CHD Living Limited

Park Lodge

Inspection report

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Ratings

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

Overall summary

This unannounced inspection took place on 19 January 2015. Park Lodge provides accommodation and nursing care for up to 35 older people, some of whom may have dementia. There were 17 people living at the home when we visited. The home was based in a large converted house and the bedrooms were on three floors. The communal rooms were all on the ground floor.

The last inspection was on 6 February 2014, when the service was meeting the regulations we looked at.

The home did not have a registered manager at the time of the inspection. There was an acting 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 2008 and associated regulations about how the service is run.

People were not safe at the home. The premises were undergoing building work and appropriate risks assessments had not been carried out to ensure people were protected from the risks associated with this. People could have access to areas where there were building works and visitors and other people could enter and walk straight upstairs to the bedrooms without passing through the reception area or signing in.

Summary of findings

Where risks were identified the provider had not always taken prompt action to comprehensively address these risks. We saw that a fire risk assessment had been carried out in March 2014. We also noted that not all the actions to keep people safe had been carried out.

The medicines administration practices were not safe. We observed and a healthcare professional confirmed that staff prepared and put the medicines of a number of people on a tray in medicines pots and then went round giving each person their medicines. This practice is unsafe as it increases the risk of people receiving the wrong medicines.

People were at risk of receiving inappropriate care and treatment because the provider did not have suitable arrangements to ensure there were adequate staffing levels in the home. As the lift was not working people could not come downstairs and had to stay in their bedrooms. During our visit we saw several people in their rooms alone. People told us it sometimes took staff a long time to answer the call bell.

People were cared for by staff who did not always receive appropriate training and support. Records showed there was an annual training programme in place but that not all staff attended the training. Records showed that staff did not receive regular supervision. Only seven staff of the 20 staff had received supervision during the last three months.

People were not always supported by caring staff. We saw some practices to show people's privacy was respected such as bedroom doors were closed when care staff were delivering personal care. People and relatives told us that the agency staff were not always caring.

We saw that people's care needs had not always been assessed comprehensively and information from these assessments used to plan the care and support people received. This was because care plans addressing people's social, psychological, religious and daily living care needs had little information in them, with no reference to previous hobbies, past times, current likes, dislikes, abilities and choices. There were therefore risks that staff might not be able to deliver the care people needed.

The provider did not have an effective quality assurance system and a robust management system to monitor and assess the quality of the service so they could make the necessary improvement.

We saw evidence that the home carried out weekly, monthly and quarterly checks of the home, but some of the checks were not done as regularly as stated and were therefore not effective.

During the inspection we found a number of breaches of regulations in relation to risk management, quality monitoring, medication, caring, nutrition, and supporting staff of the Health and Social Care (Regulated Activities) Regulations 2010, corresponding to breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 and a breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. The premises were undergoing building works and appropriate risk assessments had not been carried out to ensure the safety of people, staff and visitors to the home. Individual risks assessments for people were not updated as required to reflect their changing needs.

The medicine administration practices were not safe to protect people against risks associated with medicines

There was insufficient staff to ensure people received safe and appropriate care.

Regular checks of maintenance and service records were not conducted, so people could not be assured of living in a safe environment.

Is the service effective?

Inadequate

The service was not effective**.** The provider did not ensure that staff received training in a timely manner and were adequately supported to fulfil their roles.

A lack of knowledge of nutrition and hydration meant staff did not always ensure that people's nutritional needs were being appropriately met.

The provider had not taken full action to meet the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Requires Improvement

Aspects of the service were not caring. We saw 13 out of 17 people in their rooms alone, A few people who were able said they felt isolated and the day could be very long, particularly as the lift was out of use and people could not access the lounge area.

Despite the concerns we had about the service we saw that people at the home were clean and smartly dressed and four people spoke positively about the care they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were not comprehensive and had not been reviewed often enough to ensure these appropriately reflected people's needs and the action to take to meet any identified needs. There were therefore risks that they might not receive appropriate care and treatment.

There were not enough activities offered to people using the service.

People said they knew how to complain and would do so if something was wrong, but two people commented that they didn't always feel that they were listened to.

Summary of findings

Is the service well-led?

Inadequate 

The service was not as well led as it could be. The home did not have a registered manager. The acting manager did not have a clear understanding of their management role and responsibilities. They did not understand their legal obligations with regard to CQC requirements for submission of notifications.

