Carewell (Health Care) Limited

St Mary's Care Home

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?	**Good**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on 25, 26 May, 2 and 17 June 2016 and was unannounced. St Mary's care home is located in the centre of Chester-le-Street and provides accommodation for people who require nursing or personal care. There were 30 people using the service on 25 May 2016 including people receiving respite care. On 2 June 27 people were using the service on 17 June 25 people were using the service.

At the last inspection on 1 and 2 September 2015, we rated this service as 'Inadequate'. We served warning notices on the service and asked the registered provider to take action to make improvements, for example, on people's topical medicines, staff supervision and documentation. The registered provider put in place an action plan to improve the service.

At the time of our inspection there was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. St Mary's Care Home is owned by Carewell Healthcare Limited. One of the partners of Carewell Healthcare Limited employed a regional manager for other services provided by them. This regional manager had offered support to the manager of St Mary's Care Home and was present during the inspection.

People who used the service and their relatives were complimentary about the staff. Staff displayed caring qualities towards people and treated them with kindness and respect.

We found the service met the requirements of the Mental Capacity Act 2005 (MCA) and had made applications to the appropriate authority regarding the Deprivation of Liberty Safeguards (DOLS).

The service had received a certificate from the initiative, "Focus on Undernutrition" in care homes. Staff confirmed to us they had completed the training. The initiative uses the Malnutrition Universal Screening Tool (MUST) which gives recommendations about people's nutritional requirements if they are at risk of malnutrition. We found the home had not followed the requirements. Staff were not aware of what snacks were available for people who were diabetic.

The service had put in place fluid charts for people. We found staff had recorded the amount of fluid they were giving to people but not the amount they had actually drunk. The fluid amounts had been totalled; however there were no target fluid amounts in place. Staff therefore were unable to assess if people were at risk of dehydration. By 2 June 2016 the manager had begun to put in place target fluid levels. On 17 June 2016 we found information for staff had been put in people's files from Association of UK Dieticians regarding hydration including meeting the needs of older people.

We found Medication Administration Records for people's prescribed topical medicines had not been completed. We also found there were no dates of opening on people's topical medicines and topical

medicines had not been destroyed in line with the manufacturer's guidance. Following our visit on 26 June 2016 the manager had put in place a new system to manage people's topical records, however we found the system was not always adhered to.

The management team told us staff provided activities for people each afternoon. Staff told us they were not always available to do this as they were often called away to carry out other duties. During our inspection we saw staff had put a film on the television for people who were then left unsupervised. We found staff were not deployed to provide appropriate supervision of people.

Staff had received training in safeguarding and were able to tell us what actions to take if they had concerns about anyone using the service.

We looked at 10 people's care records and found they contained personalised information to enable staff to provide appropriate care of people. However not all of the records gave staff guidance to manage the risks to people.

Staff had not received supervision in line with the registered provider's policy. This meant the service had not provided staff with meetings with their manager to discuss any concerns and their personal learning needs.

We found records in the home were at times inaccurate or they were not up to date. This meant we could not always be assured that people's care needs were being met.

The home had in place handover information between nursing staff and care staff. We found the handover information to an agency nurse who was on duty at the time of our inspection was inaccurate and if the information had been followed for one person it would have put them at risk.

We found the service had in place a number of quality audits to measure its performance. The manager then drew up a remedial action plan for each month. However, we found some of these audits were undated and the audits did not tell us what records had been checked by the manager. We found the audits did not address the deficits we found in the service.

During our inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

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.

We found people's topical medicines charts did not give guidance to staff about their application and were not completed to demonstrate staff had given people their topical medicines. We also found topical medicines had not been disposed of appropriately.

People's risk assessments were not completed accurately and described the risk to people with actions to be taken to mitigate those risks.

We found there was insufficient staff deployed to meet people's needs.

Is the service effective?

Inadequate

The service was not effective.

We found the home had in place the Malnutrition Universal Screening Tool, but had failed to use the tool and the advice given on it to reduce the risk of malnutrition.

Staff did not have in place the necessary support through training, supervision and appraisal to enable them to carry out their duties.

