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Highdell Nursing 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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

Highdell Nursing Home provides personal and nursing care for up to 22 people living with dementia and long term mental health care needs. The home is situated in the village of Idle on the outskirts of Bradford. The accommodation is provided in single rooms, some with ensuite facilities.

This was an unannounced inspection which took place on 30 September 2015. On the date of the inspection there were 17 people living in the home.

A registered manager was in place. 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.

The registered manager was not in day to day charge of the service. In the registered manager's absence, an acting manager had been employed however they were not given adequate time allocated to the running of the service. We found the lack of management support had a significant impact on the quality of the service.

Summary of findings

At the previous inspections in August 2014 and March 2015 we found a number of breaches of regulation. We found most of the issues we raised at these inspections had not been adequately addressed. These risks should have been addressed through strong leadership and management of the service. There was a lack of auditing systems in place to ensure robust documentation was maintained, medication safely administered and to ensure recruitment and training was done correctly. The acting manager told us they had not the time to ensure quality checks were undertaken in these areas. Following the inspection, the registered manager confirmed they had increased the acting managers management hours to help address these issues.

People and their relatives all spoke positively about the home. They said the care was good and staff were kind and friendly. Relatives commented how an established staff team provided care which meant they were all familiar with their relatives and their individual needs.

Medicines were not managed safely. We saw the nurse who was also the acting manager was constantly interrupted during the medication round to attend to other tasks. This increased the risk mistakes would be made. Medicines were not always given as prescribed and all medicines could not be robustly accounted for. Covert medicines were not given in line with existing legal frameworks meaning people's rights were not protected.

There was a lack of documentation available to demonstrate that staff had been recruited safely and that the required checks on their character and background had been undertaken.

Although some risks to people's health and safety were well managed this was not universally so. For example we found adequate preventative measures had not been put in place to control risks associated with poor nutrition and skin integrity. People were missing assessments detailing how they would be safely handled or evacuated in the event of a fire.

People and their relatives told us people were safe and said they had no concern over the conduct of staff that worked in the home. However following a previous safeguarding incident, we found an appropriate protection plan had not been put in place to protect people from the risk of harm.

Overall, we found the premises to be safely managed. However a programme of maintenance was required to address shabby and tired décor. Work was needed to ensure the home's environment was suited to people living with dementia.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The service had not managed DoLS appropriately, as they had let one authorisation expire and were not meeting the conditions on another. This meant legislation designed to protect people's rights was not being adhered to.

People and their relatives spoke positively about the food at the home. However appropriate plans of care were not always in place to support people to maintain good nutrition.

Staff had not been provided with timely training and were overdue training updates in a number of areas. The acting manager had recognised this and was in the process of addressing through the provision of additional training sections.

We saw some good interactions between staff and people that used the service with staff demonstrating a kind and caring approach. However, we found mealtimes were chaotic with people not receiving timely care and support.

The home utilised an electronic care record system. However we found it was poorly completed with many care plans and risk assessments incomplete or missing key information. Care plans were also not accessible for staff which meant there was a risk staff would not be aware of people's agreed plan of care. This was of particular risk when agency were on duty.

A detailed daily handover took place between staff to help ensure staff were aware of any changes in people's needs.

Complaints were appropriately managed by the home and people and their relatives told us they were satisfied with the service and had no need to complain.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of this report.

Summary of findings

The overall rating for this service is ‘Inadequate’ and the service is therefore in 'Special measures'. The service 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 expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe."

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not managed safely and people did not always receive their medicines in line with the prescribers' instructions.

Risks to people's health and safety, such as skin integrity or safe handling were not always effectively assessed and/or managed.

There was a lack of staff deployed for the safe management of the service. We also found insufficient staff at mealtimes which led to delays in people receiving care and support.

Is the service effective?

Inadequate

The service was not effective.

Staff at the home were not acting with the legal framework of the Mental Capacity Act (MCA) 2005. Where decisions needed to be made, people's capacity was not assessed and a best interest process followed.

People told us they liked the food provided by the home. However people's appropriate nutritional care plans were not always in place and people's dietary intake was not properly monitored

Staff had not been provided with timely training updates to maintain their skills and knowledge.

