Fishponds Care Limited

Quarry House

Inspection report

Adelaide Place
Channons Hill
Bristol
Avon
BS16 2ED

Tel: 01179654466

Date of inspection visit:
12 September 2016
13 September 2016

Date of publication:
14 November 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out a comprehensive inspection on 12 and 13 September 2016. The inspection was unannounced and was the first inspection undertaken since Quarry House opened in January 2016. Quarry House is a 65 bed home that provides accommodation for persons who require nursing and personal care. At the time of our inspection there were 59 people living in the home.

There was a registered manager in place at the time of our inspection. 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.

Staff were not always deployed where they were needed to meet the needs of people living in the care home. Care was sometimes rushed and staff told us they did not always have time to provide the care people needed.

People's medicines were not always managed safely. We found that incidents and accidents were not fully reviewed and insufficient actions were taken to minimise future risks to people.

Staff had not received sufficient training to carry out their roles effectively. Staff had not received training to ensure they could always meet people's needs and care for them in a safe way. There was inconsistency in the knowledge and understanding staff had about Deprivation of Liberty Safeguard (DoLS). Staff were not all aware of people who had authorisations in place or who had conditions attached to authorisations. This meant people rights may not be fully protected.

People and their relatives spoke positively about the staff and told us staff were kind, caring and respectful. We spoke with staff and with relatives who told us staff did not always get to know about people's individual needs and preferences because staff were often moved to work in different areas of the home.

There was a range of group activities that people could participate in and people were enjoying group activities on the days of our inspection.

Quality assurance systems were partly in place. These had identified some, but not all of the issues we identified during the inspection.

We found multiple breaches of the regulations at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff were not always deployed in sufficient numbers to meet people's needs. People who used the service, staff and relatives all told us the current staffing arrangements were an issue.

Risk assessments were completed and risk management plans were in place. These were not always updated to reflect changes needed following accidents and incidents.

Staff had been trained and recognised their role in safeguarding people from harm and abuse.

Recruitment procedures were in place and appropriate checks were completed before staff started in post.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always receive appropriate training to carry out their roles. Staff felt supported and their performance was monitored on a regular basis.

The home was not always meeting the requirements of the Deprivations of Liberty Safeguards (DoLS) authorisations.

People had access to health care professionals. However, staff did not always communicate effectively and did not always follow the recommendations, instructions and advice they had been given

Is the service caring?

Requires Improvement

The service was not always caring.

People and relatives told us staff were kind, caring and respectful and we saw people being treated with compassion and dignity. This was not consistent at all times.

People's care was sometimes rushed and staff were not always

able to spend quality time with people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care monitoring charts were not always fully completed.

Care plans were not always person centred and did not always reflect people's changing and current needs.

A complaints procedure was in place and this was easily accessible.

Is the service well-led?

Requires Improvement

The service was not always well- led.

Systems were in place for monitoring quality and safety. These were not always followed and actions were not taken consistently when improvements were needed.

People and staff spoke positively about the registered manager. The provider had arranged, prior to the inspection, for regional staff to provide additional support and guidance to the home.

The registered manager was aware of their responsibilities with regard to notifications and information they were required to send to the Commission.

Quarry House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook a comprehensive inspection of Quarry House on 12 and 13 September 2016. This involved inspecting the service against all five of the questions we ask about services: is the service safe, effective, caring, responsive and well-led.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by two inspectors on each day.

Before carrying out the inspection we reviewed the information we held about the care home. We had received concerns from relatives about the quality and safety of the service provided. We also looked at the notifications we had received. Notifications are information about important events which the provider is required to tell us about by law.

During our inspection we spoke with 12 people who lived at the home and five visitors. Some people were not able to fully express their views about the care they received. We observed the way staff interacted and engaged with people. We spoke with the registered manager, a representative of the provider, a senior manager, two visiting health professionals and 13 staff that included registered nurses, care staff, activity and catering staff. We observed how equipment, such as pressure relieving equipment and hoists, were being used in the home.

We looked at 12 people's care records. We looked at medicine records, staff recruitment files, staff training and competency records, audits and action plans, and other records relating to the monitoring and management of the care home. Following the inspection, the registered manager sent us further information that we had requested.

Requires Improvement

Is the service safe?