The registered provider met the requirements of the Mental Capacity Act. We found people's capacity had been assessed and applications when required had been made to the appropriate authority to deprive people of their liberty and keep them safe.

Is the service caring?

Good

The service was not always caring.

Staff demonstrated they cared for people by engaging them in conversations, adjusting their clothes when they stood up to preserve their dignity and supporting people to make choices. We observed staff acting with kindness towards people.

Staff provided information to people and their relatives on a range of subjects including choices for lunch as well as sharing information about people's health and social care needs.

Visitors told us they were welcomed into the home by staff and felt able to visit at any time.

Is the service responsive?

Inadequate

The service was not responsive.

We found people's care records were not always personalised and did not always demonstrate that the person's care was designed to meet their needs.

We could not be sure that people's care plans had been reviewed as staff had been given guidance which meant they did not know what to write.

As there was no activities coordinator in place staff were required to carry out the activities with people. However, staff told us due to other duties they were not always available to arrange and carry out activities.

Is the service well-led?

Inadequate

The service was not well led.

We found records in the home were at times inaccurate or they were not up to date.

There was a range of audits carried out in the home to ensure people received a quality service. The audits failed to identify the deficits we found during the inspection.

Since our last inspection the manager had carried out quality surveys on the home. The responses were largely positive. People had commented on the heating in the building and the need for things for people to do. We saw a new thermostat had been installed. Signs were in the home for visitors to suggest if they wanted refreshments they could ask staff.

St Mary's Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 25, 26 May, 2 and 17June 2016 and was unannounced.

The inspection team consisted of three adult social care inspectors.

Before we visited the home we checked the information we held about this location and the service provider, for example we looked at the inspection history, notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We also contacted professionals involved in caring for people who used the service; including; the local authority commissioners and no concerns were raised by these professionals before our inspection.

Prior to the inspection we contacted the local Healthwatch. Healthwatch is the local consumer champion for health and social care services. They gave consumers a voice by collecting their views, concerns and compliments through their engagement work. Healthwatch told us they had recently visited the home and shared with us their findings.

During the inspection we spoke with people who used the service, three of their relatives and friends. As some people were unable to speak for themselves we carried out observations of their care and interactions with staff.

We spoke with 14 staff including the supporting regional manager, the manager, nursing and care staff, kitchen and domestic staff.

We looked at the care records for 10 people including food and fluid charts used in the service. We also looked at six staff records including recruitment files as well as records held by the manager to monitor the service.

Inadequate

Is the service safe?

Our findings

At our last inspection we found the provider had breached Regulations 9, 12, 17 and 18 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found the provider had made some improvements but had continued to breach these regulations.

Not everyone in the home was able to speak to us and let us know if they felt safe. We observed interactions with staff and found people did not display any distress reactions in the presence of staff. One relative told us they thought the home was, "Alright."

We checked to see if people were given their medicines safely. We spoke to staff who were able to give us a good account of how to order, store and destroy people's unused medicines. We found people's medicines were locked away. People who needed medicines known as PRN (as and when required medicines) had care plans in place to tell staff what people needed and when. Controlled drugs are drugs which are liable to misuse and as such have stricter guidelines for storage, administration and disposal. We found these drugs were stored appropriately and regularly checked. We checked people's Medication Administration Records (MAR) and found these were well maintained. Each MAR chart had a photograph of the person so staff could check to see if they were giving the medicines to the correct person. We saw if there were any discrepancies found in the MAR these had been investigated and actions taken.

We looked at people's topical medicines (medicines used for external application) and found where people had been prescribed topical medicines there were administration charts in people's rooms. However, we found the administration charts did not always describe where people were meant to have their topical medicines applied and the frequency with which the applications were to be carried out. There were no dates of opening on people's topical medicines. We found topical medicines in people's rooms which were out of date or did not belong to the person in whose bedroom we found them. This meant people were at risk of not receiving their creams as prescribed. Following the first day of our inspection the manager told us in an email all topical medicines were to be removed from people's rooms and stored in a separate cabinet. On the final day of inspection we found topical medicines were in people's bedrooms.

