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Parklands Nursing Home

Inspection report

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Date of inspection visit:
13 October 2016

Date of publication:
02 February 2017

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?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 13 October 2016. Our previous comprehensive inspection of this service took place on 15 October 2015 and a rating of 'Requires Improvement' was given overall.

Parklands Nursing Home is registered to provide accommodation for persons who require nursing or personal care, diagnostic and screening procedures and treatment of disease, disorder or injury. They can accommodate up to 30 older people at the service, who may also be living with dementia. When we carried out our inspection there were 20 people living at the service.

The service had a registered manager. 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.

There was a lack of robust quality assurance processes in place at the service. Some checks and audits had been introduced, however; they had failed to identify areas of concern. The provider had failed to use quality assurance processes to learn lessons and drive improvements at the service. People and their families were not always aware of who the registered manager was and did not have regular access to them. In addition, there was not a positive atmosphere at the service as people and their families did not always feel involved in changes or developments.

Risks to people's health and well-being were not always well managed at the service. Risk assessments were not always robust and checks did not always highlight areas of concern. Documentation was not always effective in providing staff members with the information they needed to effectively manage risks. This placed people at risk of potential harm. In addition, systems in place for medication management were not always robust to ensure that people's medicines were stored and administered correctly. Some areas of the service were not always clean and presented an increased infection control risk to people at the service.

Incidents at the service were reviewed by the registered manager and used to update care plans and practice. Where there were potential safeguarding concerns, the service had not been proactive in seeking the advice of external organisations, such as the local authority safeguarding team. The service was not able to demonstrate that staffing levels were sufficient to meet people's needs. Basic care needs were being met, however; staff were often rushed and lacked time for additional care, such as activities. Staff members had been recruited robustly and appropriate checks had been completed prior to their employment.

People were not always treated with dignity and respect. At times, staff members did not handle people's property appropriately and did not always communicate with people whilst providing them with care and support. Care plans had been written for people, however; they did not always show that people or their family members, where appropriate, had been involved in the planning process.

The care provided to people was not always in accordance with their individual needs and preferences. Improvements had been made to some care plans in this area, but not all. In addition, there was a lack of activities and stimulation available to people, therefore they were not able to engage in their hobbies and interests. There were systems in place for complaints to be made, however; people and their relatives were not aware of the complaints policy and did not feel that action was taken in response to their concerns.

Staff members received training and supervision to help them perform their roles. People did not always feel that they were provided with choice, or that their consent to their care and support arrangements had been sought. Not all people were happy with the food available at the service and we found that were not always supported to have their meals in a timely manner. Food provided was nutritious and regular drinks and snacks were offered. People were supported to attend medical appointments both within the service and in the local community, such as outpatient appointments, if required.

The principles of the Mental Capacity Act 2005 had been followed for those people unable to make decisions for themselves. Decisions were taken following a best interests' process and authorisations under the Deprivation of Liberty Safeguards had been submitted where appropriate.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Risks to people and others were not always well managed.

The premises were not always clean and free of infection control risks.

Staff members had been trained in abuse and were aware of the action they should take to safeguarding people against it.

Staffing levels were sufficient to meet people's basic needs, however; people sometimes had to wait to have their needs met. Staff members had been recruited safely.

People were supported to take their medication safely, however; the systems for recording and managing medicines were not always robust.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff members received training and support from the service.

People did not always feel that staff sought their consent to their care, treatment and support. Records indicated that consent was sought and that the principles of the Mental Capacity Act 2005 had been followed when people were unable to make their own decisions.

People were not always positive about the food they were provided with at the service.

Medical appointments were supported by the service and regular visits by the GP were carried out. The outcomes of these appointments were used to develop people's care plans.

Is the service caring?

Requires Improvement

The service was not always caring.

There were times when members of staff did not always treat people with dignity and respect.

People and their family members were not always involved in planning people's care, however; improvement was taking place in this area.

There were positive relationships between people and members of staff. Staff treated people with kindness and compassion.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive person-centred care which was provided in accordance with their individual needs and preferences.

There was a lack of activities and stimulation for people living at the service.

There were systems in place to receive and act on complaints, however; people and their relatives were not always aware of the procedures to follow or the action taken as a result of a complaint.

Is the service well-led?

Inadequate

The service was not well-led.

The quality assurance systems at the service failed to identify areas of concern and action had not been taken to make improvements in these areas.