Our findings

People were not always protected against the risks associated with medicines. During our inspection, we identified shortfalls with regard to obtaining, storing, administering and recording of medicines. We brought our concerns to the attention of the registered nurses or the registered manager during the inspection.

Senior staff or registered nurses checked and recorded medicines received into the home on people's individual Medicine Administration Records charts (MARs). We found occasions where the amounts of medicines received had not been recorded. Quantities of medicines left over from previous months were not recorded. This meant people's medicines could not always be accurately accounted for.

We received a concern prior to the inspection from a relative that a person's pain relieving medicine was not available when it was needed and they had been told it was out of stock. During the inspection, we found medicines were not always available when needed. For example, one person was prescribed a time critical medicine to be given half an hour before breakfast. The registered nurse prepared to give this person all of their morning medicines at 10am, after the person had breakfast. The time critical medicine had not been administered the previous day, and the registered nurse could not find it on the first day of our visit. They told us, "We don't have any." We spoke with the visiting GP later in the day after they had completed their visit. The staff had not reported to the GP that the person had not received this medicine for two days. The staff had not taken any action and had not requested a repeat prescription from the GP.

One medicine that required additional security had not been signed for to confirm it had been given, in the recording book. This was not in accordance with best practice that requires two staff to sign for the giving of this type of medicine. The omission had occurred on 4 September 2016 but it had not been noted or reported. We brought this to the attention of the registered nurse at the time. The provider's medicine policy was not up to date and referred to out of date legislation. The policy did not give clear guidance about the giving of medicines that required additional security.

Medicines were not always dated when they were opened. For example, a bottle of pain relieving medicine was being used for one person. The date had not been recorded when the bottle was first opened. This meant medicines may be given when they were no longer effective.

The storing, recording and administering of non- medicated creams was inconsistent. For example, one person had four different topical creams in their rooms. One of the creams was currently prescribed. They had all been opened. The date of opening was not recorded. This meant creams may have been used when they were no longer prescribed and when they were no longer safe or effective.

Where people were prescribed pain relief medicine, to be taken when it was needed, we heard people being asked if they needed it. People's preferences about how they liked to take their medicines was recorded. For example, for one person their records stated, "Likes to take his medicines from a spoon with water."

The administration of the creams was recorded on the MARs, or on charts kept in people's rooms, and at

other times they were not recorded at all. A registered nurse told us they signed the MARs on behalf of the care staff who applied the creams. The provider's medication management policy did not provide clear guidance for staff with regard to the management of topical creams.

Individual risk assessments were completed. They identified risks to people and gave guidance to staff on how to support people safely. Assessments included risks such as eating and drinking, use of equipment such as bed side rails, communication, bathing and falls. The risk assessments were reviewed monthly. However, they were not always updated after an incident or accident had occurred that resulted in a change to the person's level of risk.

Accidents and incidents were reported and recorded on the electronic care planning system and paper copies given to the management team. The reports were not always fully completed or reviewed to identify trends or patterns with regard to the incidents and accidents reported. Over a three month period there were a total of 76 incidents reports. These included 52 falls, 27 of which resulted in people sustaining injuries. Individual risk assessments were not always updated after an incident or accident to reflect changes to the care people needed as a result of an injury. This meant people may not always receive the care and the treatment they needed.

The above were breaches of regulation 12 (1) (2) (a) (b) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The shortfalls in medicines management and incident and accident management had been recognised in part by the provider and an action plan had been agreed the week before our inspection. A further updated action plan was sent to us the day after the inspection.

People we spoke with who were able to express their views told us they felt safe. Comments included, "I feel safe. It has helped me get stronger again being here" and "I feel safe at night." However, we also received comments such as the following from one person, "Not so many staff as there were. Staff all seem different at the moment, don't see the same people."

We observed people were not consistently safe because staff were not always available to meet people's needs when they needed care and support. On several occasions people's calls for help were unanswered until we found staff on their behalf and asked that they provide the care and support people were asking for.

On the first day of our visit staff told us they did not have enough staff in all areas of the home to meet peoples' needs. Each floor of the home was divided into two separate areas, so there were eight separate areas over four floors within the home. Staff were not available to provide the care and support people were asking for in all areas of the home. On the first day of our visit, one person called repeatedly by the locked door leading to the staircase. We spoke with them for 10 minutes. We also heard another person in this area calling repeatedly from their bedroom. We went to the other area of the same floor and found the two care staff busy addressing the needs of people in that area.