We found topical medicines for people who had passed away in other people's rooms and also found eye drops which had been opened and not disposed within the required time frames. This meant people's medicines were not disposed of appropriately.

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

We saw the provider had in place a range of risk assessments and had put actions in place to mitigate risks to people. These included, for example, what actions to take for a person who was at risk of falling. However, we found one person had a fall and the cause of their fall was included in their care plan review but had not been carried forward to their risk assessment. Actions had not been put in place to reduce the risk of this person from falling. Another person was at risk of choking and we found staff were not given instructions on

how to reduce this risk. This meant staff were not given the required guidance to manage the personal risks to people.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw people had in place Personal Emergency Evacuation Plans. These described people's needs should they need to evacuate the building in an emergency. The plans were stored in people's care files and were not immediately available to any rescue service. This meant despite having the plans in place to advise staff, rescue personnel could not be aware of people's needs in an emergency situation.

We reviewed accidents and incidents in the home and found accidents had been recorded by staff. However we found the accidents had been recorded in five different accident books in no sequential order, and found that accidents involving people who used the service were recorded in staff accident books. The manager had looked at the accident reports and summarised them on a monthly sheet which recorded the person's name, the location of the accident in the home and the time, with comments. The monthly sheet did not include dates so the manager was unable to identify patterns and if for example a person's falls coincided with a short term illness.
During our inspection we were present when the fire alarm rang. Staff gathered at an appropriate point but no staff member knew how to turn off the fire alarm. We spoke to the manager who told us the alarm had been installed a couple of months ago. They had been given the instructions that day by maintenance staff to share with other staff members.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the early part of the inspection we found staff were busy and responded quickly to people's call bells. We looked at rotas and found the numbers of staff on the rota reflected the manager's expectation. On the third day of the inspection we observed a volunteer giving out drinks to people on their own. It was agreed following the previous inspection a volunteer should be accompanied by a member of staff to keep people safe. Staff confirmed to us they were too busy getting people up to support the drinks round. Later on the same day the inspector observed five people in a lounge without support or supervision. One person stood up and their body language indicated they were angry with another person in the lounge. The inspector called the supporting regional manager from the office who intervened and removed the person from the lounge. This meant staff were not deployed to provide the required care and supervision of people.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helped employers make safer recruiting decisions and also prevented unsuitable people from working with children and vulnerable adults. We found the registered provider carried out these checks and required prospective staff to complete an application form detailing their previous experience and knowledge. The service also asked prospective staff for the names of two referees. They sought references before the staff member was employed. We found the service carried out appropriate checks to ensure only suitable people were employed in the home.

Staff told us they felt able to whistleblow and raise concerns they had about the service. The regional manager confirmed to us staff had used the procedure. Staff had also been trained in safeguarding and

were able to tell us what actions they would take if they had concerns. One member of staff told us they would report their concerns to the manager and if they did not get an appropriate response they would contact the local authority safeguarding team. This meant staff knew what to do if they had safeguarding concerns.

The registered provider had in place a disciplinary policy. The manager and the supporting regional manager spoke with us about how this had been used when a member of staff's conduct was called into question. This meant the people were kept safe from staff whose actions may have put them at risk.

The registered provider had in place a range of checks carried out on a regular basis to ensure the building was safe for people to live in. For example we found fire checks, water checks and checks on window restrictors were carried out. Staff had access to a maintenance book where they reported issues which needed attention. We saw contractors were brought into the home when required. For example there were up to date gas and electrical safety checks in place as well as hoist checks and Portable Appliance Testing (PAT).

We saw the home was clean and tidy. Staff showed us their completed cleaning schedules and were able to describe to us what actions they carried out during their cleaning to reduce the spread of infections. The manager had carried out infection control audits and found the home was appropriately cleaned.

Inadequate

Is the service effective?

Our findings

At our last inspection we found the provider had breached Regulations 12, 14, and 18 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found the provider had made some improvements but had continued to breach these regulations.

One person said, "I am well looked after." Their relative confirmed that the person enjoyed their stay at St Mary's and they had no concerns about the home. One person told us they enjoyed their meals in the home, and another person said, "The food is good."