There was a registered manager at the service however; they were not always accessible. People and their families were not always aware of who the registered manager was, or how they could raise issues with them.

The culture at the service was not always positive and open.

Parklands Nursing Home

Detailed findings

Background to this inspection

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

This inspection was carried out on 13 October 2016 and was unannounced. It was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before 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 reviewed the PIR as part of the planning process for this inspection, as well as other information we held about the service, including previous reports and statutory notifications sent to the Care Quality Commission (CQC) by the provider. Statutory notifications are information about important events at the service, such as safeguarding concerns, which the provider is required to send to us by law. We also spoke with the local authority and clinical commissioning group, who have commissioning and monitoring roles with the service.

During the inspection we spoke with seven people who were living at the service. We attempted to speak with other people at the service, however; they were unable to communicate with us due to the nature of their condition and complexity of their needs. For these people we carried out observations of the care they received, including 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 also spoke with six relatives of people who lived at the service, to seek their views of the care and support that their family members received. Additionally, we spoke with the registered manager (who was also the provider), two nurses (including the clinical lead nurse), two members of care staff and the cook.

We reviewed care plans for nine people to see if they were reflective of the care that people were receiving. We also looked at staff files for six staff members, which included recruitment and training information.

Records relating to the management of the service were also reviewed, including audits and quality assurance checks, to monitor how the service was being managed.

Requires Improvement

Is the service safe?

Our findings

Risks at the service were not always well managed. The registered manager showed us that they had introduced systems to help them identify risks at the service, however; these systems were not always used effectively, to ensure that risks to people and others at the service were identified and controlled. For example, we saw that a system had been introduced to prompt staff members to check that emergency exits were clear and free of obstructions. Staff members had completed these checks on a daily basis, however; we observed that two emergency exits were blocked by laundry trolleys, which prevented wheelchairs from being able to access them. Staff members confirmed that the laundry trolleys were usually stored in this way. This meant that, in emergency situations, these exits would not be accessible for people who required a wheelchair for mobility.
We discussed this concern with the registered manager. They explained that there were alternative exits throughout the building which would be accessible in the event on an emergency. Some of these were located in people's bedroom and staff would be able to support people to access these if required. Following the inspection visit, the registered manager also informed us that the laundry bags had been moved, to enable improved access to the emergency exits. They also told us that they had installed fire curtains in the loft space of the service, which would help to slow the spread of a fire, if one broke out.

We also found that individual risks to people were not always well-managed. We checked people's care plans and found that risks had been assessed, however; at times the care plans and risk assessments contradicted themselves and the control measures to manage risk were not always clear. For example, we saw that a Waterlow tool was in place to assess the risks of people developing pressure ulcers. In one person's file we found that the assessment score in the care plan was lower than the most recently updated score in their risk assessment. This showed that risk levels were re-assessed, however; care plans were not always updated as a result, which meant that staff members may not take appropriate action in response to the changing levels of risk.

We also saw that one person's care plan stated that they were at risk of becoming agitated and anxious. There was a lack of detail of the behaviour they would display or how this may affect those around them. There was also a lack of information about what may cause this behaviour, so that staff may take action to minimise potential triggers. The care plan did however contain guidance regarding the best approach for staff to take to manage this behaviour and help the person return to a calmer state of mind.
The registered manager and clinical lead nurse told us that risk assessments were regularly reviewed to ensure that they were accurate and up-to-date. We checked risk assessments in people's care plans and found that they were updated on a regular basis. However; we saw that when they were updated and the level of risk was changed, it was not always clear what the current level of risk was. We saw that in some cases both 'high' and 'low' risk had been indicated on the same form, along with a note of the date of change of risk. This meant that staff members may not notice when a change in risk occurred and therefore may not take appropriate action to manage risks to people. The registered manager and the clinical lead nurse told us that they would review the layout of these risk assessments if the future, to ensure the current level of risk was clear.

Risks to people were not always assessed fully and risk assessments did not always contain clear guidance regarding risks and how to manage them. This was a breach of regulation 12 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The premises and equipment at the service was not always clean and properly used or well maintained. During the inspection we observed that a number of people had pressure relieving mattresses on their beds. These needed to be set to a specific weight setting so that they would have a therapeutic effect for each individual. We compared the settings of these mattresses to people's care plans and found that, in many cases, they were not set correctly. We saw that care plans stated that pressure mattresses should be set according to the person's weight, however; we saw that one person who was recorded as weighing approximately 50 kilograms and their mattress was set to 150 kilograms. We saw a number of other mattresses which were set to high settings, including 180 kilograms, despite nobody in the service weighing this much.