There were four registered nurse vacancies. The provider assessed that two registered nurses were needed for each shift. The current situation was that most shifts had one registered nurse on duty. The shortages were being covered mainly by care staff, and sometimes by agency staff. The posts had been filled, but the staff had not yet started in post. In addition there was a Deputy Manager vacancy. There was an evident lack of clinical oversight on each floor of the home. For example, one registered nurse commented, "Often I am the only nurse on duty and when I'm asked to look at look at people's skin or do their dressings it's impossible." This current shortage of registered nurses meant that when people had care needs that needed

to be addressed by a registered nurse, they may not always receive the care when it was needed.

Throughout the inspection, staff told us the staffing was insufficient. Staff told us they found the job stressful. We heard comments between staff such as, "It's too busy" and "It's not fair it's three o'clock and she [member of staff] hasn't been able to take her lunch break." One member of staff told us, "The numbers [of staff] might look ok, but we have a resident here [in one area of the home] who almost needs one to one care because he falls a lot and someone has to stay with him." Staff also told us they were often allocated to work in different areas of the home. They told us this meant they were not always familiar with people's needs." A relative had noted this and commented, "It is difficult for staff as they are making relationships with people and then get moved" and "Amazed that they [the management] can't recognise the harm they do to people by moving staff around." On the second day of our visit the atmosphere in the home was calmer and people were attended to in a more timely manner. However, we still found there was inconsistency in staff responses to people's needs throughout the home and at different times of the day.

The failure to deploy sufficient numbers of staff to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager contacted us after the inspection and told us they were reviewing the allocation and deployment of staff to make sure people received the care and support they needed.

Staff had a good understanding of their responsibilities with regard to safeguarding people from avoidable harm and abuse. They had received training. They were able to describe how they would recognise abuse, and how they would act on any concerns. Staff told us how they would report concerns immediately to senior staff or to the manager. They told us they also had access to the local authority safeguarding team contact details.

Safe recruitment processes were completed. Staff had completed an application form prior to their employment and provided information about their employment history. Previous employment or character references had been obtained by the service together with proof of the person's identity for an enhanced Disclosure and Barring Service (DBS) check to be completed. The DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified. Where required, the service had ensured that staff were appropriately registered with the correct bodies, for example the Nursing and Midwifery Council.

The environment and equipment was maintained to ensure it was safe. We reviewed the maintenance log and equipment commissioning certificates for the home. Documentation showed the electrical installation at the service was certified. The provider had dedicated maintenance staff that monitored all aspects of the environment and the equipment within the service. For example, there were systems to ensure that water temperatures were safe and legionella checks were completed. Lift maintenance had been completed and when required repairs had been undertaken.

Systems were in place to ensure that fire safety was adhered to. There was a fire risk assessment in place and records showed that regular tests of the fire alarm were completed. In addition to this, the emergency lighting was tested periodically and maintenance completed on fire-fighting equipment such as extinguishers. At the entrance of the home there was an overview of each floor, showing what level of assistance each person individually required to support them during an evacuation. People also had personal emergency evacuation plans (PEEPS) recorded in their care plans.

Requires Improvement

Is the service effective?

Our findings

The registered manager sent us training records after the inspection. They showed that 68 nursing and care staff were employed at the care home. Of these staff, the records indicated that 11 staff had not completed the provider's induction programme and they had not completed fire training. We asked the registered manager to clarify the accuracy of the training records and received two further updates after the inspection. The training matrix's we received did not provide clear detail about the specific training provided to staff when they started in post. We were told that a new induction programme had been introduced in August 2016. The induction training staff received before this date was not clear.

The training records showed the refresher and update training completed by staff. They showed that some staff had not received this training when it was due. This did not demonstrate the provider had ensured staff had received training in key areas of their roles. This meant people were at risk of being cared for by staff that were not suitably trained to provide the care and support they needed.