We looked at people's food and fluid charts and found staff had written down the amount of fluid they had given to people, but not necessarily the amount they had drank. For example we observed a staff member giving a person a mug of tea. The guidance to staff stated a mug contained 300 mls. The mug was almost full to the top and the person drank half of what they had been given. The staff member wrote the person had drank 240mls. This meant the amount consumed by people was not always accurately recorded.

We saw the home had on display a certificate which they had been awarded for completing the County Durham 'Focus on Under Nutrition' initiative. This initiative uses the Malnutrition Universal Screening Tool (MUST) to assess if people were at risk of malnutrition. We found one person was assessed as being at risk level one and despite losing weight their risk scoring had decreased. The advice given in the tool with regards to reducing the risk of malnutrition was not reflected in people's care plans. We checked the person's food intake charts and found there was no information recorded which indicated the risks were being mitigated. We looked at another person's MUST tool and found there were no risks recorded; however the person had lost weight every month for seven months. When we applied the MUST scoring system we found the person was at risk. Again, none of the advice given in the tool with regards to reducing the risk to the person was reflected in their care plans or reviews. This meant people were at risk of malnutrition.

We asked staff what was available for people who had been diagnosed with diabetes as morning and afternoon snacks. Staff were not aware of what was available. The manager told us fruit and yoghurts were available for people. This meant people were not being offered snacks if they were diabetic. During our inspection we checked people's food and fluid charts and found there were no snacks recorded.

At one lunchtime period we observed a person asleep with their meal in front of them. Their main course was half eaten and their milky pudding was untouched. We expressed concern to the member of staff that the pudding would be cold; they told us the pudding was cold by the time it left the trolley. One member of staff confirmed to us the pudding was meant to be hot. After lunch we observed another person sitting at the table with the same pudding untouched. We were not assured that people had been encouraged to complete their meal. At another lunchtime period we observed a person who was at high risk of malnutrition was given the wrong meal, this meal was replaced, we observed them putting their hand to their plate and to their mouth but did not have the manipulation skills to pick up their food. They did not receive support to eat.

We found a dietician had offered advice to the home on two occasions about one person at risk of malnutrition. Records did not demonstrate their advice had been followed and they had received all the recommended dietary supplements. This meant staff were not following professional guidance.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff new to the home were required to complete the Care Certificate as a part of their induction to the service. The Care Certificate is used by providers to ensure social care support workers have the knowledge and skills which they need to provide safe, compassionate care. We looked at staff training and found the manager had in place a staff training matrix, this showed when staff had completed training and if any staff member required updated training. We saw that most staff had received training pertinent to their role. For example staff had received training in dignity and respect, and moving and handling. We also found some staff who had not received any training according to the matrix for their role, and staff who were carrying out roles for which they had received no recent training for example the safe handling of medicines. We found senior carers' training in the safe handling of medicines was undertaken between 2011 and 2014. We spoke to the manager about this and they demonstrated staff competencies in the administration of people's medicines had been assessed in November 2015.

During the inspection we looked at staff supervision records. A supervision meeting takes place between a member of staff and their manager to discuss, for example, a staff member's progress, concerns or training needs. The supporting regional manager provided us with the new updated supervision policy. The new policy stated staff were expected to have six supervision meetings per year. We found staff had not received supervision in line with this policy. We discussed this with the manager during the inspection, who provided us with a supervision matrix and at the time of the inspection told us they had no further evidence. Following the inspection the manager emailed us to state they had found further evidence and provided us with an updated supervision matrix. This matrix showed us one staff member who we spoke to during the inspection was missing from the list. We looked at the new matrix and found that although more supervision meetings had been held there were still staff who had not been supervised in line with the provider's policy.

From the information provided by the manager we found there were 40 staff employed by the home, and out of 36 staff who were eligible for an appraisal over half of them did not have an appraisal in place.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at communication methods in the home and saw that information was available to staff on staff notice boards and in files in the offices. The manager had held flash meetings; these meetings are held quickly to inform and advise staff of updates on issues about the home. The registered provider also had in place handover sheets to ensure information was passed between shifts. We looked at the handover sheet which was passed to the nurse on the last day of our inspection and found the information passed to the nurse was inaccurate, which left an individual person at risk should the nurse have followed the instructions. This meant the communication system in place to manage a handover placed one person at risk.