We spoke with staff members about pressure mattresses. They told us that they checked them when they went to people in their rooms and recorded that they had done so in the daily records. We checked people's daily records and saw that staff had ticked to say that they had checked the mattress, but there was no evidence to show that they had checked the mattress was at the correct setting, or compared the settings to each individual person's weight. This showed that the equipment in place to help manage people's pressure ulcers was not used correctly and therefore placed people at risk of potential harm. The systems in place for checking them were not robust, however; we did see records which showed that people's care had been effective and on the occasions when pressure wounds developed in the past, they had been well-managed and healed quickly.

The service was not always clean and free of risks associated with infection control. Relatives we spoke with told us that they didn't feel that the environment was as clean as it could be, which made them feel they had to do some cleaning themselves during visits. One relative told us, "I had cleaned her frame because it was all sticky and dirty from food." They went on to say, "It's not always clean, I don't like to sit on the chairs as they are so sticky and stained."

Throughout the inspection we observed that people's bedrooms and communal areas were not always clean. We found that carpets were stained and worn in places, as were chairs in communal lounges. In one person's bedroom we found that their specialist feeding equipment was not clean, with evidence of dirt, which appeared to be a dried liquid, on the equipment and the table it was on. We also saw that in some rooms there were patches of missing plaster on the walls. This would make it difficult for effective cleaning to take place and was therefore a potential area for bacteria to develop.

We spoke with the registered manager about the cleanliness of the service and looked at cleaning records which they showed us. We saw that staff members ticked to show that they had cleaned areas of the home. We did see cleaning taking place during the inspection, however; this was not always effective in managing the concerns we noted. We also found that cleaning records were not checked against the actual state of the service, therefore there were not effective systems to manage the cleanliness of the service.

The premises and equipment used by the service were not always clean or suitably maintained to ensure they were safe for people to use. This was a breach of regulation 15 (1) (2) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback about how safe people and their relatives felt the service was. Some felt that, at times the service wasn't as safe as it could be, whilst others had no concerns. One person said, "I do feel

safe, people are generally attentive." A relative told us, "Not always, no - I don't feel he is safe." Another told us, "She is sort of safe, not really. You see anyone can get around the back of this building through the car park and look at the residents through their window doors. In the hot weather those end fire doors were propped open – so anyone could walk in" We checked and found that there were no records to show that there had been any incidents where the security of the service had been an issue, and this concern had not been shared with the registered manager prior to our inspection.

Staff members told us that they felt people were safe. They explained that they were trained to recognise abuse and were able to tell us about the systems in place to report incidents, including potential safeguarding concerns. One staff member said, "If I was worried about anything I would report it." Another told us, "We report things to the manager if we are concerned." The registered manager showed us that incidents were reported and assessed by them. We found that these had been investigated to learn lessons about how to improve the management of incidents in the future, but they had not always been reported to the local authority safeguarding team. During the inspection we found two such incidents, however; the registered manager contacted the safeguarding authority and discussed the incidents with them during the inspection.

The feedback about staffing at the service was also mixed. Some people and relatives felt that staff members were able to meet their needs, however; others felt that only basic needs were being met and that the use of agency staff impacted on people's care. One person said, "The agency staff are not as good as they could be." A relative told us, "The agency aren't as good as the permanent."

People also told us that, at times, they had to wait to have their care needs met. One person told us, "They always come in and say they will be back as soon as they can - but sometimes it's a long wait." Another person said, "They respond to the bell quickly enough, five to ten minutes, but then they go away and don't come back for ages." Relatives also told us that people had to wait to receive the care they needed. One said, "Yesterday it was about 20 minutes after I pressed the bell - they hadn't come." During the inspection we observed that staff members responded when call bells were sounded and did try to meet people's needs proactively, so that they did not have to ring the call bell.

We spoke with the registered manager about these concerns. They told us that the service had used agency staff, however; they had recently recruited additional staff members which meant their reliance on agency had reduced. We looked at staffing rotas and saw that shifts were mainly covered by permanent staff, with agency staff used to cover any gaps. We saw that the service endeavored to use the same agency members of staff, so that they were familiar with people and the service.