We spoke with the registered manager about staff training in dementia awareness. The registered manager told us that staff currently received training online. Staff also received online training for caring for people whose behaviour may be challenging. This was not sufficient and staff told us they were not confident they had the knowledge to provide the most effective care for people who displayed behaviours that may be considered challenging or aggressive. This placed people living in the home and staff at risk of harm and injury. We spoke with a member of staff who spoke positively about the support they received from the dementia wellbeing service. However, the provider's training was insufficient to support staff to meet the needs of some of the people they were providing care for. The incident records for the week before our inspection included two occasions where people had displayed challenging behaviours. One incident had resulted in a member of staff sustaining a minor injury.

Care staff in designated team leader roles administered medicines within the home. One team leader told us they had administered medicines in a previous role and they had not received medicine management training since they had worked at Quarry House. They told us the registered manager had observed their practice and then confirmed to them they were competent. However the detailed staff competency assessment record had not been completed. This meant people were at risk of not receiving their medicines in a safe way because staff training and competency assessments had not been fully completed.

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

Where staff had completed an induction we received positive comments. One member of staff told us, "The induction was really good. I had on line training then I shadowed other staff for two weeks." Another member of staff was new in post and told us, "The training I've had so far has been really good." The registered manager told us the induction programme included moving and handling, food hygiene, fire safety, health and safety, Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) infection control and safeguarding.

The Care Certificate which was introduced in April 2015 is a training process designed to ensure staff are suitably trained to provide a high standard of care and support. The registered manager told us that the service would be commencing the Care Certificate shortly, and we saw the documentation and plan in place to confirm this.

Staff received individual performance and group supervision. The registered manager told us that they aimed for staff to receive supervision approximately every two months. We saw that individual reflective supervisions were completed if the need was identified due to a concern being identified with a specific staff member. Group supervision held for registered nursing staff showed matters such as staff allocation and supervision were discussed, together with other staffing matters and accident and incident reporting. We reviewed individual care staff supervision records that showed training needs, record completion, the duty rota and staffing were discussed. Staff we spoke with told us they felt supported and told us they received supervision on a regular basis.

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.

In the records we looked at, consent had been obtained and consent forms were signed for the taking of photographs, use of door sensors and use of bed side rails. In the same care plans there was no confirmation of the care and treatment people had consented to. Where people were noted as not being able to communicate their needs and wishes verbally, the records did not confirm how consent to care was obtained. The staff we spoke with told us they were aware that people needed to agree to care. Staff described how they asked people before they provided care. A member of staff described how one person communicated their consent with gestures. This was not recorded in the person's care plan.

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 procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager had not fully met their responsibilities with regards to the Deprivation of Liberty Safeguards (DoLS). Applications for people living at the home had been made and were awaiting assessment by the local authority. Six people at the home had a current authorised DoLS. The registered manager understood the requirement to notify the Commission when a DoLS was authorised.

DoLS applications had been made for four people living in the home who were subsequently assessed as having capacity to consent to their care and treatment. For example, it was noted that one person asked to go home. An application made had been rejected because the person had capacity. The registered manager told us they were seeking further guidance and direction from the DoLS team.

We found inconsistencies with regard to compliance with the conditions attached to people's DoLS. We spoke with a member of staff who told us about the conditions attached to one person's DoLS. They told us they were supporting the person to go outside the home each week. We spoke with other staff who did not have an understanding of what DoLS meant or who had DoLS in place in the area of the home they were currently working in. Therefore, the compliance with DoLS and attached conditions was inconsistent.

The above was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to eat and drink. One person told us, "The food's really nice. If I don't like it I'll have something else." Another person commented, "This is tasty" as they were eating their breakfast.

The catering team were informed of people's specific dietary needs. These were recorded in the main kitchen. We observed meals served to people in their rooms and in the communal areas. Staff offered people choices of drinks and provided support and encouragement to people. The support staff provided varied. Whilst we saw positive interactions with people, for example, one person was asked, "Can I get you to try this. If you don't like it I'll get something else." On other occasions the support appeared rushed. For example, we saw a member of staff assisting two people to eat at the same time. One person was supported to eat their main meal. However, when they were given their dessert, we observed they managed to eat this independently. This meant people's independence was not always encouraged.

People's weights were recorded and a graph was produced that calculated if the person had recorded a significant weight loss or gain. There was also a nationally recognised tool used to calculate people's risk of malnutrition or obesity. When a person had been identified as having a significant weight loss or gain, additional actions were recorded if required. For example, if a person had suffered a weight loss, an alert was created in the electronic records that the staff needed to monitor and record the person's food and fluid intake for a specified period of time. There was also an increase in the frequency of recording of the person's weight. We saw that people had been referred to the GP when there were concerns about people's fluid and dietary intake and when they had lost weight, and food supplements had been prescribed.