We found the home had a number of empty rooms which were open. The rooms contained assorted items of furniture and equipment. We found one person asleep having chosen to have a nap on one of the beds in an empty bedroom. On one door we saw a sign which said, "Do Not Enter." The padlock to the door was open and we found, wheelchairs, fans, commodes and keyboards. People who accessed these rooms were at risk of trip hazards.

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

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. We found the service had assessed if people had capacity and made applications to the local supervisory body to deprive people of their liberty. Some applications had been authorised and we saw the manager was aware of when the authorisations were due to expire.

Good

Is the service caring?

Our findings

One person said,"[Staff member] is very caring." Another person told us the staff were, "Really very good" and they found the volunteer, "Wonderful". A relative told us, "Staff are pleasant enough." We found there was a calm relaxed atmosphere in the home. In the foyer, records were played on an old type record player. Information and thank you cards were on display.

During our inspection we observed all staff irrespective of their work role in the home act with kindness and patience towards people. Staff responded to people's need and engaged them in conversation. Staff had converted a small lounge area into a double bedroom so partners could be together.

People were able to choose when they got up in the morning and those who were able could walk around the home freely. The home had a garden area which people could access. We observed one person using this in the rain as they wanted to smoke. A member of staff offered to get their coat for them.

One person told us it was their birthday and showed us their birthday card. We saw that a birthday cake had been prepared for them in the kitchen. We found staff enabled people to celebrate their special occasions.

We saw staff supported people to make their own decisions. For example we observed one person stand up during their breakfast and tried to carry their bacon sandwich and cup of tea out of the dining room. The person was unsteady on their feet. A staff member intervened, the person said they wanted to go to their room and the staff member carried their breakfast to their room for them. Another person waved their arms and indicated where they would like to sit at the table, the member of staff took them to their preferred table.

The service had arranged a meeting for people who used the service and their relatives to encourage their involvement. The minutes of the meeting showed relatives asking the manager questions and them responding with appropriate answers. We asked the manager how often these were held, the manager told us the relatives wanted to talk to the registered providers of the service and as one registered provider had not been available to attend another meeting they had not arranged a subsequent meeting. This meant relatives' involvement in the service had reached an impasse.

People's bedrooms were personalised so that people had familiar things around them. We found one person's bedroom to be particularly messy and in need of cleaning. Staff explained to us it was the person's wishes that their room remained like that as they did not like people touching their personal possessions. Staff explained to us that whilst they respected the person's wishes they also needed to ensure hygiene levels were maintained to prevent infection. They told us they had to work with the person to secure their permission to enter their room and clean.

We observed staff were friendly with people and helped them do their buttons up. When people stood up staff arranged their clothing to maintain their dignity. We also observed one member of staff use hand signals to communicate with a person and gave them a thumbs-up sign to check on their well-being. As they

walked away they immediately engaged another person in a conversation about their tea. Another member of staff spelt out words to assist a person with communication.

Visitors told us staff welcomed them into the home. We observed staff giving people information about their relatives and enquiring about relative's own well-being. We also observed people being given information about the meal choices and encouraged to make their decisions.

We spoke with the manager regarding arrangements for advocacy in the home. The manager cited one person for whom staff thought an advocate was beneficial but was unable to tell us if an advocate had been sourced. People who were able to self-advocate in the home told us staff listened and were good to them. One person said, "This is the best home I have been in."

During our inspection we observed staff enabling people to have a bath or shower, at which point staff kept the doors to bathrooms closed and people were assisted out of the bathrooms in their dressing gowns or clothing. This meant staff maintained people's dignity and privacy.

Staff spoke to us about people with respect. In particular they talked about a person on end of life care with kindness. When people raised issues with us staff were willing to support and help people seek solutions. One member of staff was aware that a person with living with dementia may refuse a drink and they walked away to avoid the person becoming distressed before returning and trying again. This meant staff were willing to try to engage people to deliver their care

Inadequate

Is the service responsive?

