C.T.C.H. Limited

Parton House

Inspection report

Parton Road
Churchdown
Gloucester
Gloucestershire
GL3 2JE

Tel: 01452856779
Website: www.ctch.co.uk

Date of inspection visit:
10 May 2016
11 May 2016

Date of publication:
15 June 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 10 and 11 May 2016 and was unannounced. Parton House provides care to 36 older people with a physical and/or sensory disability. The home was last inspected on 18 September 2015 to follow up on breaches of regulations found at the comprehensive inspection on 20 April 2015. These had been met. At the time of our inspection 27 people were living in the home and of these 14 people were living with dementia. Accommodation was provided over two floors with shaft lifts to access the first floor. There were 36 bedrooms, each of which had en suite facilities and there were an additional bathrooms and shower rooms. People had access to three lounges, a home cinema and a dining room. There were pleasant grounds around the home which were accessible to people.

There was a registered manager in post. 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 and associated Regulations about how the service is run. The registered manager was on annual leave at the time of our inspection. A representative of the provider was present in their absence.

People received inconsistent care and support which impacted on their safety and well-being. Changes in people's physical or mental well-being were not always responded to in a timely fashion. Staff were reactive rather than proactive and people's health potentially suffered as a result. Risks to people had not always been explored or investigated to prevent them from reoccurring. This was not helped by poor record keeping and making sure care records and medicines administration records were accurate and up to date. People were not always treated with dignity and respect. They had access to a range of activities which were being reviewed to make sure they provided meaningful and individualised opportunities for people. When staff were appointed not all of the checks needed had been carried out to ensure they were fit to carry out their duties. Quality assurance audits were not robust and the service was not always well-led.

People and visitors were positive about the care and support they received. They were involved in planning and reviewing their care and support. Their concerns were listened to and action had been taken in response. People were supported by enough staff who understood them well. Staff were kind and compassionate and cared for people. They were supported to develop in their role and their training needs were monitored. A range of training had been provided and more was scheduled. Staff had individual meetings to help them reflect on their performance.

People and their relatives were able to express their views through residents and relatives meetings as well as annual surveys. As a result trips and outings had been arranged and there had been improvements to the laundry. A three year refurbishment of the home had reassured them about concerns about the environment. The provider recognised the issues raised at the inspection and confirmed action would be taken to improve the standards of care and support provided.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can

see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. People were not always kept safe from the risks of potential harm. Control measures were not effectively used to minimise risks or taking action to prevent further harm.

Gaps in the recruitment and selection process for new staff could potentially put people at risk of harm, by the appointment of staff who had not been fully checked.

People were not having their medicines when they needed them and in accordance with their prescription.

People were supported by enough staff to meet their needs.

Strategies were in place to protect people from the risks of potential abuse.

Is the service effective?

Requires Improvement

The service was not always effective. People's capacity to consent to their care and support was not consistently assessed or recorded, potentially risking them having decisions made on their behalf when they were able to make these choices for themselves.

People's nutritional needs had not been monitored closely to ensure they had enough to eat and drink and any weight loss was stabilised.

People were supported by staff who had access to training and individual meetings.

People were referred promptly to a range of healthcare professionals.

Is the service caring?

Requires Improvement

The service was not as caring as it could be. People were not always treated with dignity and respect.

Staff cared for people and understood them well but focused on completing their tasks.

People's care and support was discussed with them.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's care records did not provide a consistent overview of their changing needs and the care they were receiving.
People had access to some activities and outings. There were plans to offer a range of meaningful and individualised activities throughout the day.

People knew how to raise concerns and complaints. These were listened to and action had been taken to address the issues raised.

Is the service well-led?

Requires Improvement

The service was not routinely well-led. People did not benefit from a service which was managed well. Quality assurance processes were not robust and did not consistently improve people's experience of their care and support.

People were asked for their views and opinions about the service they received and these were acted upon.

Parton House

Detailed findings

Background to this inspection

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

The inspection took place on 10 and 11 May 2016 and was unannounced. One inspector and an expert by experience carried out this inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert's area of expertise was older people living with dementia. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we have about the service including notifications. A notification is a report about important events which the service is required to send us by law.

As part of this inspection we spoke with twelve people using the service and four visitors. We spoke with the representative of the provider, five care staff, the cook, two domestics and joined staff at a handover between shifts. We reviewed the care records for five people including their medicines records. We also looked at the recruitment records for three new staff, staff training records, complaints, accidents and incident records and quality assurance systems. We observed the care and support being provided to people. We used the Short Observational Framework (SOFI) for inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We received feedback from four health and social care professionals.