A senior member of staff told us they received support and guidance from the multi-disciplinary team. A GP visited the home each week and provided support, direction, advice and guidance to the staff team. We spoke with a health professional who told us they had concerns about communication in the home. They told us that instructions and guidance were not always being followed. This meant people may not always receive the health care support or treatment they needed at the time they needed it.

We saw from the care records where advice and guidance had been provided by other health professionals. For example, from the tissue viability nurse for a person with a pressure ulcer and from the community dementia wellbeing team, for a person with behavioural challenges.

The environment had been well planned and designed throughout. All of the bedrooms were large and tastefully decorated and furnished with wheelchair accessible en-suite shower and toilet facilities. There were wide corridors throughout the home. There were seven lounges and satellite kitchen areas that provided a range of communal living space and easily accessible areas for preparing refreshments when people and visitors wanted them.

Requires Improvement

Is the service caring?

Our findings

We observed that staff were not always available to provide support and maintain people's dignity when it was needed. For example, staff were not available to adjust a person's clothing and their legs were fully exposed. The person who was sitting in a wheelchair in a communal area was trying, unsuccessfully, to pull their dress down over their legs. We called for staff on behalf of the person.

We heard staff talking between themselves about their workload and how demanding their jobs were, on a number of occasions during the inspection. We were able to hear their discussions which took place in communal areas of the home. This meant people who lived in the home may also have heard this communication between staff.

We observed a member of staff being disrespectful to one person. They repeatedly asked the person to stand up. Another person commented, "This is slavery" and the staff member replied quite curtly, "No it isn't I'm asking them to stand."

People and relatives told us that staff were kind and caring and most of our observations confirmed this. Comments included, "Staff are nice. No problems there" "The carers are great with people" "The carers really do care" "The staff are always kind. If I cry which I do often, they do try and comfort me" and "The team leader is wonderful." One relative also commented, "My only worry is if social services decide Mum can't stay here and has to be moved. We're really pleased [with the care] and the carers are really kind."

We watched interactions with staff and people looked relaxed and comfortable in their presence. Staff were attentive and sensitive to people's individual needs. One member of staff bent down to the level of the person so they could speak with them. The member of staff quietly repeated the question as the person had not heard the first time. The member of staff took time to make sure they clearly understood what the person was trying to communicate back to them.

When people got up in the morning before breakfast, staff offered hot drinks. The staff checked people were comfortable and warm enough. They told us the people who were up early and in the communal areas had chosen to get up. One member of staff told us, "It's their [the person's] choice." We spoke with people who confirmed they had chosen to get up. We heard one person being asked, "Would you like another cup of tea. It's really no trouble." One person came out of their bedroom in their night clothes and asked a member of staff, "Should I get up yet?" The member of staff responded kindly, "It's entirely up to you."

Staff told us how they demonstrated a caring approach to people. They told us about the importance of getting to know people. Staff were able to describe how they made sure people's privacy and dignity were maintained. For example, one member of staff commented, "It's things like making sure others don't come in [to the room] when we're helping people to get up."

People were given important information about the home. For example, on arrival people were given a 'Resident Handbook' that contained key information about the home and the management structure. There

was information on fire procedures, the catering facilities, the care standards people should expect and how to make a complaint. In addition to this, people were provided with telephone numbers for a range of organisations, including the Commission, Care Direct and the local safeguarding teams. This ensured that key information was communicated to people that allowed them to understand more about the care home they were in and contacts they could make with the home or with external agencies, if needed.

The home had received a card from relatives, complimenting the care provided to a person. The card read, 'Words cannot express the gratitude we have for you all, the care, love and support you showed us and [person's name] in her final weeks surpassed all of our expectations. You truly are an exceptional team.'

Requires Improvement

Is the service responsive?

Our findings

During the inspection, we found people were at risk of not receiving the care and treatment they needed and preferred because care records were not always accurately maintained. We found examples of recording inaccuracies that meant we were unable to establish if care had been provided in accordance with people's assessed needs. For example, one person with a pressure ulcer used a pressure relieving mattress. The mattress setting needed adjusting according to the person's weight. There were no details recorded about the setting required for this mattress. It was set for a person with a weight of 60kgs. When the person was last weighed, in August 2016, they were 77.9kgs. This meant the person may not be receiving the level of pressure relieving protection they needed. We were unable to determine how long the setting had been incorrect because there were no checking systems in place.