Is the service caring?

Requires improvement

The service was not always caring.

Staff demonstrated a kind and caring attitude towards the people they were caring for.

However the mealtime experience required improvement, with people not being responded to within appropriate timescales.

Is the service responsive?

Requires improvement

The service was not always responsive.

An electronic care recording system was in place however it lacked complete and personalised information on people's care needs. Care records were not readily available to staff increasing the risk that plans of care were not followed.

A detailed daily handover was in place to help keep staff informed about changes to people's needs.

People and their relatives told us they were satisfied with the service. We found complaints were appropriately managed.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

The provider had not acted on feedback from previous inspections to improve the quality of the service as we found many of the issues we had previously raised were still outstanding. This demonstrated poor leadership and management.

There was a lack of checks and audits in place to monitor and improve the quality of the service.

Highdell Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. We also checked whether the provider had made improvements following regulatory breaches identified at the August 2014 and March 2015 inspections.

The inspection took place on 30 September 2015 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case experiences of services for older people.

We used a number of different methods to help us understand the experiences of people who used the service. We observed care and support in the lounge and communal areas of the home. We spoke with three people who used the service, five relatives, three care workers, the cook, the registered manager and the acting manager. We looked at a number of people's care records and other records which related to the management of the service such as training records and policies and procedures.

On this occasion, we did not asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However we reviewed all information we held about the provider.

Before the inspection with spoke with the local authority to get their views on the service .

Inadequate

Is the service safe?

Our findings

We examined the provider's medication management arrangements. Medicines were administered to people by registered nurses. No person at the home had been found to have the capacity to self-medicate.

Our observations of medicine administration demonstrated dysfunctional arrangements existed which placed people at risk. The registered nurse on duty was also the acting manager. During the medication round, we observed them being interrupted to attend to people coming to the home, answering the telephone and attending to staff questions. This increased the risk of medication errors.

We looked at medication charts and reviewed records for the receipt, administration and disposal of medicines. We conducted a random sample audit of medicines to check their quantity. We found medication administration records (MAR) were not complete and in some instances demonstrated medicines had not been administered according to the prescribers wishes.

We saw three people had been prescribed medicines for pain relief. The prescriber had asked for the medicines to be administered four times a day yet we found nurses were treating these medicines on an 'as necessary' PRN basis and were not routinely offering them to people. We asked the nurse why this was so; their answer confirmed the medicines were not being administered correctly. This meant people were not being offered their routine pain relief , and as such they could have been experienced pain or discomfort.

We were told one person was receiving their medicines covertly. Medicines may only be administered to people in care homes without their knowledge (covertly) within current legal and good practice frameworks designed to protect the person who is receiving the medicine and staff involved in the administration. The home had in place a medicines policy but this did not include guidance on covert medication. We spoke with the manager and acting manager to ask for evidence of best interest meetings, GP, pharmacist and family involvement, a management plan and review documentation. We were told by them that this correct process had not been followed. Our observations and discussions demonstrated medicines were being administered covertly but not in accordance with the Mental Capacity Act 2005.

We conducted a random sample audit to check the stock balances of four medicines dispensed in named boxes. We found discrepancies in all four of the boxes. This meant that we were unable to account for all medicines and therefore could not confirm whether people had received their medications as prescribed.

Some prescription medicines contained drugs that are controlled under the misuse of drugs legislation. These medicines are called controlled medicines. We inspected the controlled medicines register and found all medicines were accurately recorded. However one person had recently been admitted to the home with two controlled medicines. Neither of these medicines had been recorded on the person's MAR sheet, therefore their prescribed medicines was not obvious to nurses administering medicines. The records showed this person had not been offered any of these medicines since admission.

We found the date of opening had not been recorded on bottles of medicines and creams. This meant that there was no record of when the medication would no longer be useable.

When medicines were prescribed to be given as needed there were no care plans, (PRN protocols) in place to give guidance on the frequency or circumstances when these medicines should be administered. This meant there was a risk people would not be consistently offered their medicines when they needed them.

We inspected medication storage and administration procedures in the home. We found medicine trolleys and storage cupboards were secure, clean and well organised. We saw the drug refrigerator and controlled drugs cupboard provided appropriate storage for the amount and type of items in use. Our observations of records showed drug refrigerator and store room temperatures were not recorded. The acting manager told us they had asked for a room thermometer to be provided but this had not been forthcoming.