Inadequate

Is the service safe?

Our findings

People had not always been protected against the risk of harm. A person who was having bed rest and needed to be turned every two hours had three unexplained bruises and an injury over a period of two months. A body map and daily notes had been completed to record these. There was no explanation of the bruises or evidence an investigation had looked into the possible reasons for these. The person's skin and pressure area care plan stated they were at risk of developing pressure sores and a wound care plan had been put in place in response to these risks. There was however no wound care plan. Staff were unable to explain to us how the bruises and injuries had occurred, stating the person had fragile skin. Another person who was at risk of developing pressure ulcers had a red sore on their heel. This was recorded in their daily records and on a body map. There was no evidence of what action had been taken and of any follow up care and treatment. This failure to investigate reasons for unexplained bruising could potentially place people at risk of further harm or injury.

Concerns had also been raised with the provider about unexplained bruising on another person's legs. In response to the complaint, investigations and discussions with health care professionals suggested it was possibly caused by the person moving when in bed. Another concern had been raised about call bells not being accessible to people when in their bedrooms. On the first day of our inspection four people who were in their bedrooms were unable to access their call bells. People would be unable to raise the alarm in an emergency. On the second day of our inspection people in their bedrooms had their call bells within reach. A visitor commented their relative had often been told they had to wait to go to the toilet when they had rung their call bell, which distressed them.

People were not receiving safe care and support. Risks had not been diminished and equipment provided to keep people safe had not been used correctly. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were potentially put at risk of care being provided by staff who were unfit due to gaps in the recruitment process. Most checks and information had been carried out prior to staff starting work in the home. There were however gaps in employment on all the application forms checked. This meant that although the reason for leaving former employment with children or adults had been verified, due to the gaps in employment history a full picture had not been obtained. Proof of identity and a satisfactory Disclosure and Barring Service (DBS) check were in place. A DBS check lists spent and unspent convictions, cautions, reprimands, final warnings plus any additional information held locally by police forces that is reasonably considered relevant to the post applied for. References had been requested from the last employer and to check the character of new staff.

People could potentially be at risk of harm because effective recruitment procedures were not being operated. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not being safely administered or managed. Despite medicines administration

being audited and discrepancies being discussed with staff we found the medicines administration record (MAR) had gaps where staff had not signed to confirm medicines had been taken. Seven MARs were checked and each had gaps. Some of the gaps had dots which indicated staff had taken the medicines to people. One person needed eye drops daily but there were gaps which implied this had not happened. A healthcare professional had raised concerns when checking a person's sight about the poor readings due, they thought to not having their eye drops given each day. Another person had been prescribed cream daily but did not have this applied for three days because the MAR stated it could not be found. It had been supplied five days previously. Other people had not received their medicines because they were out at appointments; there was no evidence their medicines had been adjusted to ensure they were given as prescribed. People had not received their medicines in accordance with the prescriber's instructions potentially placing them at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were able to manage their medicines for themselves if they wished. They had been provided with secure facilities in their rooms to store them. Staff had completed medicines training and confirmed they were periodically observed administering medicines to assess their ongoing competency. Medicines which needed additional storage were correctly administered and managed. Staff monitored the blood sugar levels of people living with diabetes. During a handover they discussed concerns about a person's high blood sugar levels which they said would be passed onto their GP.

People's care records identified the range of risks relevant to them such as the risk of falls, developing pressure ulcers or poor nutrition and hydration. Risk assessments described how any hazards were minimised and what strategies were put in place to keep people safe whilst promoting their independence. For example, sensors had been provided in people's rooms to alert staff if they moved out of their chair or their bed and crash mats had been provided for people at risk of falling out of bed. When people's needs changed referrals had been made to the appropriate healthcare professionals, for instance, to review the equipment they used to move or reposition. A delay in the response to a referral for one person had resulted in the registered manager (a moving and handling trainer) advising staff if a person was unwell and unable to transfer they could use the hoist and a sling which had been placed in the person's bedroom. Staff were observed doing this to reduce the risks of falls. When people had accidents and incidents these had been recorded and any emerging themes had been followed up to prevent further harm. People had been referred to their GP to explore physical reasons for the falls such as a urine infection or to a Physiotherapist or Occupational Therapist to provide equipment to reduce risks.