One person had undergone a clinical procedure whilst they were living in the care home. The records did not provide sufficient details of the procedure undertaken or details about the equipment used. Staff did not report clinical signs and symptoms that indicated further intervention was needed. A representative for the provider responded to concerns raised by a family member and instructed the registered nurse on duty about the clinical actions that were needed.

Where peoples' assessments stated they needed specific care tasks to be monitored we found records were not always fully completed to confirm that people had received the care and treatment they needed. For example, one person's care plan stated they needed to have their blood sugar checked each month. It had not been recorded as completed since July 2016. Another person needed specific care for their contracted hand. The records were not completed on 7, 8 or 9 September 2016. Another person, assessed as at risk of developing pressure ulcers, had a monitoring system in place called a SSKIN bundle. This was not completed for 11 September 2016 which meant the person may not have received the care they needed.

A document called 'This is me' and a section in the care plan called 'Life history' was not completed for everyone in the home. Where they had been completed the information provided detailed information about the person's previous life and lifestyle, their likes, dislikes and preferences. Staff told us how this information helped them to build relationships with people who may not be able to communicate or recall their past experiences.

Care records did not always provide evidence that people and their relatives had been fully consulted and involved in their care planning. People's individual needs, wishes and preferences for care and support were not always recorded. For example, one person's care records stated, "Doesn't like the hoist or sling… becomes distressed…. needs reassurance." The person did not have a completed life history. There was no further documentation about why the person became distressed. There was no documentation to explain how the person was reassured or if the reassurance had been successful.

The above were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A comprehensive activity programme was in place, and the weekly programme confirmed a wide variety of activities were offered to people. On the days of our inspection, we saw musical and art and craft sessions. The people that participated obviously enjoyed these activities. We saw active participation and people humming along to music played by a visiting harpist.

The occupational therapist employed by the home considered people's individual abilities when planning the activity programme. This was to make sure they provided activities that were therapeutic, meaningful and entertaining for people.

In one person's care records, where an application for a DOLs had been made but had not been authorised, their assessment highlighted a lack of stimulation. There was detail about how the person could be supported to access the garden. The records showed that gardening activities had taken place and the person had attended.

Requires Improvement

Is the service well-led?

Our findings

We spoke with the registered manager about quality assurance systems in place to check the quality of the service provided and to help ensure risks to people's health safety and welfare were monitored. We established there were some auditing and quality monitoring systems in place. However, these were not robust and the audits did not have the detail or depth to identify the shortfalls we identified during the inspection. The registered manager told us they completed daily checks within the home. This check involved making observations to check the environment and speaking with people about their care provision. They told us this sometimes happened more than once a day, however these daily observations were not being recorded.

There were systems that monitored care documentation. This was completed within seven days of a person's admission to the home. An admissions audit was completed by the registered manager. This reviewed that necessary records were in place and contained the required, accurate information. In addition to this it ensured all documentation corresponded to relevant care plans within the person's care records and that all of the records had been signed by the relevant people. The audit had resulted in areas for improvement, for example additional records being required and further information being needed.

The registered manager told us they continued to monitor the updating of care plans on a monthly basis, using the home's computerised system. However, the monitoring system had not identified some of the shortfalls we found and noted earlier in the report.

For example, the audits had not identified where people had no 'Life history' or 'This is me' documents completed. The audits had not identified the shortfalls we identified in care planning and monitoring records as previously noted in this report.

Some of the provider's auditing systems were not consistently used. For example, there was a 'Weekly Nurses and Team Leader Report' document available for the staff to use. This recorded recent admissions to the service, any discharges, accidents or complaints. It recorded who was at high risk of falls, malnutrition, dehydration and pressure sores. If effectively used, this document would give an overview of the highlighted areas and act as an early identification tool to establish if people were suffering a decline in health. However, during our inspection only two records were produced for Chester and Mayfield units dated for the period of 27 July 2016 to 31 July 2016. This showed this audit had not been consistently used to allow it to be effective.