Quality assurance systems used by the provider to assess the quality of service were not effective in that areas that required improvement were not identified so the appropriate remedial action could be taken.

The provider had annual systems in place to get the views of people and their relatives about the quality of the service.

Park Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 19 January 2015 and was unannounced. It was carried out by an inspector and a specialist advisor who was a qualified nurse. Before the inspection, we reviewed information we had about the service such as notifications the service was required to send to the Care Quality Commission (CQC).

During our visit we spoke with nine people living at the home, two relatives, one nurse, three care staff, and two ancillary staff. We also spoke with the acting manager and the area manager for the provider.

We looked at the care records for five people. We also looked at other records that related to how the home was managed including the quality assurance audits that the acting manager and provider completed. We also reviewed five staff employment files and the training records for all staff employed at the home. We reviewed 10 people's medicines records.

Inadequate

Is the service safe?

Our findings

People were not always protected against the risks associated with the premises because the provider did not always ensure that the premises were safe. On the day of the inspection the premises were undergoing building works but we did not see that appropriate risk assessments had been completed and that risks were being managed appropriately to ensure people and others were safe. The main refurbishment, which included structural work, was based on the ground floor, but we saw there was no partitioning off of the works from the main areas of the house where people, visitors and staff could walk. The workmen were entering and exiting the house from a second main door at the front of the house that was open and not locked. We saw visitors enter by this door and walk straight upstairs to the bedrooms without passing through the reception area or signing in. The acting manager told us that only one person was living on the ground floor at this time and was not independently mobile. The other people living at the home were based on the first and second floors and staff told us they were also not independently mobile. Nevertheless, the risks in relation to the building works and access to the home whilst the building work was being carried out had not been assessed to help ensure the safety of people, staff and visitors. We spoke to the acting manager about the need to ensure people were kept safe during the building works and they said they would speak with the builders.

During our visit people on the first and second floors were unable to access the lounge areas on the ground floor because the lift giving them access to the ground floor was out of use. Staff told us and records showed that the lift had broken down on three occasions since December 2014. We however saw evidence that the provider was taking steps to remediate the situation. The acting manager phoned the lift maintenance company while we were there to follow through the lift repair.

We asked staff about the evacuation procedures they would take while the lift was out of use and they could not tell us. We asked if they had any equipment to use for evacuation such as slider sheets. These rescue-sheets work by sliding a person with limited mobility to safety in an evacuation. They said they did but they had not received training on how to use them and wouldn't know what to do. When we looked we could only find one evacuation slider sheet on the second floor, although staff told us there were more they could not locate them. This lack of training and knowledge of evacuation procedures could pose a threat to people's lives in an emergency situation.

We saw that a fire risk assessment had been carried out in March 2014 by an external company. We saw that 11 areas of non-compliance had been identified. The provider sent us an updated version of the fire report with the actions that had been taken. However, we saw that one action which had been identified to keep people safe had not been carried out. This was that all staff undergoes a fire awareness course on a yearly basis which included the provision of hands on fire extinguisher use. Training records showed that only seven out of 20 staff had received Fire Awareness training in the last 12 months. We saw that additional fire awareness training was planned for January 2015, 10 months since the initial report.

There was no evidence of personal emergency evacuation plans (PEEPs) for all people to assess and plan how they would escape in the event of a fire, and to ensure that appropriate fire safety measures were in place. We informed the London Fire and Emergency Planning Authority (LFEPA) about these concerns.

In the risk assessments for manual handling we did not see any details for the type of equipment, the size or type of sling required to safely move a person. We saw a box of slings on the second floor, in current use by people were not marked with a person's name. When staff were asked how they knew which one to use for which person they said they didn't and would just use one. Another staff member did say that they needed sorting out and allocating to an individual person

In one person's bedroom, there was a mattress on the floor and an alarm mat. In the supporting information for the use of the mattress, there were no details for the rationale and to explain why it should be used, the only explanation being "a history of falls" identified. Another care plan had a risk assessment for the use of bedrails for a person, this was dated 2011 and not been updated since.

We saw evidence that the provider carried out weekly, monthly and quarterly checks of various aspects of the service provision, although some of the checks were not done as regularly as stated. Monthly water temperatures checks were irregularly carried out and we could not see any record of tests before June 2014. Again checks of the

Is the service safe?

hoists used for lifting people were irregular and no checks had been done between April and July 2014. We found the same for the checks of slings used with the hoists, prior to July the previous check was March 2014 and before that December 2013.