People were kept safe from the risk of emergencies such as fire. Each person had an individual personal evacuation plan in place which described the support they needed in the event of evacuation from the home. A summary sheet had been produced for emergency services. An out of hours system was in place for advice and support for staff from management. An emergency file contained information needed about local services. There was a maintenance plan in place for the refurbishment of the home upgrading communal areas and carpets over the next three years. Carpets on the first floor were rucked which could potentially be a trip hazard. Individual rooms were refurbished before new people moved into the home. Servicing contracts were in place for equipment. Health and safety checks had been carried out at the appropriate intervals for fire, water, legionella and electrical systems.

People were supported by enough staff to meet their needs. Staff commented they were "stretched" and "busy". They said additional staff would be made available if needed. At the time of the inspection agency staff were being used to make sure staffing levels were maintained. A relative said, "They do their best." Wherever possible the same agency staff were requested to provide consistency and continuity. New staff had been appointed to fill three vacancies and there were still two vacant positions available. Cleaning staff

said cover had not been provided for annual leave or sickness which put increasing demands on them. This was evident during our inspection. Carpets in shared areas needed some attention. Cleaning staff said they prioritised bathrooms, toilets and people's bedrooms.

People's rights were upheld. Staff understood how to recognise potential abuse, how to record and raise concerns. People told us, "I am perfectly happy and as safe as houses" and "I feel safe enough here; there are staff I can call on if I need anything". A healthcare professional said they felt people were safe. Staff had kept their safeguarding knowledge up to date and were confident action would be taken to address any issues raised. Safeguarding alerts had been shared with the local safeguarding team, Police and the Care Quality Commission. People had been advised how to keep valuables and money safe in their rooms in locked facilities or in the home's safe. When necessary action had been taken to address poor staff performance which had impacted on people's safety. For example, an agency member of staff had been stopped from working in the home due to poor moving and handling techniques. This information had been shared with their employers and the appropriate authorities.

Requires Improvement

Is the service effective?

Our findings

People's records about their capacity to make choices and decisions had not always been completed correctly. People were supported to make decisions and choices about their day to day lives. People unable to make decisions about their care and support had been assessed in line with the recommendations of the Mental Capacity Act 2005 (MCA). The 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. Three people's care records indicated they could make decisions about their care and support and then stated decisions had been made in their best interests. The representative of the provider thought this to be evidence of poor recording. Other MCA assessments and care records had been completed correctly. Failure to ensure an accurate record could lead to decisions being taken in people's best interests when they are able to make these decisions for themselves. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 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. People who were unable to consent to their care and support had been assessed to see if there were any restrictions to their liberty. If the assessment indicated there were restrictions in place advice had been sought from the local supervisory body whether a DoLS authorisation was needed. For example, one person had been assessed as unsafe using their mobility scooter and it had been decided with social care professionals not to carry out the necessary work to repair the scooter. The supervisory body said this was a restriction and not a deprivation of liberty because they were still able to leave the home. Records evidenced 10 authorisations had been submitted. Wherever possible the least restrictive solutions had been found to prevent DoLS authorisations being needed, such as the use of alarms and sensors.

People had not always been supported to eat and drink sufficiently which could impact on their health and well-being. People's eating, drinking and nutrition care plans had been maintained inconsistently. One person's care plan stated when they were unwell they needed a fortified diet. During February and March 2016 they lost a significant amount of weight and they were supposed to have their weight monitored each week. Records indicated during that period of time they had been weighed once; they had continued to lose weight. This had been highlighted by an audit by commissioners in April 2016 and the person had been weighed twice since then confirming they were starting to gain weight. The care plans for two other people identified as at high risk of malnutrition had not been reviewed as planned each month.

People had been prescribed a fortified drink to supplement their diet. On the first day of our inspection four cups of this fortified drink had been left in the lounge with varying amounts having been drunk. There did not appear to be any monitoring of whether people had consumed these drinks. The representative of the provider had also discussed with staff the timing of these drinks which had been given mid-morning and