This was a breach of the Regulation 12 (2g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

When we looked at the staff recruitment files we found documentation required to demonstrate staff were of suitable character to care for vulnerable people was not consistently present. There was some evidence appropriate checks were undertaken before staff commenced employment, but this was not universally so. Care worker personnel records included proof of identity, including photographic identification, proof of residence and where necessary proof of eligibility to work in the United Kingdom. However we found in four care workers files there was no evidence that a criminal records check had been undertaken. We saw care workers had completed application forms but commonly some required fields had not been completed. For instance one application form did not record educational or past employment history. The application form did not record the reference details; these were recorded on a roughly torn piece of paper loosely held in the file. In one file we saw the declaration regarding the Rehabilitation of Offenders Act 1974 was left blank by the applicant. Subsequent DBS checks revealed a past criminal offence. Whilst the offence did not prevent employment there was no risk assessment in place detailing that this had been considered in the recruitment process. This demonstrated the provider was not taking appropriate steps in recruitment to ensure people employed were of sufficiently good character.

This was a breach of the Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us people were safe in the home. They said they felt comfortable in the company of staff and didn't raise any concerns over their practice. They said care was delivered by an experienced staff team who they knew well and had confidence in. One person told us, "This is the safest home my husband has been in." We found some risks to people's health and safety were well managed. For example, assistive technology was used to help prevent the risk of falls and following falls one person had been moved to a ground floor room to reduce the risk of further falls. Risks associated with diabetes were well managed, for example care staff and the cook were aware of how to ensure one person had a low sugar diet without missing out on desserts.

However, we found other risks to people's health and safety were not well managed. For example we found eight people were lacking manual handing risk assessments demonstrating the risks associated with mobilising had not been adequately assessed. All people in the home were lacking a personal evacuation plan to assist staff to evacuate them safely in the event of an emergency and the manager was unable to describe how they would evacuate a bed bound person in the event of a fire. In addition two people who had recently lost weight did not have an up-to-date nutritional risk assessment and an appropriate plan of care in place. There were no risk assessments in place demonstrating the process for installing bed rails in two people's rooms or for assessing the risks associated with this equipment. We raised these issues with the acting manager during the inspection and they subsequently sent us an action plan informing us of the action they would take to address these deficiencies in risk management.

This was a breach of the Regulation 12 (2a&b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with two care workers who demonstrated a good understanding of protecting vulnerable adults. They told us they were aware of how to detect signs of abuse and were aware of external agencies they could contact. They told us they knew how to contact the local safeguarding authority and the Care Quality Commission (CQC) if they had any concerns. They also told us they were aware of the whistle blowing policy and felt able to raise any concerns with the acting manager knowing that they would be taken seriously. However we were concerned about how a safeguarding risk relating to care practices in 2013 had been managed by the service. We concluded appropriate procedures had not been followed to ensure people were protected from harm. Although the provider had put in place a risk assessment detailing how they were managing the risk, we found it to be not wholly appropriate. In addition, the provider was not fully adhering to the control measures within the risk assessment such as close monitoring of the staff involved and ensuring all had received safeguarding training.

This was a breach of the Regulation 13 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoke positively about their bedrooms, for example one person said "I have a nice room, I have photos of my grandchildren." We completed a tour of the premises and inspected six people's bedrooms, toilets, bathrooms, the laundry and various communal living spaces. All hot water

Is the service safe?

taps were protected by thermostatic mixer valves to protect people from the risks associated with very hot water. Heating to the home was provided by cool surface or covered radiators thus protecting vulnerable people from the risk of a burn from a hot surface. We saw fire-fighting equipment was available and emergency lighting was in place. We saw fire escapes were unobstructed. We saw upstairs windows had opening restrictors in place to comply with the Health and Safety Executive guidance in relation to falls from windows. We found all floor coverings were well fitted and as such did not pose a trip hazard. Communal areas were sited downstairs and included two small lounges and a dining room. These rooms were quite small for example the dining room could fit no more than 10 people in it, therefore limiting the number of people that could eat in the dining room. The décor within the building was tired and dated and in need of investment. We found a couple of areas where maintenance was needed to address risks. In the lounge the window was propped open with a ceramic vase as it would not stay open on its own and two lights were out of their fittings in the dining room, one of the fitting had a jagged sharp edge.