The paragraphs above show there was a lack of effective risk assessments to ensure the safety of people, staff and visitors to the home. This was a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had also not carried out assessments in relation to staffing levels, meeting people's needs, ensuring their safety and continuity of care whilst building work was being carried out. Records showed that there was one registered nurse and three care assistants on duty during the day and one registered nurse and two care assistants at night. The majority of people needed support with their mobility and required the assistance of two staff to help them. As the lift was not working people could not come downstairs to the main lounge and most people had to stay in their bedrooms. We found that there were not enough staff to engage with people. There was also a lack of consistency of staff to ensure continuity of care. Records showed that agency staff were used on most shifts and two people said that they "weren't as good." The lack of and consistency of staff meant people were at risk of not receiving safe and appropriate care. This was a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not supported by staff to take their medicines safely. We observed part of the morning medicines round and found the practices used by the registered nurse were not safe. The nurse told us that while the lift was out of use medicines were taken from the locked medicines trolley on the ground floor put into individual plastic pots and carried upstairs on a tray. We saw that three pots at one time were put on the tray; the pots were uncovered and unnamed. Staff did not carry the medicines administration record chart (MAR) with them. One person had refused their medicines and a note was put in the bottom of the pot. When staff had administered the medicines they then came back down to the ground floor to complete the MAR chart. This practice was not safe as it could increase the risks of people receiving the wrong medicines. Before the inspection we spoke to a nursing professional who visits the home regularly and they told us they had witnessed the same practice a few weeks before and had mentioned to the nurse and acting manager about the use of incorrect procedures.

We saw that the majority of the MAR charts were signed correctly but on some charts there were gaps on four days in January 2015, with no explanation as to why they had not been completed. There were several omissions in the recording of the application of creams or ointments. We also saw that abbreviations were used without an explanation of the full wording; an example of this was NKDA, which stands for No Known Drug Allergy. For a person who required a variable dose of a medicine to be administered when required (PRN) the number of tablets administered was not recorded. The above two paragraphs show there was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the acting manager who said in future should the staff not be able to use the trolley on the medicines rounds, only one pot of medicines would be taken upstairs at a time and the MAR chart would be taken and signed at the time of the medicine being taken to reduce risks to people.

There were policies and procedures available to staff which set out how they should protect people from abuse, neglect or harm. Staff we spoke with regarding their knowledge of safeguarding told us that on line training was provided on the subject. Staff were aware of the actions to take and most said they would refer any incidents to the manager or would report directly to the provider's head office. However, we saw on one person's daily notes that a bruise had been noted on their arm with no explanation of how it had occurred. We did not see an entry in the staff handover notes and it was not recorded in the accident book. Staff we spoke with were also not aware of whether this had been followed up or not. As care plans were difficult to access on the computer we were not able to see if this had been recorded. We were unable to search through other care plans to see if this was a one off incident

Inadequate

Is the service safe?

because of the difficulties in accessing the computer. This meant that in that case appropriate action might not have been taken to deal with that incident, to prevent similar incidents in the future.

We discussed the difficulty of accessing the care plans on the computer with the area manager and the acting manager but they said the computers had always been slow and they would discuss the problems with the provider.

Inadequate

Is the service effective?

Our findings

People were cared for by staff who did not always receive appropriate training and support. One staff member said they had only received an induction of one day and felt this was not enough for them to do their job properly and particularly what action to take in an emergency.

Records showed there was an annual training programme in place. The records we reviewed covered a 12 to 36 month period, dependent on training type. We found that training was not regular and did not always meet staff's needs. We saw that levels of attendance at the training courses varied greatly. An example of this was that only six staff had completed nutrition and hydration training in the last 24 months and only eight staff had attended Dementia Awareness training in the last 24 months although the majority of the people at Park Lodge had dementia. Only six staff had attended health and safety awareness training in the last 12 months. One staff member said "There has been no competency testing in relation to medicines administration since 2013, nor has there been any training in respect of medicines."

Staff we spoke with said much of the training was on line but this could be difficult to access as there weren't enough computers at the home and they were very slow. Staff did not say they felt unskilled to do their role but did say they would appreciate better access to training.