possibly affecting people's appetite for their main meal of the day. Cold drinks were displayed on tables but people were not observed helping themselves to these and they had not been offered to people. At lunchtime jugs of water and squash were provided. People who could helped themselves or others to a drink and staff offered people at one table a drink but others did not have a drink. People were potentially at risk of becoming dehydrated. People were observed being offered a plated meal and two people asked for smaller portions saying "It puts me off eating when there is too much food on the plate." People received food prepared in the way advised by a speech and language therapist so they could eat safely. This included blending food. Staff blended each food item separately. Although it was noticed the food on the plate was very bland in colour and did not look very appetising. People did not receive suitable or nutritious food and hydration which could impact on their health and wellbeing. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's views about the quality of food was mixed. They commented, "You don't want to eat but it's lovely when you do" and "Food is disgusting, sometimes I cannot eat it as it is too salty". People had a choice of two main meals and their tea meal reflected their personal choices. Snacks such as fresh fruit, savoury snacks and biscuits were provided in the dining room for people to help themselves if they wished. People were offered snacks at tea and coffee breaks. The cook described how they fortified people's meals with cream, butter and milk powder. People had support from staff to eat their meals which was done at their pace.

People were supported by staff who had the opportunity to acquire the skills and knowledge to meet their needs. People commented, "We have the best staff in the world" and "They are absolutely superb". New staff completed the provider's induction as well as registering for the care certificate. The care certificate sets out the learning competencies and standards of behaviour expected of care workers. The representative of the provider said those new staff who had not yet started the care certificate would be completing this in due course. Changes had been made to the management and delivery of training with a senior manager being appointed to oversee training for all staff employed by the provider. A training record highlighted when training was due or when refresher training was needed. All staff were due for moving and handling training. A member of staff confirmed their moving and handling training had been postponed due to illness of the trainer but it would be rearranged. This was confirmed by the representative of the provider. Training included face to face courses, open learning, assessments and observations of staff carrying out practical tasks such as medicines administration or moving and handling. If the registered manager had concerns about the capability of staff this was dealt with through their individual meetings. This resulted in either additional support or the performance management of staff.

Staff had been supported by management through individual support sessions (supervision meetings) where they discussed their role and responsibilities and their learning needs. A schedule had been put in place indicating staff would have meetings every two months. An annual appraisal had also been scheduled to reflect on the performance of staff. Staff said they had supervision meetings and felt supported in their roles. Staff had attended between one and three individual meetings during 2016 and annual appraisals had been carried out. Group support sessions were held to reflect on best practice such as the administration of medicines. Two staff meetings had been held, since December 2016, to exchange ideas and good practice. The representative of the provider confirmed another meeting was planned.

People had access to a range of healthcare professionals to help them stay well. They benefitted from the enhanced services provided by a local surgery, whereby one GP was responsible for visiting each week; this meant that people saw a doctor when they needed to and their medication was reviewed regularly. Any appointments had been recorded in people's notes so staff could follow up any referrals which were outstanding. They were observed following up a referral with an occupational therapist to assess people for

equipment. People living with diabetes had access to annual eye checks, the services of a chiropodist and tests on their blood sugar levels. Healthcare professionals said staff made referrals to them and one said they "act on my advice".

Requires Improvement

Is the service caring?

Our findings

People's dignity was not always respected. Four people were observed without access to their call bells when in their bedrooms so they were unable to request staff help when needed. Two people were observed being helped to go to the dining room for meals only to discover their clothes needed to be changed. They had been left sitting in wet clothes. One person was observed during both days of our inspection sliding off their seat in the lounge. On one occasion staff fetched a pillow from their room to give them more support. Later in the day they were again observed to be sliding off their chair. They had been moved and the cushion had not been put back behind them. The cushion was on a nearby chair. One person was observed being given a drink without any verbal interaction or introduction from staff. Staff were very task led making sure people's personal care and support had been completed. Their interactions with people were very aloof because they were so busy. During meal times staff did not engage in conversation with people or explain what they were giving to them. Staff did not always respond promptly to people's distress. On three occasions we informed staff about people's discomfort to which they responded. People were addressed with a range of endearments rather than their names. People's care records had only identified their preferred from of address; there was no evidence they had given their permission to be called "dear" or "darling". A person with difficulty expressing themselves verbally had no communication aids to help them express their thoughts. They indicated they were frustrated at not being able to communicate with people. People's care and support was not always delivered in a way which promoted their dignity or respected them as individuals. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care records reflected their individual preferences for their religious, cultural and spiritual beliefs. People were supported to celebrate religious festivals and to participate in religious services of their choice. Where people had a preference for the gender of staff providing their care this was respected. People wore clothing that reflected their age, gender and previous life style. Their foot wear was appropriate. People's right to family life and privacy was promoted. For example, a person was able to have private time with their spouse using a small lounge. They had also enjoyed a private viewing of a film in the home's cinema. People's personal information was kept securely and confidentially.