The registered manager did not have a set dependency tool in place to guide them on the exact numbers of staff required to meet people's needs. They told us that staffing was based on people's assessed needs and they were able to increase this if people's needs changed. Staffing rotas showed that staffing levels changed, with a slight reduction in staffing at weekends. The registered manager explained that this was due to the fact that administrative tasks such as meetings and appointments did not usually take place at the weekend, therefore staffing requirements were not the same as during the working week. As there was no dependency tool in place, it was not possible to tell if this reduced staffing level was sufficient to meet people's needs. During the inspection we saw that people's basic needs were being met, however; we did observe that staff were moving from task to task and that, at times, people had to wait to receive their care.

The systems in place to record and monitor medication administration were not always effective. The nurse showed us that medicines were stored safely and that they counted in new medicines on a monthly basis. We checked and found that regularly administered medication stock levels were correct, however; we also

found that the stock levels for three different 'as required' (PRN) medicines did not match the records. This meant that people may not have been given this medication correctly, or that dropped or wasted tablets were not recorded. This also showed that the systems in place to monitor medicines were not effective.

People were supported to take their medication by nurses at the service. They told us that they always received their medication on time and that the staff made sure they got the correct medicines. One person said, "Yes they get it right, spot on." A nurse showed us the systems which were in place for storing and recording people's medicines. They showed us that the recorded each time medicines were given using a Medication Administration Record (MAR) chart. We saw that MAR charts were completed in full and observed the nurse providing people with the correct medication at the correct time.

Requires Improvement

Is the service effective?

Our findings

People felt that most staff members were provided with the training the needed to perform their roles, however; they expressed that some staff members possessed better skills than others. They explained that most staff knew what they were doing and had the skills they needed to meet their needs. One person said, "The majority are well trained to look after me but maybe the newer ones less so." Another told us, "Some carers are better than others but they all seem to be trained to a level." Relatives were also mixed in their feedback regarding staff training. Some felt that staff were well trained whilst others felt that some staff would benefit from additional training. One relative told us, "Yes they know what they are doing, they are so good here, all the staff." Another said, "Staff know their stuff."

There were systems in place to ensure that staff received the training and support they required. Staff members told us that they received training which included an induction when they started working at the service. This included mandatory training modules as well as shifts where they shadowed experienced members of staff to get to know people and the service. One staff member told us, "I spent time following my supervisor; I got to know the residents."

We spoke with the registered manager about induction training at the service. They informed us that the service had systems in place to allow new staff to start working on the Care Certificate, however; they had not implemented this yet as they were encouraging new staff to enrol on vocational qualifications, such as Qualification Credit Framework (QCF) awards in health and social care. Records confirmed that staff members did receive this training and most new staff had been signed up for QCF's. We also discussed those staff that had not been signed up for a QCF, as it was not felt they were ready for this yet. The registered manager informed us that they would consider commencing the Care Certificate for these staff members, to ensure that they developed the skills they required to perform their roles.

Staff members also received on-going training from the provider. Staff told us that training took place regularly to help ensure they were able to build on their skills and were aware of the latest developments in the industry. Some staff members told us that at times, training had not gone ahead due to staffing problems, however; most told us that their training was up-to-date. One staff member said, "My training stopped, we have been very busy." Another said, "My safeguarding training I think was about a month ago." The registered manager showed us that they maintained a training matrix, which they used to record when training took place and when staff were due for refresher training. This showed that staff training was continuous and that future training was booked in.

Supervisions were carried out for staff members on a regular basis. One staff member said, "Oh yes, we have loads of supervisions." Another told us, "I have had three supervisions." The registered manager showed us that supervisions were conducted on a regular basis, and that each supervision was themed to help develop staff knowledge and skills. We looked at records of staff supervisions and found that the service had themed supervisions which changed on a monthly basis. Supervision records were a printed record of the key topics to be covered regarding the theme of that supervision, which did not always record that a conversation had taken place between the supervisor and member of staff.

We discussed this with the registered manager. They explained that they used additional methods to discuss staff concerns, as well as training and development needs. These included staff meetings, observations and informal discussions between staff and management. These conversations were not recorded so we were unable to review the content of them, although we did see that staff meetings were carried out and developments shared with staff.

People did not always feel that they were offered choices about their care and support needs or that staff sought their consent before providing them with care. One person told us, "They don't usually ask me - they come into my room when they get around to me." Another person said, "They don't ask you dear - you know it's your turn on their schedule." During the inspection we observed staff members offering people choices and seeking their consent before providing them with care or support. We saw that staff were respectful of people's wishes and listened to what they had to say. People's care plans also demonstrated that they had been asked to consent to the content of the plan and showed that, where possible, people had signed to say they agreed to it.

