if they were happy with the service they received.

The service had a registered manager in post and he had been there since 2011. We were informed prior to our visit that the current registered manager will be leaving the service in June 2016. A new manager has been appointed and a period of handover was planned to ensure consistency in the transition period.

At our inspection in September 2015 we asked the registered provider and registered manager to take action on how the quality and safety of service people received was assessed and monitored. We asked the registered provider to send us an action plan telling us what action they intended to take, who was responsible and when they anticipated these actions would be completed.

The registered provider had quality assurance systems in place to assess and monitor the service. The registered manager and named leads within the service were responsible for the day to day audits / checks including reviewing accidents and incidents, care plans and medication. However we found that the staff did not use these effectively to highlight, address and resolve concerns. Our inspection found issues that had not been identified by the audits carried out. For example, the weekly clinical risk reviews for April and May 2016 that had not identified the inadequate recording of information relating to repositioning or pressure care relief across all units inspected.

The analysis of accidents and incidents was not consistent across all units. Neither staff nor the registered manager robustly analysed occurrences in sufficient detail in order to identify themes and trends, to learn from them or take steps to minimise the risk of further harm. For example, we noted that one person had fallen on a number of occasions but consideration had not been given as to why this had continued to occur. This meant that the registered provider was not always aware if adjustments were needed to the premises, equipment or staff practices as the result of similar occurrences. Where concerns had been identified no action plan had been put in place to demonstrate what improvements were required, a time scale for remedial action or to acknowledge when issues had been resolved. This meant that there had been a lack of accountability and oversight by the registered manager and the registered provider to ensure the quality and safety of the service provided to people.

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

The registered provider had recently introduced a new area manager to support the service. Through discussions with this person and a review of the 'provider audit' that they had completed in March 2016, we saw that some areas for improvements at the service had been highlighted and a provider review action

plan had been introduced. The area manager spoke confidently about the improvements required at the service and since our inspection has provided regular updates on progress made in relation to the concerns we raised.

Resident's and relative meetings had not always taken place at the service and minutes of meetings for all three units we visited were not available. These meetings give people the opportunity to express their views and make decisions about changes that may be required in the service. The area manager has confirmed following our visit that monthly meetings have been arranged from June 2016 with people who use the service and their family members to ensure that people have the opportunity to provide constructive feedback at the service. Customer feedback sheets have been introduced on each unit which will ensure that feedback on any actions identified will be shared with people for their knowledge moving forward.

Prior to the inspection, we reviewed the statutory notifications that the registered provider had submitted to the CQC. Notifications enable CQC to monitor any events that affect the health, safety and welfare of people who use the service. The registered manager had notified CQC and other relevant agencies of incidents that had occurred at the service. However we found that we had not been notified about a number of authorised Deprivation of Liberty safeguards applications for people who lived at the service. The registered manager took immediate action to rectify this and the appropriate notifications have now been submitted to CQC.

Personal records were stored in a locked office when not in use. The registered manager had access to up-to-date guidance and information on the service's computer system that was password protected to ensure that information was kept safe.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

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

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider did not have systems and processes in place to assess, monitor and improve the quality and safety of care. People were at risk of receiving care and support that was not suited to their needs as care plans did not contain up to date and accurate information. 17(1)(2)(a)(b)(c)(f)

The enforcement action we took:

We issued a warning notice and told the registered provider to be compliant by 3 October 2016.