People and their relatives had mixed views on whether there were enough staff within the building. Some said there were sufficient staff, for example one person told us, “There are always plenty of staff, and I can do what I want" they added, "I have a buzzer and it is answered quickly". However, two people’s relatives told us there were not enough staff particularly at meal times. We found this to be the case at mealtimes with people experiencing delays in care and support.

During lunchtime there were two staff in the dining room, which was not enough to assist the people who needed assistance eating, as well as dealing with requests from others to go to the toilet and leave the room. One person asked three times to go from the table but there were insufficient staff to ensure this request was responded to within an appropriate timeframe. We observed some people were trying to stand and leave by themselves unsuccessfully. This meant the care workers were interrupted from assisting people with their food to go and ensure others sat down as they were in danger of falling. This situation went on for 15-20 minutes. Due to some people needing two care workers to provide support it took a significant amount of time to ensure people were able to safely leave the room and some people were left sitting at the dining room table for an unacceptable period of time after lunch.

At breakfast time we observed a person was sat at the table who needed assistance with their meal. We saw they did not get their food until after 10am when everyone else had finished due to lack of staff available to assist.

We found there were insufficient staff deployed to ensure safe management of the service. The registered manager was no longer in day to day charge of the service and had recruited an acting manager. However they were provided with insufficient management time to undertake their duties. The acting manager only worked two to three days a week and most of this time was on shift as a nurse. This was the case on the day of the inspection and we saw they were constantly interrupted during the medication round to answer the phone and deal with staff and visitor queries. This situation was not conducive the safe delivery of care and treatment.

The manager told us that they had not the time to complete key management tasks such as ensuring the home met was compliant with Deprivation of Liberty Safeguards and that audits were completed We found deficiencies in these areas which could have been addressed with sufficient management time allocated. The manager told us that due to nurse staff shortages they were having to cover shifts and this reduced their management time. Following the inspection, the registered manager confirmed the acting manager’s hours would be increasing to ensure further management time was available.

We found one night nurse was regularly working 14 or 15 hour night shifts in addition to a lack of sufficient rest between shifts. This increased the risk they would make errors. We raised this with the manager who said they had an action plan to address but due to insufficient night staff cover this was not currently possible.

This was a breach of the Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA) and specifically the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom Our scrutiny of records initially showed three people were subject to DoLS and a further three authorisations had recently been made to the supervisory body. Closer scrutiny of one authorisation showed the DoLS had expired six weeks ago. We asked the acting manager if the DoLS were still required. They told us they were but said, they hadn't had chance to review the authorisation. This demonstrated that the home was depriving someone of their liberty without necessary authorisation. Another DoLS authorisation had attached conditions. We saw from records and a discussion with the acting manager that the conditions were not being met. This demonstrated this person's rights were not being protected as designed through adherence to the DoLS conditions. The acting manager assured us this would be urgently actioned.

Where people lacked capacity, we found the provider was not following a best interest process in line with the requirements of the Mental Capacity Act (MCA). For example we found relatives had consented to the provision of healthcare vaccinations without an assessment of whether the person had capacity to consent to the treatment themselves and best interest process followed.

This was a breach of the Regulation 11 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw electronic care plans recorded whether someone had made an advanced decision on receiving care and treatment. The paper care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form. We spoke with staff who knew of the DNACPR decisions and were aware that these documents must accompany people if they were to be admitted to hospital. Electronic and paper records correlated with each other. This assured us the correct agreed process would be followed in a medical emergency.

We asked staff about their induction, training and development. Staff told us they felt supported by the acting manager but access to training had declined during within 2015. We looked at six staff files in which were held training records and certificates. These files demonstrated staff were not accessing training in sufficient subjects or with sufficient regularity to maintain their competency. Furthermore the files we accessed showed training needs had not been met for a number of years. Evidence of an induction programme to prepare new employees to work with vulnerable people was not available. Evidence we did see illustrated the induction programme consisted of information to orientate staff to their work environment and little else. The acting manager said they were "unhappy" with the current training provision and recognised staff training was overdue. We saw they had booked a trainer to deliver key mandatory sessions to staff during October 2015.