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 so that they can 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.

Members of staff told us that they had received training and refresher sessions in the MCA. They were able to describe the principles of the Act to us and worked to ensure that decisions made on people's behalf were in their best interests. The registered manager showed us that care plans had MCA assessments in place and that, where possible, these had involved input from people and others important to them, such as relatives who were involved in their care. We also saw that the registered manager had completed applications for DoLS authorisations when appropriate and had a system in place to monitor these.

We received mixed feedback about the food at the service. Some people were happy with the meals that they received, however; others told us that the food wasn't as good as they would like. We were also told that there was a choice of different meals available. One person said, "You do get a choice but the quality is not very good. Some days it is better than others but today was not good." Another person told us, "Food is okay - good enough to eat." A third said, "It's alright - it's passable, it is hot and we do get a choice." Relatives felt that the choices on offer were sometimes limited and repetitive. One told us, "It's always fish fingers on Fridays and it's always casserole on Thursdays."

During the inspection we observed that people were able to choose what they ate at meal times and appeared to enjoy the food on offer. We saw that people were served their meals in the dining room, but could also have them in other areas of the service if they wanted. There were staff members available to help people eat when required, and we saw that some people were also supported by their family members. However; we saw that one person had to wait for over 20 minutes after others had received their meals, before a member of staff was available to help them. We saw that people were offered drinks and snacks, including homemade scones, throughout the day.

Care plans contained information about people's dietary needs and preferences, as well as information about specialist diets. The cook was able to tell us about which people needed specific diets to help with their health or weight management and we saw that there were plentiful stocks of fresh and in-date food and drink items for people. Care records showed when people were offered drinks and there were also charts available to record people's food intake. These records were used to help identify if there were concerns about people's eating or drinking, however; it was not clear if and when they were reviewed by senior or management staff.

People told us that the service helped them to see healthcare professionals when they needed to. They explained that there were regular visits to the service from GP's and other professionals if necessary and the service would also support them to attend outpatient appointments if necessary. One person told us, "The doctor is here quite a lot really." Relatives also told us that their family member was able to see healthcare professionals when they needed to. They also told us that the service kept them updated and that they were able to take people to appointments in the community.

Staff members confirmed that there were regular GP visits to the service and also told us that they contacted the GP or emergency services between visits if people became unwell. One staff member said, "The doctor comes every week on a Wednesday." Another said, "We do call the doctor or the ambulance." Records showed that medical visits took place and that care plans were updated as a result of these visits when appropriate.

Requires Improvement

Is the service caring?

Our findings

People were not always treated with dignity by members of staff. They, and their relatives, told us that they felt that staff were usually attentive and made sure they were treated in a dignified manner, however; they did tell us that there were occasions when this was not the case. One person described being hoisted by staff to help them get up. They told us, "They don't always talk to me as they do it, but they do take care." Another person told us, "They don't have time to talk, they are in and out and gone." During the inspection we observed one occasion where a person was helped from their wheelchair into an armchair using a hoist without interaction from members of staff. We saw that the staff members spoke to one another, but not the person who was being repositioned. We saw other occasions where staff did speak with people when using a hoist or other equipment.

We were told that, at times, people had to wait for a member of staff to support them to use the toilet. One person said, "Waiting is very painful you know when you want to go to the toilet, you should not have to wait like that." Relatives also told us that they felt their family member had to wait sometimes. One told us, "Mum had pressed her bell on Tuesday afternoon when I was here because she wanted to go to the toilet. 20 minutes later no-one had been to her - she had wet herself by then."

Relatives also told us that they felt there were times when their family members were not treated with dignity and respect. One relative told us that their family member often liked to go back to their bedroom, but had to wait for staff to support them with their mobility. The person's relative regularly had to ask members of staff to provide this support. They said, "I feel like I am pleading with them to take him, it's like begging them to do it." This showed that people were not always treated with dignity and respect as members of staff did not always have time to ensure that their needs were being met.

The registered manager told us that staff members would endeavour to meet people's needs and wishes, however, at times this could lead to conflict between their wishes and preserving their dignity. For example, they told us that staff members had offered to change the incontinence pad for one person. They declined to have this changed, which may have resulted in a potential loss of dignity.