Our findings

At our last inspection we found the provider had breached Regulations 9, 12, and 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found the provider had made some improvements but had continued to breach these regulations.

In one person's care plan we saw they were able to make meal choices as long as they could see the options available. We observed a staff member seeking people's preferred lunch options. They pointed to the person and said, "Soft" before leaving the room. This meant the person was not given a choice. We also found care plans did not include people's topical medicines and guidance was not given to staff to ensure people's personal needs, for example, to maintain their skin integrity was in place.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found hydration and nutrition care plans did not always meet people's needs. People's fluid intake charts did not have in place an expected daily amount. We saw people's daily fluid intake varied and where a person's fluid intake was low the service had not put in place actions to mitigate risks of dehydration. Between our inspection visits the manager had begun to put in place instructions to staff with notices in the front of each person's daily charts advising them of the amounts, and if the person did not tolerate the amounts to contact their GP. One GP visited during the inspection and advised the staff to try to get a person to consume 1000mls. We found this person on some days had consumed approximately half this amount.

During our inspection we found one person who was at high risk of pressure ulcers. The service had not responded to reduce the risks to the person. For example, we found the person did not have in place turn charts to relieve areas of pressure on their body. Staff told us the person could move in their bed. We found the bedrails were covered with bumper cushions. There was a bed rail assessment in place and the bed rail assessment checklist asked if there were hourly checks during the night to which the assessor had responded 'Yes'. However we found there were no hourly checks during the day. This meant any risks associated with bed rails was not being monitored during the day.

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

Although there was evidence to suggest people's care plans were reviewed on a monthly basis we found one person's medication care plan had last been evaluated in January 2016. Staff told us they had been instructed not to write, "No change" so the staff were unsure of what to do. This meant we could not be assured that this person's plan was contemporaneous.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our visit we saw a GP visit the home. We saw the home had made referrals to other professionals when people needed their assistance. This included the SALT team who had carried out assessments about people needing soft or pureed diets. One person accessed the local community and told us about going to a church group. The manager spoke with us about connections with a local school and visits made by local churches. The home was making preparations for Care Home Open Day when homes across the country open their door and invite the local community in to join in celebrations. This mean the home had in place links with local groups.

When the Healthwatch team visited the home they asked the service to consider displaying an activity planner to show what activities are taking place at various days of the week. We spoke with the supporting regional manager and the manager about activities for people in the home. They told us although the home did not have an activities coordinator in place staff had now taken on the role and they had found staff had different skills to support people. They also told us that they had started out with an activities planner for the week but this was no longer needed as staff knew what to do.

During our visit we observed a member of staff engaging people in the downstairs lounge in a game of skittles. People were enjoying the activity which prevented them from becoming isolated. We spoke to staff about providing activities to support people. They told us this was subject to their availability and they could easily be taken away to carry out other duties. One the final day of our inspection we observed staff trying to engage people in choosing a film. We found staff left the people to watch a film. One person said, "This is rubbish." One staff member described the people using the service as, "Stir crazy" because they were not getting out. Staff raised concerns with us about the condition of the two mini buses owned by the home and felt they were not safe. We found one mini bus was no longer used and the second mini bus had a current MOT certificate.

We looked at complaints made about the home. People and their relatives told us they had no complaints about the service. The manager had investigated the complaints and provided an outcome to the complainant. This meant the manager took complaints seriously.

One person told us, "Staff are very good. They ask all the time if there is anything I want or need." They told us they just had to press the buzzer and staff came to them. We observed staff responding quickly when people used their call buttons.

We saw people had in place pre-admission assessments. One person confirmed staff had visited them before they were admitted and said they were asked, "Quite a lot" of questions. This meant the service had sought information about a person which enabled them to make the transition into the home

We looked at 10 people's care records and found evidence to indicate that care records had been personalised. For example we found in people's files documents entitled, "All about me" and a map of people's lives. This gave staff background information about people, their likes and dislikes. We saw on some people's bedroom walls framed histories about people. The manager explained this was a local school project where children came into the home and asked people about their histories before creating a framed memento of their life history.