We saw on the minutes of the staff meetings that supervision should take place every eight weeks. We asked to see the supervision records and were shown the period covering November and December 2014 and January 2015.The acting manager told us previous records were not available. The records we saw showed that only seven out of 20 staff had received supervision during that period. We did see that staff meetings had been held monthly since September 2014, these were mainly attended by the staff on duty that day, we did not see if the minutes of the meetings were available to those who could not attend. The lack of training and supervision meant that staff were not appropriately supported in their roles. This was a breach of Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not taken full action to meet the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). DoLS ensure that a service only deprives someone of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them.

When we asked the provider they were unable to produce the policies and procedures in relation to the MCA and DoLS. This meant that staff did not have access to clear guidance about their duties with regard to MCA and DoLS. When we asked four staff members to explain what MCA and DoLS meant to them and the people they were caring for, three of them were unable to give a clear explanation of the impact this could have on people. The provider sent us an up to date version of the MCA and DoLS policies and procedures after the inspection

We saw that to exit the main front door there was a key code. When we asked staff and the area manager how they ensured that this did not unduly restrict people's freedom so they were free to leave, they told us the number was located beside the door. We were unable to locate this and staff who were with us at the time, were also not able to find the number. This meant that people might have been subjected to restrictions to their liberty that could have amounted to a deprivation of liberty. The acting manager said this would be rectified and the number put beside the lock. The above three paragraphs show that there was a breach of Regulation 18 of the HSCA 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people were supported to eat and drink sufficient amounts to meet their needs. One person we spoke with said about the food, "It's very good, if you dislike what is offered you get an alternative." We also saw examples where some people's diets were not fully catered for. A person's care plan under nutrition stated to give a soft/ pureed diet, but these are two different types of diet and consistency of food. When asked staff were unable to explain the difference between a pureed and a soft diet. Another person had a special dietary need and when we asked staff, they could not explain what this meant in terms of the food the person could and could not eat. We looked at the person's care plan and saw that it contained no information about how to meet their dietary needs.

Inadequate

Is the service effective?

A person who was diabetic had no information in their care plan in relation to this condition to keep them healthy. The risk assessment in place did not refer to the blood sugar levels that should be monitored and the signs and symptoms to observe should the person have low or high blood sugar levels. Staff therefore did not have enough information about the needs of the person so they could take appropriate action where required.

One relative we spoke with was concerned that when they visited food and fluids were not always available. They told us of one occasion recently when they visited they found their relative had been left without water or the additional supplement they should have. They had spoken to staff about this but felt they had to keep reminding staff to obtain this.

We observed the lunch being served. Food was put onto hot plates and covered before being carried two plates at a time on a tray up to people's bedrooms. Pureed food was treated in the same way and on tasting the food we found it was lukewarm and sometimes cold. We spoke to the area manager about this and they said that while the lift was out of use a microwave oven would be used to ensure food was kept hot.

The fact that staff did not always ensure that people's nutritional needs were being appropriately met meant there was a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the cook who told us that people were asked each day what they would like from a menu and that alternatives were always available. A record was kept of what each person had eaten and when asked, the cook was able to explain to us the special dietary needs of two people who had additional nutritional needs. Records were kept of the temperature of cooked food and the fridge and freezer temperature were within the correct limits.

We spoke with the acting manager about how people could access other health services. They told us that appointments could be made when people required them with their GP, the physiotherapist or the podiatrist. Specialist help was also available through the speech and language team and from the local impact nursing team who called at the home to assist staff with people's changing needs, where referrals were made. One of the staff had received specialist training in the care of people's feet and could help people to maintain healthy feet without the need to book specific appointments.

Requires Improvement

Is the service caring?

Our findings

Our observations and other findings during the inspection show that people were not always supported by caring staff. During our visit we saw 13 out of 17 people in their rooms alone, without the television or radio on or without a magazine or book to read. We spoke with a few people and asked them if they felt isolated and some people said they liked going to the lounge and the day could be very long. One person told us "Staff put me to bed between 6 and 7 and then there's nothing to do except watch the television." Another person described the staff as "being under pressure" particularly as the lift was out of use. Another person said that it sometimes took staff a long time to answer the call bell and this could be upsetting.

Some people and relatives felt that agency staff were not as caring as the permanent staff. One person said, "There are so many agency staff and I am not keen on them." When we asked why that was they replied "They do not know what they are doing and when I try to help them they object." One relative who visited the home regularly was worried, saying "Staff are good although the agency staff are not up to standard." They went on to explain they did not know what help to give their relative.

We observed lunch which was served in a bedroom that had been converted into a sitting room on the first floor. We saw that three people and two staff were watching television just prior to lunch being delivered but staff were not engaging or talking with the people. When the meals arrived one staff member started to cut up a person's food without speaking to them or telling them what they were doing or what food they had received.