We were also told that there were times when people's laundry went missing or was damaged. One relative told us that they had witnessed a member of staff grab hold of a person's clothing when attempting to support them to move. This had caused the clothing to rip and they told us that other items of clothing had been ripped on other occasions. Another relative also told us that their family member's clothing had been damaged in the past.

People were not always treated with dignity and respect. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans were in place for each individual at the service however; some people told us that they had not been involved in producing the content of their care plans. Some people told us that they had not been involved at all in care planning, whilst others told us that they had been asked about how they would like

their care to be, but had not seen their care plans.

Some people's relatives also told us that they had not been involved in creating care plans for their family members, whilst others told us that they had been involved. We were told by some relatives that they had not seen the care plan which was in place, therefore were not aware of the care arrangements which were in place for their family members. One relative told us, "We did meet when she came in but I can't recollect seeing or signing a care plan." We were also told, "When we first came in we were involved in writing the care plans."

We spoke with the registered manager about how people's care was planned and who was involved. They explained that they had tried to involve people and their relatives as much as possible, however; they had identified that this was an area in which work was on-going to be able to show the involvement of people and their family members. They showed us that they had started to take action to address this. This included evidence of re-written care plans which had been signed by people and their family members. We saw that work had started to improve the levels of involvement of people and their relatives in care planning, and that further improvement was also planned.

People told us that they had developed positive relationships with members of staff at the service. They explained that staff members treated them kindly and spoke to them politely and with compassion. One person told us, "They are kind and patient with me - I can't say otherwise." Another person said, "The staff are alright, yes. They don't rush me." A third person told us, "Well they are certainly kind, not rough with me no."

Relatives also told us that they were happy with the way staff members interacted with their family members. They told us that members of staff had spent time getting to know their family member and were able to communicate with them in the way they wanted. In addition, staff members had shown that they cared about people's welfare and wanted them to be happy at the service. One relative told us, "Oh yes, she has a very good relationship with the carers. So do we!" Another said, "They are so good here, all the staff. If there is a problem, they sort it out straight away."

Staff members told us that they were positive about working with people and enjoyed getting to know them and trying to make them as comfortable and happy as they could at the service. One staff member said, "I really love my job. I want to make sure that people are okay and happy." During the inspection we saw that staff were kind and polite to people whenever they interacted with them. They were patient with them and supported them to do as much for themselves as possible.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive person-centred care at the service. Care was often task-orientated, in order to ensure that staff were able to meet people's basic needs, rather than based on the specific wishes of each individual.

People told us that staff were not always able to provide care in the way that they wanted. They told us that the care they received was given in a way which suited the service and staffing levels and did not always take their preferences into account. For example, people told us that they had been asked about their preferences regarding when they would like support to get up in the morning. However; they went on to tell us that they regularly had to wait until later than their preferred time before staff were able to provide them with support. One person told us, "I want to get up at 9am and it is now 10am and I am still not up." During the inspection we saw that people's preferred times to get up had been recorded and were on a summary sheet for ease of access by members of staff. We saw that a number of people were waiting until after their preferred time to get up, some by over one hour.

We spoke with the registered manager about this. They told us that they this was not the usual level of performance from staff members, and that people were usually able to get up much closer to their preferred times. We saw care notes which showed that people's recorded times of getting up varied on a daily basis, however; they were often closer to people's preferences than we observed during the inspection.

None of the people we spoke with were able to tell us about their care plan and when it was last reviewed. They couldn't tell us about the content of their care plans and weren't aware of any meetings held in which they discussed their care or made sure the care plan was reflective of their care needs and wishes. Some relatives told us that they had been involved in care plan reviews, however; others told us that they had not been and were not aware of the content of their family member's care plan.

The registered manager told us that they were in the process of reviewing all the care plans at the service. They explained that they had not managed to re-write all the care plans, but they planned to. Part of this process was to ensure that the content of care plans was accurate and reflected people's preferences as well as their specific care needs. They told us that this would help staff members to deliver more person-centred care. We checked care plans and saw that some had been revised and showed evidence of being more person-centred and had evidence of people and their family members being involved in the review process. The new care plans had more detail about people's history and their preferences and provided staff with more information about people's needs. However; we saw that some people still had the old version of the care plan in place, which did not provide as much person-centred information.