People said, "Staff are considerate of everyone's' needs" and "They treat me nicely, personal care is done with dignity". A visitor commented, "I am really pleased with how she is looked after, staff speak to her nicely". Healthcare professionals said people were "really well cared for" and "well looked after". Staff said they worked well as a team and conversations with them showed how much they cared for people. At times they treated people with kindness and compassion. Staff were heard asking people's permission before they carried out any care or support. Call bells were heard to be ringing at peak times throughout the day and staff were seen to be answering these.

People were encouraged to retain their independence doing as much as they could for themselves. Their care plans clearly detailed what they were able to do and what they needed help with. For example, doing their own personal care, helping around the home and taking care of their own medicines. One person had taken on several tasks such as delivering the post and helping in the garden. There were some signs

displayed around the home to help people find their way around, although they too confusing for people living with dementia to understand. Each person had chosen a picture which was displayed on their bedroom door so they could recognise their room.

People's preferences for the way they were supported, their personal histories, likes and dislikes had been discussed with them or their relatives. Staff understood people well and at times there was light hearted banter. Each person had a named member of staff who was scheduled to meet with them each month to chat about their care and support. In this way people could be involved in making decisions about their care. Those people who were involved told us they were asked, "If I am happy with the way things are." People had information about local advocacy services. Occasionally people had appointed a lasting power of attorney (LPA) for health and welfare property and/or financial affairs. Documentary evidence had been obtained to verify each person's LPA.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care that was responsive to their needs. When peoples' needs changed their care records had not always been kept up to date to reflect their current care and support. Despite an audit of care records which highlighted shortfalls when records had not been updated there continued to be inconsistencies and discrepancies with people's care records. This could potentially lead to people receiving inappropriate care and support. Assessments of people's care scheduled to be done each month had been completed sporadically with some having gaps of up to four months. For example, commissioners identified that one person, whose needs had drastically changed, had care records which did not reflect their current physical status. Two care plans had been updated in response. However there continued to be gaps in the review of other care plans for this person. Another person had been identified at high risk of malnutrition and their care plan had not been updated since November 2015. People were put at risk of potentially receiving inappropriate care and support because their care records had not been reviewed and updated to reflect their current needs. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans reflected their preferences, past histories and interests. There were some quite detailed and personalised care plans for instance describing what toiletries people wished to use or that they liked to wear make-up. People's daily records did not reflect this level of personalisation purely recording whether people had received their personal care and support. A healthcare professional confirmed this saying paperwork was "not very person centred, with entries more of a task allocation, stating "checked and fine".

People discussed their care and support with named members of staff and signed these records to confirm the discussions. People's strengths were highlighted in their care plans and staff were prompted to encourage them to do as much as they could for themselves. A person said, "They [staff] respect my independence." Each person had a document called "This is me" which provided an individualised overview of people's lifestyle and wishes for the care they received. These were kept in the office and not in their bedrooms where they could be shared with staff and visitors.

People's preferences and lifestyle choices had not always been promoted. People told us, "I'm bored" and "It's a bit dead here, they wake me up in the morning, it's quiet, then it's quiet in the afternoon". A schedule of activities was displayed and made available to people in their rooms. This gave them information about activities which were scheduled most afternoons in the lounge such as board games, a quiz, indoor skittles, bingo, reminisce therapy and hand massage. A separate diary had just been put in place to record the activities each person had been offered and whether they had joined in or refused them. This evidenced hand massages, chatting with people individually, foot spas and reading to people. Photographs had been taken of trips out to local places of interest, the theatre, the pub and tearooms. People were observed enjoying a music and movement session. The representative of the provider said they had booked a new session from another source, which encouraged people's mobility with movement to music. The representative of the provider was aware of the need to improve people's experience of social activities and discussed how this could be done. For example, offering activities at different times of the day in response to people's individual interests or preferences and appointing a named member of staff to be responsible for

planning activities.

People were supported to maintain relationships with those people important to them. Visitors said they could visit whenever they wished and were made to feel welcome. People had access to Wi-Fi and Skype facilities if they wished to use them to keep in touch with family and friends.