The provider required the registered manager to compete a monthly audit of medicines. The audit showed that people's records should be reviewed, together with a general audit of the medicines such as checking the ordering, storage, administration and disposal. Although we found evidence these audits had been completed, they were not always effective. For example, as reported within the 'Safe' section of this report, we found shortfalls in the management of medicines. These would have been identified had the medicines audit been effective.

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

We received mixed feedback from people and relatives about the quality of the service. Before our inspection, we had received concerns about the quality and safety of the care and service provided for people. A representative of the provider, senior managers and the registered manager held a meeting the week before we inspected. They identified shortfalls in the quality and safety of the service they were providing for people. They had devised an action plan that had identified some, but not all of the issues we identified during our inspection.

A further action plan was sent to us within two days of our inspection. We also received confirmation of the additional support the home was receiving to address the issues we had identified and which we fedback to the representative of the provider, a senior manager and the registered manager at the end of our inspection.

Messages were communicated to staff through meetings. Different levels of meeting were held at the home. For example, we saw minutes relating to meetings held with registered nurses and senior care staff, and other meetings were held with care staff. The registered manager told us they aimed to have a meeting each month. We reviewed the meeting minutes for the meetings involving care staff which showed matters such as policy acknowledgement, staff handovers, record keeping, admissions, laundry procedures and staffing had been discussed. Registered nurse meeting minutes showed that staffing, clinical needs, schedules and handover requirements were discussed. In addition to this, the registered manager communicated matters they expected to be passed to them, for example concerns raised by people or their relatives.

People and their relatives had been given the opportunity to complete a satisfaction survey. The most recent survey had been given to people in July 2016. The survey asked that people comment on the care and services they received, including the environment in which they were cared for. Feedback was also sought in relation to the facilities, if people felt their privacy and dignity was respected and if they felt the service communicate well. People's views on staff attitude and care provision were also sought. The registered manager showed us the completed surveys, however the results had not yet been calculated. The registered manager said that following a review of the results, an action plan would be completed for any identified areas of improvement.

A survey for staff to complete to seek their views on their employment had been created by the registered manager. The survey requested staff to give their views on their employment, including their job role and responsibilities, the communication and teamwork, their working environment and the management of the service. The registered manager told us the survey would be given to staff in the future.

There was a business continuity plan produced by the provider that set out the procedures and strategies to be followed in the event of an incident that caused disruption to normal working. If this incident affected the ability of the care home to give care provision as usual and maintain adequate safety and well-being of people and staff, the plan had guidance on the action that should be undertaken. These could be events such as disruption to gas, water or electric provision or failure of equipment within the service.

The registered manager told us they were well supported by the provider. The registered manager also told us they received sufficient financial support from the provider and where required funding was available for equipment to meet the needs of people at the home. They told us they had regular meetings with the provider and discussed issues such as general business matters, staffing issues and complaints. In addition to this, the home received a periodic quality assurance visit from a senior manager. During these visits,

people and their relatives were spoken with together with staff and observations were completed. A visual inspection of the home was completed together with a review of some records. A review of safeguarding incidents was completed. Information about staffing, including vacancies were discussed and recorded. Areas identified for improvement during these visits were recorded. The most recent visit, completed in July 2016, identified shortfalls. However, actions had not been taken to address all of the issues identified.

The registered manager told us how they kept up to date with best practice in the nursing and care sector. They told us they were a member of a local care forum. They told us they attended meetings provided by the organisation which focussed on best practice. Quarterly meetings were held with the provider's other managers to share experiences and ideas. The registered manager received regular newsletters and information from the Royal College of Nursing (RCN) in relation to current best practice. The registered manager also attended the annual care roadshow.

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 Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way. Risks to people were not sufficiently assessed. Insufficient actions were taken to mitigate risks. People's medicines were not safely managed. Regulation 12 (1) (2) (a) (b) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always lawfully deprived of their liberty because staff did not understand the requirement of DoLS. Regulation 13 (5).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not being followed to assess, monitor and mitigate the risks to people. Systems were not being followed to assess, monitor and improve the quality of the service provided. Accurate records were not always maintained. Regulation 17 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing was insufficiently deployed and did not always meet people's care and treatment needs. Staff did not receive sufficient training to enable them to provide the care people needed. Regulation 18 (1) (2) (a).