People were not provided with sufficient activities or stimulation to ensure that their preferences, hobbies and interests were met. People told us that they did not receive enough activities to do and did not feel that they were mentally or physically stimulated. They said that they were bored and that there was nothing for them to do and that staff were often too busy to help them. One person told us, "I like music but not the sort that is on now. I will have to wait until my husband can come and change it."

Relatives also told us that they felt there were not enough activities at the service. One relative told us, "There are no outings, no bingo, no activity coordinator. No-one to take him into the garden - they said they don't have enough staff to take him." Another said, "She hates sitting in her room on her own but the only thing on in the lounge is the TV on all day."

Staff members told us that they were not always able to provide people with activities as they had to prioritise meeting people's basic care need. They explained that they did try to spend time with people on a one-on-one basis, however; this was limited by the care tasks which were required to be completed first. During the inspection we saw that people provided with minimal activities throughout the day. People were able to watch the TV in the lounge, or relax in their bedrooms for most of the day. In the afternoon we saw one staff member spending some one-on-one time with people, talking to them about some of their photographs, however; they were not able to offer this to all the people living at the service.

We spoke with the registered manager about activities at the service. They told us that they arranged for entertainment to come to the service and showed us that a reminiscence session was carried out every two weeks and a singer came in to the service, also on a two-weekly basis. They also informed us that a hairdresser regularly visited and church services were also held for those that wanted to attend. The vicar also visited the service outside of arranged church services, to spend time with residents. The registered manager also stated that staff were able to carry out ad-hoc activities throughout the day, depending on people's wishes at a given time. These activities were not recorded and they acknowledged that there was work to be done around developing activities provision and the way people's participation was recorded. There were systems in place to record planned activities and people's level of participation in them.

Care and treatment was not always provided in a way which reflected people's individual needs and preferences. This was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback about complaints and the way that they were handled by the service. People told us that they felt they were able to complain if they had any issues and that they would be listened to. However; they did not always feel that anything changed as a result of their complaints being made. One person told us, "I have complained in the past." Another said, "I have also complained about [a specific issue] - this has not changed."

Relatives also told us that they were able raise any issues that they had, however; they were not always clear of the outcome of their complaint. One relative told us, "They do listen to us but not sure what happens about what we raise. They never get back to us." Another relative said, "No-one ever gets back to you to say how they are changing things so it won't happen again."

None of the people or the relatives that we spoke with were aware of the content of the provider's complaints policy. They explained that they complained to staff or management when they needed to, however; they weren't aware of the set procedure for handling or responding to any complaints which were raised. One relative told us, "I would like to see a copy of the complaints policy but I don't know where to get it from."

We spoke with staff and the registered manager about complaints at the service. They told us that complaints were welcomed and they used them to help learn and develop the service. The registered manager showed us that there was a complaints policy in place, which was available to people and their visitors at the front desk. There was also a system to record complaints and any action taken as a result. However; informal complaints and feedback from people or their family members were not always recorded

so the registered manager was unable to demonstrate what they had done in response to these concerns. For the formal complaints that had been made, we could see that appropriate action had been taken.

Inadequate

Is the service well-led?

Our findings

There were not effective quality assurance systems in place at the service. The registered manager had implemented some checks and audits to help them manage the delivery of people's care, treatment and support. However, these checks were not always effective at identifying areas of concern, therefore were not able to be used to help the drive improvements at the service.

Concerns regarding the safety of the environment for people and those visiting the service had not been identified during routine checks and audits. For example, we saw that a system had been put in place for senior staff to check fire escapes were clear on a daily basis. During our inspection we found that two of these were blocked by laundry trolleys and staff confirmed that this was the normal practice at the service. The provider had failed to highlight these concerns during the checks which were carried out; therefore action had not been taken to ensure that the fire escapes could be used safely.

The medication audit system which had been introduced was not robust as it had failed to identify when stock levels of medication were not correct. This meant that people may not have received the correct dosages of their medication and there was no way of checking how or when any mistakes may have happened. The lack of robust checks placed people at increased risks of not receiving their medication correctly.

During the inspection we found issues around the cleanliness of the service. We saw that cleaning tick lists had been put in place for staff to complete, however; there was no evidence to show that these had been checked by the registered manager or provider to monitor how effective the cleaning had been. This meant that areas which required additional cleaning or improvements required to the cleaning processes in place were not identified and that the systems in place for governance and infection control had failed to identify this.