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

People and their relatives generally spoke positively about the food provided by the home. For example one relative said "[my relative] likes the food, food is good, proper cooked dinner." Another person told us how they had enjoyed their breakfast that morning.

We found there was a lack of cooked breakfast options available at breakfast. The cook started at 10am and as a result the care workers prepared breakfast which consisted of boiled eggs, toast, cereal or porridge. We concluded this was a missed opportunity to provide increased nutrition to some people. For example we looked at one person's food and fluid charts and saw they had refused cereal on several mornings but there was no evidence that anything additional was offered to them. Another person we spoke with told us they liked bacon for breakfast but that he was having "more of the same" referring to cereal.

We found nutritional risks to people were not well managed. One person of low body weight had lost 13% body weight in 3 months, yet the service had failed to assess the risk of malnutrition and put in place an

appropriate plan of care to control those risks. Another person had lost weight and although the service had recognised this and referred them to the dietician, correspondence from the dietician noted there could be a lengthy delay in support being provided. An appropriate care plan had not been put in place in the meantime to control the nutritional risks to this person. Care records also showed this person was to be weighed weekly but this was not happening. Some people's food and fluid intake was being monitored, however this showed people of low weight were not being offered snacks between meals and where they refused there was no evidence that another choice was offered. This showed the service was not doing all is reasonably practicable to assess and mitigate nutritional risks to people

We found people's healthcare needs were not always fully assessed and appropriate plans of care put in place. We found people had access to a range of health professionals such as doctors and district nurses. We found there were no cushions in any of the wheelchairs owned by the home, which increased the risk of skin integrity problems. One person was assessed of being at very high risk of developing pressure sores; however there was no skin care plan in place and/or preventative measures in place such as a specialist foam mattress. NICE guidelines CG179 Pressure ulcer: prevention and management of pressure ulcers recommends using a high-specification foam mattress for adults who are assessed as being at high risk of developing a pressure ulcer in primary and community care settings. Following the inspection the manager told us they had put an appropriate plan of care in place including a suitable mattress.

This was a breach of the Regulation 12 (2a&b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's relatives told us the service was good at dealing with behaviours that challenge. For example one relative told us "They know how to look after him here, 100% calmer, no problems with behaviour." This was confirmed by the staff we spoke with and the incident records we reviewed which showed these incidents were rare indicating strategies in place were appropriate.

Adaptions were needed to the building to make it more dementia friendly. There was a lack of signage on doors informing people which room they were entering. This reduced the likelihood people could navigate around the home independently. Some corridor doors had numbers on them indicating which bedrooms were further down the corridor. However we found one of these stated it was the door to room 9 and 10 when in fact it was room 6 and 7. We found heavily patterned carpets were in place for example within the dining room which were not appropriate for people living with dementia. This was confirmed through our observations, where we saw one person couldn't walk on the carpet as they thought the patterns were obstacles and they were seen trying to step over them.

Requires improvement

Is the service caring?

Our findings

People and their relatives all told us that staff were always kind and caring and treated them well. For example one relative told us, “All staff know our names, staff are excellent, lots of them have worked here for years, there is no staff turnover.” They described how they had chosen the home because it was homely and friendly and had the personal touch. Another relative told us, “All the staff are brilliant with him, they understand his moods, they are really good to him.” A person who used the service told us, “I am always treated nice; all the nurses help me if I need it”. Another person said, “I like it here, I have no complaints”.

Permanent staff we spoke with demonstrated a kind and caring attitude towards the people they were caring for. They were able to tell us personalised information about the people they were caring for. As most staff had worked at the home for a long period of time this had allowed strong relationships to develop.

People told us they felt listened to by staff and they could raise any issues with them which would be promptly dealt with. People and relatives said people’s choices and preferences were respected such as where they wanted to sit, what they wanted to do and when they wanted to get up and go to bed.