People we spoke with said their families helped them to communicate their needs. But for people without relatives we did not see what processes were in place to support people to make their own decisions. We did not see any evidence that staff communicated with people in different ways when required or that an advocate was used to help people with their communication needs.

Despite the concerns we had about the service people received we saw that people at the home were clean and smartly dressed. One person who had chosen to remain in bed was dressed in a comfortable shirt and jumper. Two people spoke kindly about the staff and the home saying, "It's very good here" and "Staff are very kind". One person said, "I'm very comfortable here, staff are very friendly and I can do mainly what I prefer to do." Another person told us, "Everything in fine I have everything done for me and I am very happy." A visitor told us, "I've got no complaints, the care is good and staff are always around." We heard one person calling for their newspaper and saw a staff member go to the reception to get it.

During the inspection, we saw that bedroom doors were closed when care staff were delivering personal care to people to maintain their privacy. The bathrooms had a bathing rota and people we spoke with said they could choose to have a shower or bath.

Requires Improvement

Is the service responsive?

Our findings

The provider had not always ensured that people's care needs were assessed and information from these assessments used to plan the care and support people received. This was because although the acting manager told us that all of the care plan records were up to date, our findings showed that this was not the case.

The care plans we saw had a photograph of the person for ease of identification, but the standard of information was not comprehensive enough and had not considered who the person was or how they would like to be cared for. The care plans addressing people's social, psychological, religious and daily living care needs had little information in them, with no reference to previous hobbies, past times, current likes, dislikes, abilities and choices.

We asked people about their involvement in the development of their care plans, but they were unable to comment on their input into these by saying "I don't think so" and "what is that?" We explained what the care plan was but they were still unable to confirm any input into its development. Because we were unable to fully access people's care plans we could not see if relatives or other professionals had been involved in the development of peoples care plans. We asked the acting manager about this but they could not tell us who had been involved in the development of the care plans.

One person's care plan had a record relating to wound care but information was limited and there were gaps in the updates of the progression of the wound. There were some photographs to monitor the wound, but these were not being used consistently. The photographs did not have dimensions to give an indication of the size of the wound and there was no specific care plan for the management of the wound. The skin care plan stated the skin was "intact", when the photographs clearly showed it was not. We saw one care plan where it stated a serious infection was present but without any details. We could not also see any infection control measures to prevent the spread of this infection to other people or staff.

We saw from the care plan of a person that they were losing weight and they were on a special diet but there were no further plans as to how this weight loss was going to be monitored or managed. There was also no clear information to manage the person's continence care needs to help maximise their dignity.

Another person's care plan stated that their blood sugar levels should be tested twice daily yet records showed this was only carried out once daily. A fourth person was prone to seizures, but there was no detailed information on actions to take or warning signs for staff to look for so they knew how to monitor the person for seizures and what to observe for. Their care plan contained general statements such as "maintain a safe environment, monitor at all times, and give medication as prescribed."

Care plan reviews were also not carried out comprehensively in line with all the information relevant to the person's needs. Those we saw did not give an overview of the care delivery nor refer to relevant risk assessments. For example the skin care plans did not include the Waterlow score for that month and the nutrition care plan reviews did not include reference to weight loss or gain or the Malnutrition Universal Screening Tool **(**MUST**)** or Body Mass Index (BMI) scores.

The provider did not have an activities co-ordinator and we did not see a programme of activities that could be offered by staff. The lack of activities and staff meant that some people were isolated in their rooms. We spoke to the area manager about this and they emailed us after the inspection to say that during the time the lift was out of use and people could not access the main lounge an extra staff member would be on duty. We were also told that an activities coordinator had been advertised for. The above shows that there was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider's complaints procedure was displayed in the main reception area. People said they knew how to complain and would do so if something was wrong. But two people commented that they didn't always feel that they were listened to. We saw in the complaints file that the provider had received 11 complaints since October 2014, these included, lack of food at night, staff rudeness, poor handling by staff and personal dignity not being respected. We saw these individual complaints had been addressed to the satisfaction of the complainants.

Inadequate

Is the service well-led?

Our findings

People were not protected against the risks of poor care and treatment because the provider did not operate an effective system to monitor and assess the quality of the service, so areas for improvement were identified and promptly addressed. The findings in this report and the number of breaches of regulation we found showed that the systems were not effective in identifying areas where people might have been at risk so that the provider could take the appropriate action to protect people.