Inadequate

Is the service well-led?

Our findings

At our last inspection we found the provider had breached Regulation 17 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection we found the provider had made some improvements but had continued to breach the regulation.

There was not a registered manager in post. The manager told us they waiting for their DBS to come through before applying to CQC to become registered. The manager had submitted notifications to CQC and we saw the rating for the last inspection was displayed on the website in line with registration requirements. We found the manager was supported by a regional manager employed by one of the partners of Carewell Healthcare Ltd to work in other services they provided.

The manager was unable during the inspection to provide us with all the information we requested. Following the inspection the manager contacted us to state they had found an additional three files of evidence pertinent to the inspection. We revisited the home to look at the evidence.

We found the registered provider had recently purchased a new set of policies for the home in order to bring the service up to date and in line with the CQC's five key questions. The supporting regional manager sent us the new supervision policy. The policy stated the manager was to have in place a plan for supervision meetings. The manager showed us their training matrix. We found the manager did not have a plan in place for their supervisions.

We looked at the manager's supervision and training matrices and found these were not always accurate. When we compared the training records with the supervision records we found there were staff missing from the manager's records of supervision.

We saw the home had in place a range of audits to monitor the quality of the service. For example, these included care file audits. We saw these had been delegated to nightshift staff whose role it was to go through people's files and tick if the document was present in the care files. We spoke with the nightshift staff who confirmed they had carried out the audits.

We saw the manager had in place team meetings with, for example, kitchen staff and care staff. From the minutes we found the registered manager gave directions to staff. The manager also held flash meetings with the staff on duty to give instructions to staff. For example, in January 2016 the manager had held a flash meeting with the nurses and senior carers about their working routine and when people's daily records should be completed. Over a period of five days the manager gave instructions for staff at each handover to remind each other that all food and fluid charts should be completed in full and all topical medicines charts should be completed. We found these instructions had not always been followed by staff.

We saw audits were in place to monitor cushions, mattresses and health and safety issues. We also saw there were audits in place for medicines; these audits were not dated and there were ticks in boxes which stated audits of people's topical medicines were carried out but these failed to state which person's topical

medicines had been audited.

The manager had carried out daily walkabouts in the home. We saw there was a walkabout checklist in place. The manager was required to comment on their observations such as, "The home and general areas looks clean and tidy" and "All residents appear well care for and staff are engaging positively with the residents." The responses to these questions were for the most part positive. The manager had ticked the box to say "Charts are completed correctly." We asked the manager which records they had checked; they told us they had looked at the daily food and fluid charts but were unable to state whose records they had checked. Each month the manager had in place a remedial action plan which listed actions to be taken to improve the service. We found the remedial action plans did not include the deficits we had found in the service.

We found systems and processes had not been implemented in the home to avoid people being put at risk. For example an agency staff member had not received a timely induction; nursing handover notes failed to describe accurate food and fluid requirements and staff were not aware of how to manage the fire alarm system.
We asked the manager for copies of the accident records since our last inspection. The manager gave us five accident books. Two of these books were marked "Staff" and we found they contained accident reports about people who used the service. The manager provided us with copies of the audits of accidents. We found the audits did not always accurately match the numbers of accidents which had taken place.

During our last inspection we looked at the records kept in the home. We found people's records were not stored securely, for example, we found a cupboard was open which contained people's records. During this inspection we found the same cupboard used to store people's records was open. This meant people's personal records were not stored securely.

We found records were not always up to date and accurate. These included topical medicines records, care plans and risk assessments. In one person's records we found contradictory information regarding them being at risk of choking. This meant staff did not have clear information to care for the person.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the service worked in partnership with local health professionals. Relatives told us the serviced worked in partnership with them and they were kept up to date with their family member's activities and needs. Links had also been established with a local school to look at people's life histories.

A survey of people who used the service and their relatives had been carried out. People had made positive comments about the service and had raised concerns about the activities in the home and the heating. We saw a new thermostat had been installed to better manage the heating. As there were no facilities available for visitors to make tea or coffee the manager had responded with notices in the home to say staff would be happy to make drinks for visitors.