We observed the delivery of care and support. People looked comfortable, well dressed and clean which demonstrated staff took time to assist people with their personal care needs. Staff were seen to be respecting the privacy and dignity of the people who were using this service; for example by knocking on bedroom doors before entering and allowing people time to respond.

We saw staff respected and involved people who were receiving care. For example by addressing people by their preferred name and supporting people to be independent where possible. Each room visited showed signs of individual choice and personal touches such as photographs, prized possessions and personal furniture.

However we concluded the service was not consistently caring as during lunchtime there were insufficient staff to ensure that people were consistently treated with dignity and respect. For example people had to wait lengthy periods of time before their requests such as to go to the toilet, and to leave the table were actioned by staff. People who were assisted to eat, had their meals interrupted by staff having to attend to other people who required assistance

We concluded that although staff did their best to ensure day to day personal care and comfort of people was maintained, the lack of management oversight meant that people’s strategic care needs, such as assessing and managing risks and protecting their rights under the Mental Capacity Act was not robustly met. This demonstrated a lack of care at management and provider level.

Care records were not accessible to staff and a number of agency staff were regularly used by the service. We observed on the day of the inspection an agency staff member was not familiar with the person they were caring for and there was no practicable way for them to access care records. Without access to this persons records this meant agency staff would not be able to understand the person and their specific needs.

There was no formal mechanism to place to involve people and their relatives in the creation and review of their care plans. Care records were stored electronically, and there was no means for people to sign to demonstrate they were involved in the plan of care. We received mixed feedback from people’s relatives as to whether they were involved in care reviews. Some relatives said they were involved informally. Another told us “I've not been told about a care plan.”

Requires improvement

Is the service responsive?

Our findings

People told us they were very happy with the level of care provided by the home. Relatives also told us the home provided good quality care that met their relatives' individual needs. Two relatives told us about how their relatives had become calmer and less anxious after moving to the home and staff were attentive in responding to any changes in their needs.

Care records were stored in electronic format. However they were only accessible from one computer terminal in the nurse's office which care staff did not have regular access to. This meant there was a risk staff would not adhere to care plans, particularly those less familiar with people's needs such as agency staff.

We looked at people's electronic care plans and found they did not include clear instructions to enable staff to carry out effective care. Some care plans were in place covering key area of care and support. We saw specialist care plans were in place to help manage conditions people had such as diabetes. However people had a number of key care plans and assessments missing for example around tissue viability and nutrition. Where care plans were in place we found they were basic with a lack of personalised information. For example one person's continence care plan contained a lack of information on the type of incontinence product they required or how often they required support with toileting. Another person's eating and drinking care plan mentioned another person's name. Sections on people's life histories, mental capacity, medical history or any specialist equipment they had were blank. We saw that some care plans had not been regularly reviewed, some reviews were not relevant to the plan of care they were reviewing and others concluded "no change" when people's circumstances had changed. This suggested that blanket reviews with little thought to the persons needs had been undertaken.

Records of daily living were very basic and there was a lack of information surrounding the care and support each person had received. As such we were unable to confirm whether people received the required care and support due to the lack of proper records being maintained.

Where people were on charts monitoring their food and fluid intake this was not always robustly monitored. For example some entries recorded the person had eaten "half a dinner" rather than recording the specifics. Without this information, their nutritional input could not be accurately assessed and monitoring.

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

Because of the lack of proper and accessible care records, the acting manager had put in place a detailed handover system which provided staff with updates on each person with the aim of ensuring responsive care was provided. Staff confirmed they kept up-to-date with people's needs through the handovers. They told us the acting manager was "holding it all together" through use of this system. We saw staff communicated well with people and their relatives following any changes in people's health needs. For example one relative told us how if there was an incident such as a fall, this was always promptly communicated to them and necessary action taken by the home to keep them safe.

People and their relatives told us they were generally happy with the care and support provided and had no need to complain. A complaints log was in place and we saw evidence minor complaints were also logged and action taken to prevent a re-occurrence. We saw a low number of complaints had been received and those that had were handled appropriately. The complaints procedure was on display within the entrance area to bring it to the attention of people who used the service.

We spoke with care staff who told us they organised activities such as playing dominos with people and organising beauty sessions. However there was no dedicated activities staff available and we found care staff were too busy undertaking routine care and support tasks to allocate any time to activities and meeting people's social needs. During the inspection we saw no evidence of any meaningful activities with the television just turned on for people to watch.