The acting manager did not ensure that daily, weekly or monthly checks of the building and of maintenance certificates, housekeeping, complaints and the clinical folders were carried out as required. We saw that monthly checks for medicines, health and safety and infection control had been carried out in December 2014 and weekly checks made of the safety of stairs and carpets, and fire exits. However, these checks had not been carried out regularly as indicated and others that were completed did not have dates attached to them. We could not therefore evidence if these checks had been made regularly and comprehensively. This lack of oversight of the home meant that people were not always protected against the risks of poor care and treatment because these systems were not always effective in identifying areas for improvement and for ensuring that prompt remedial action was taken to make improvements. The above shows that the provider was in breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had not had a registered manager since the end of November 2014. A member of staff, employed as a registered nurse was in the role of acting manager. They divided their time as three days as acting manager and two days as a registered nurse. The area manager told us they spent two days a week at the home to assist the acting manager. Interviews for the manager post were due to be held on 30 January 2015. The area manager later rang us to say that no-one was recruited at these interviews, but further interviews for the recruitment of a manager would go ahead.

From our discussions with the acting manager, it was clear they did not have an understanding of their management role and responsibilities. They did not understand their legal obligations with regard to CQC requirements for submission of notifications; they had not always submitted these in a timely manner. The acting manager had not informed the CQC when a DoLS order had been applied for and the outcome. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider did not ensure care records could be located promptly when these were required. They used a computerised system to maintain people's care records and staff informed us these were printed at periodic intervals so hard copies of people' care records were available for staff to access. We found that care plans and daily notes which were kept on the computer system were not easily retrievable. The system was slow and it took us half an hour to open one set of notes. For that reason, we were not able to see if staff kept detailed records of the care and support people received.

The paper copies of care plans that we looked at were also not up to date and did not reflect peoples current care needs. The acting manager reported that they had not been able to print any care plans recently because the printer had not been working, although the printer was working on the day of the inspection. Staff told us that accessing the daily notes could be restricted if another staff member was already using the computer. These same computers were used for staff to access on line training. This meant that staff could not access information about people promptly if this was required and could not update daily notes as and when the care and support was given to people and therefore staff might not have access to the latest information about a person.

One senior staff member said they would prefer to keep written notes but said that the typed notes were easier to read and to check spelling. We spoke with the acting manager about the lack of access to people's records and they said it had always been like that. However, the lack of prompt access to people's records meant there were risks that a person's records might not be easily retrievable and located promptly should these be required in an emergency. The above shows that there was a breach of Regulation 20 of the HSCA 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had systems in place to enable people and their relatives express their views about the quality of

Inadequate

Is the service well-led?

service provided at the home. Annual surveys were conducted for people who used the service and their families. We saw the results were displayed in the main reception area so people and their relatives could read these.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People who use services and others were not protected against the risks associated with the unsafe use and management of medicines by means of making appropriate arrangements for the safe keeping of medicines.** Regulation 12(1)(2)(f)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person did not have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by receiving appropriate training, professional development, supervision and appraisal.** Regulation 18(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider did not have suitable arrangements in place for obtaining and acting in accordance with the consent of people who use services in relation to the care and treatment provided for them.** Regulation 11(1)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People who use services were not protected from the risks of inadequate nutrition and dehydration, by means of the provision of a choice of suitable and nutritious food and hydration, in sufficient quantities to meet service users' needs and support, where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs. Regulation 14(1)(2)(b)(4)(a)(c)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People who used services were not protected against the risks of receiving care and treatment that was inappropriate or unsafe by means of the planning and delivery of care and, where appropriate, treatment in such a way as to meet people's individual needs and ensure their welfare and safety. Regulation 9(1)(a)(b)(c)

Regulated activity	Regulation
	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person did not notify the Commission without delay of any requests to a supervisory body or any application made to a court in relation to depriving a service user of their liberty. Regulation 18(1)(2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not ensure that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user; and ensure that the records referred to in paragraph (1) (which may be in paper or electronic form) are kept securely and can be located promptly when required;

Regulation 17(1)(2)(a)(b)(c)(d)(i)(ii)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision People who use services and others were not protected against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the services provided and identify, assess and manage risks relating to the health, welfare and safety of service users and others. Regulation 10(1)(a)(b)

The enforcement action we took:
We issued a warning notice