We spoke with the registered manager about checks and audits which were in place at the service. They showed us that they had implemented some new systems, such as audits of staff files and care plans. We could see that these checks had been more robust than some of the others at the service and had led to improvements. The registered manager also told us that they planned to introduce a formalised dashboard summary of audits, to help support their quality assurance processes. They also told us that they would continue to review the audits in place at the service. Since the inspection they have told us that they have implemented an additional cleaning audit to check a sample of 2 to 3 bedrooms on a weekly basis.

The registered manager was able to show us that they had implemented an action plan to address a number of areas at the service where they had identified that improvements were required. We saw that some parts of the action plan had been completed whilst others were still marked as 'active'. In most cases, actions on the plan had been met within their target date or were still active before the target date expired. We saw that some target dates had been missed and an extended date applied on the action plan, however; some had been missed without a note to clarify the new target date. In addition, we could not see how the planned actions at the service had been shared with people or their families, or how their feedback had

been sought in identifying areas for improvement.

The registered manager showed us that the provider had recently implemented an information governance toolkit at the service. They planned to use this to help improve the arrangements for the management of information at the service and to help develop improved quality assurance systems.

There were not robust systems or processes in place at the service to allow the provider to assess, monitor and improve the quality and safety of the care being provided at the service. This was a breach of regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was not always clear and accessible leadership at the service. People told us that they were not always able to see or speak with the registered manager when they needed to. They explained that they were not sure when the registered manager would be at the service and that they weren't always easy to see when they were there. They also told us that they could not remember a time when the registered manager had come to see them in their rooms or in the communal areas of the home to talk to them and see how they were doing.

Some relatives also told us that they didn't feel they had regular access to the registered manager. One relative told us, "It is not always easy to see the manager because we never know when she is going to be in." Another told us, "You never know if she is going to be here, she doesn't have a set work pattern so it is very difficult if you want to speak to her about anything. She stays in the office all of the time if she is in and you feel separate from her." A third relative said, "She is not really approachable." We did speak to some relatives who were positive about the management of the service and felt that they had been well supported. One relative said, "She's always accessible."

Staff members were positive about the registered manager. They told us that they felt they provided them with the support they needed and were available, either at the service or over the phone, if necessary. One staff member said, "Yes, I feel well supported by the manager." Another told us, "We can always get hold of her if we need her." We saw that, in addition to the registered manager, there was a clinical lead nurse and a team of nurses who worked at the service. They were able to provide support for junior staff in the absence of the registered manager, who also responded out-of-hours when required.

The service did not always have a positive and open culture. People and their relatives told us that they didn't always receive information about the service and felt that they didn't have a lot of interaction with the management of the service. They told us that they hadn't been involved in meetings or discussions about the way the service was run and weren't aware if any feedback surveys had been carried out. One relative told us, "We used to have them [feedback meetings] but I don't think we have had one for ages." Another said, "Since [name of family member] has been here, there has not been one."

We saw that there was a poster in the service advertising forums for people living at the service, as well as their relatives. None of the people we spoke with were familiar with these; however we did see that there were some meeting minutes recorded from them. Relatives told us that they did not receive information about what was said at these meetings, or about developments at the service.

We spoke to the registered manager about these meetings and how the information from them was used. They told us that they used the forums to try to include people in the service as much as possible, for example, when a recent extension was developed. It was not clear how or if the outcomes of these forum meetings were cascaded to people and their relatives, or if there were changes taking place at the service as a result. This meant that people were not able to share their views about the development of the service on

a regular basis as part of a forum, therefore action could not be taken based on people's collective feedback. The registered manager told us that they and other staff members had regular discussions with family members about the development of the service and current or future developments. As these conversations were usually informal in nature, there were no documents to provide us with evidence of this. They also told us that they attempted to conduct satisfaction surveys, and showed us evidence of these. They explained that a high proportion of these were not returned, which made it difficult to be able to use the survey to drive improvements at the service. Similarly, they showed us evidence that meeting were not always well attended by people or their family members.

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 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 9 HSCA RA Regulations 2014 Person-centred care Care and treatment was not always provided in a way which reflected people's individual needs and preferences.

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 RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

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 Risks to people were not always assessed fully and risk assessments did not always contain clear guidance regarding risks and how to manage them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises and equipment used by the service were not always clean or suitably maintained to ensure they were safe for people to use.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There were not robust systems or processes in place at the service to allow the provider to assess, monitor and improve the quality and safety of the care being provided at the service.

The enforcement action we took:

Warning Notice Served