People were encouraged to raise any concerns they might have directly to their key worker (a named member of staff) or to the registered manager. A person commented, "Some staff are excellent, they talk straight and do not fob me off." People had information about the complaints procedure in their service user guide and a complaints poster had been displayed on a noticeboard. The Provider Information Return stated "a simple matters of concern form is available to all to try to prevent concerns becoming full blown complaints". Five complaints had been received in the past 12 months mostly around laundry and housekeeping issues. Complaints had been investigated and a report had been produced evidencing the findings and the response to the complainant. When needed action had been taken in response to the issues raised and an apology had been given to the complainant. Seven compliments had also been received. People and their relatives had also been invited to meetings throughout the year to discuss experiences of their care with the registered manager. Minutes of these had been displayed with comments about any actions taken. For example, environmental improvements and offering trips or outings.

Requires Improvement

Is the service well-led?

Our findings

People did not consistently receive a service which was well-led. Quality assurance systems were not as robust as they could be. Audits had been carried out for a range of systems and processes. Care plan and medicine audits highlighted where there were shortfalls in the recording process. These had however been allowed to be carried over for significant periods of time in some cases. The way in which failure to maintain the quality of systems and processes had been dealt with was not effective. For example, through individual meetings with staff or through disciplinary proceedings. The service had not been managed well resulting in staff who worked hard to complete tasks, reacting to risks and incidents as they occurred rather than being guided to reduce risks and prevent accidents. Feedback from social and healthcare professionals reflected the inconsistent and ineffective management of the service. New audits which had been carried out by a representative of the provider had been introduced resulting in action plans for the registered manager to complete. In addition each month a theme was explored in depth such as fire systems or communication. These had found areas for improvement. However breaches identified as part of this inspection had not been picked up through these quality assurance processes. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said they were mostly happy and content with their day to day care. One person commented, "The staff are the best in the world" and a visitor said they felt the care was good and the staff showed a level of concern. Healthcare professionals said that although people were safe and they had no concerns about their care, the needs of people living with dementia were not always totally understood by staff. This was illustrated by our observations such as signs around the home confusing people living with dementia rather than helping them and staff commenting that the memory of a person living with dementia was getting worse. The representative of the provider said they planned to offer the dementia link worker training to more staff and intended to improve people's experience of living at the home and drive up the quality of care and support.

Parton House had a registered manager who was supported by two deputy managers. The registered manager was aware of their responsibilities with respect to notifying the Care Quality Commission about notifications and incidents affecting the well-being of people living in the home. They had displayed a poster with the ratings from their last comprehensive inspection in September 2015. The provider's website stated their values for the organisation were that, "All staff believe that every person is an individual and as such is unique. All staff acknowledge that residents have the right to expect a high standard of care, delivered by safe, competent team members." The representative of the provider discussed the challenges of continuing to provide a service in the face of limited funding resources.

The registered manager attended meetings with the provider's other registered managers. The Provider Information Return (PIR) stated they attended local forums and a learning exchange network to keep up to date with current best practice, changes in local guidance and national legislation. Staff were aware of the whistleblowing policy and procedure. The PIR stated that the registered manager used performance management to "assist staff where their work performance has been found wanting".

People had the opportunity to express their views about the quality of care provided. A residents' meeting had been held three to four times a year, enabling people to talk about issues important to them. As a result trips and outings had been scheduled to take place twice a month. The feedback about these was inconsistent with some people feeling they were unable to take part. "I would love to go out in the mini bus, but I cannot go because I cannot walk" and "I do not go out in the mini bus because it reminds me of what I have lost". Photographs evidenced that for those people who had taken part in the outings it was a pleasurable and enjoyable experience. Relatives meetings had been held at least twice a year and discussion had focused on the environment of the home with feedback being given about planned improvements. Annual surveys for people, relatives and staff were due to be sent out in August 2016. A report in response to last year's survey had been displayed on a notice board which highlighted when actions had been addressed.

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	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users had not been treated with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The nutritional and hydration needs of service users had not been met. Regulation 14(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People who use services were not protected against the risks of employing unfit or improper persons. A full employment history had not been obtained in respect of person's employed. Regulation 19(2)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person was not doing all that is reasonably practicable to mitigate risks to people's safety. Unexplained bruising had not been investigated and call bells were not always accessible. People did not received their medicines as prescribed. Regulation 12(1)(2)(a)(b)

The enforcement action we took:

Issued warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had not established robust systems or processes to assess, monitor and improve the quality and safety of services. An accurate, complete and contemporaneous record had not been kept in respect of each service user's consent records. Their care records had not been kept up to date with the care they were receiving. Regulation 17(1)(2)(a)(c)

The enforcement action we took:

Issued warning notice