Inadequate

Is the service well-led?

Our findings

A registered manager was in place. However they were not in day to day control of the service. We found there was a lack of leadership and direction within the home. Although the registered manager had appointed an acting manager to complete management tasks in their absence, there were insufficient management hours provided to ensure proper management of the service. We found this had a significant effect on the quality of the service for example shortfalls were found in care records and medicines management. We found a chaotic approach to some aspects of the service which should have been addressed through strong management and leadership. For example there was no planned food menu and the food cooked on any given day was determined by the cook who worked the day previously. This was not conducive to good management of a varied and nutritious diet and the provision of food that met people's individual choices and preferences.

We received mixed feedback from people and their relatives about the effectiveness of management People and their relatives said there was a good atmosphere within the home and said staff were friendly and helpful. Relatives had concerns about the future direction and management of the home. One relative told us, "There is generally a good atmosphere here, but I don't think they are all working as a team, the owners basically have been blinkered and have forgotten they have responsibility, you can devolve management but not responsibility they are not giving staff enough support."

Staff told us that they enjoyed their role working in the home and were provided with appropriate management support. They told us they appreciated the acting manager's support through the current transitional period.

We found a lack of systems in place to adequately assess and monitor the quality of the service and we found this had an impact on people who used the service. We found risks associated with management of medicines, training, recruitment records, management of risks to people, and care records. These risks should have been identified and rectified through a robust programme of quality assurance. The acting manager confirmed they had not had time to ensure a programme of audits and checks was in place covering areas such as infection control, care quality, care records and medication.

Documentation relating to the management of the service was not readily available. For example records relating to training and recruitment were missing. As such we were not able to confirm when people last received training and whether they had been recruited safely.

At the last three inspections, April 2014, August 2014 and March 2015 we found breaches of regulation. At this inspection, we found very little action had been taken to address the issues we previously found, which showed the service had not acted on feedback from the Commission and demonstrated a poorly led service. For example in March 2015 we noted continence assessments were not detailed enough. At this inspection we found this was still the case. In the April 2014 and August 2014 inspections we found risks associated with poor record keeping and a lack of quality assurance. At this inspection, we found no action had been taken to address these risks which we first identified 17 months prior to this inspection. This demonstrated a lack of action to address risks and act on our feedback.

We found there was no system in place to assess and monitor whether the homes policies and procedures were being followed and we found evidence policies and procedures were not being followed. For example the fire training policy stated all staff would receive fire training on a monthly basis but no staff had received it within 2015. The nutritional policy stated a four weekly menu was in place but this was not the case. Policies contained old legislation that was no longer relevant. As policies had been recently reviewed, we therefore concluded the reviewer had not taken due care to properly review their content. We raised the same issue previously in 2014 but no action had been taken to address this.

This was a breach of the Regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relative's feedback on the service had been sought through quality questionnaires. We found the results of these were generally very positive. The results were displayed within the home and an action plan had been produced to address some of the points such as to provide people with more stimulation. This showed the service had plans in place to address the feedback raised by people who used the service.

Inadequate

Is the service well-led?

Following the inspection, the registered and acting manager sent us an action plan describing how they were going to improve the service, underpinned by an increase in management time. We saw staff meetings had been held and the acting manager had begun improving systems and processes such as making care plan records more accessible and addressing the risks we identified during the inspection.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe care and treatment because medicines were not managed safely. The service had not done all that was reasonably practicable to assess and mitigate risks to people's health safety and welfare.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment was not provided with the consent of the relevant person in line with the requirements of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were must be protected from abuse as systems and processes must be established and operated effectively to prevent abuse of service users

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems were not in place to assess, monitor and improve the quality of the service. An accurate and complete record of each service user was not maintained. Other records concerning the management of the regulated activity were not maintained.

This section is primarily information for the provider

Enforcement actions

The service had not acted on feedback from relevant persons for the purposes of continually improving the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were insufficient staff deployed to ensure the carrying out of the regulated activity. Staff had not received appropriate training.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Recruitment procedures were not established and operated effectively.