Shivshakti Nivas Ltd.

Park House Rest Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out this unannounced comprehensive inspection on the19 and 20 May 2016 to see if the provider had made progress following the last comprehensive inspection. The last comprehensive inspection was carried out in December 2015, led us to follow our enforcement pathway and the provider was placed into special measures by CQC as it was rated "Inadequate" overall. We received an action plan in March 2016 from the provider informing us what action they were taking to make improvements and achieve compliance.

Park House Rest Home is a care home, which accommodates up to eighteen older people, some living with dementia. On the day of our inspection 15 people were at the home; two of these people were on a short respite stay. On the second day of our inspection another person came in for a short stay.

The home does not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are registered persons". Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had recruited a manager who has submitted an application to us to become the registered manager.

We found the provider had made progress in most areas of non-compliance, but in most breaches there was still room for improvement, and in some breaches the impact on people was lower than before. The management of medicines, mental capacity understanding and the training and supervision of staff had been improved to reach compliance. However, this inspection found that there was not enough improvement to take the provider out of special measures.

Risk assessments had not been completed for all people to ensure staff were aware of the risks facing people.

Staffing levels had improved but they were still not adequate to ensure all people's needs were met at all times.

The provider had completed an audit of staffing recruitment records but had not taken any action to ensure the gaps found had been actioned to ensure the safety of people.

Peoples' nutritional and hydration needs were not adequately provided for.

People had their mental capacity assessed and best interest decisions had been made appropriately.

All people were not receiving personalised care.

The recording of complaints had improved but these were still not being investigated.

Quality assurance processes and record keeping had improved but there were still shortfalls in these areas, which had not been identified or addressed.

The overall rating for this provider is still 'Inadequate'. This means that it remains in 'Special measures'. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

We found six repeated breaches and one new breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

CQC is considering the appropriate regulatory response to the shortfalls we found during this and previous inspections. Where providers have not been meeting the fundamental standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

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.

Risks regarding individual's care had not always been identified and risk assessments were not always in place to mitigate the risk.

Recruitment procedures had not always been undertaken to ensure staff were suitable to work with people at risk.

Staffing levels were not planned to ensure the needs of people could be met.

Medicines were safely stored, administered and recorded.

Staff had an awareness of what constitutes safeguarding.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not have their nutritional and hydration needs met.

People were supported to access a range of healthcare professionals.

Staff had received training and regular supervision.

Staff had knowledge of the Mental Capacity Act 2005 and the need for ensuring people's capacity was assessed.

Is the service caring?

Requires Improvement

The service was not always caring.

People were supported by staff who respected people's privacy and dignity at an individual level.

As the staff were busy this meant at times people were not supported in a dignified and caring manner.

Is the service responsive?

Inadequate

The service was not responsive.

People did not always receive personalised care, which was in line with their needs or preferences.

Complaints were recorded but not investigated.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider was more organised and had started a quality assurance programme. They had employed a consultancy company to try and support them with their action plan.

People's records were not always accurate and well maintained and the quality assurance process was not identifying or addressing all the issues needed.

Park House Rest Home

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 19 and 20 May 2016 and was unannounced, which meant the staff and provider did not know we would be visiting. The inspection team consisted of one inspector and a specialist advisor in the care of frail older people, especially people living with dementia and those with end of life care needs.

Before the inspection, we reviewed notifications. A notification is information about important events which the provider is required to tell us about by law. We also looked at any information we had received since the provider had been registered with us.

During the inspection we spent time talking to nine people, four staff and two visitors. We looked at the care records of nine people. We looked at the recruitment records of four members of staff. We were given copies of the staff duty rotas, training matrix, staff supervision timetable and Statement of Purpose. A Statement of Purpose is a provider's description of their aims and objectives, the services they provide and the needs their services meet. We were given copies of one daily handover sheet and information about how the service met people's personal care needs. We reviewed the provider's action plan we received following the last comprehensive inspection. We also requested and received some documents, policies and procedures from the provider following the inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed interactions between people and staff.

Inadequate

Is the service safe?

Our findings

At the inspection in December 2015 we found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risk assessments were not in place to ensure the safety and welfare of people.

During this inspection we found the provider had tried to make improvements in this area and had completed some risk assessments. However, the provider in other circumstances had not identified all the risks and had therefore not completed appropriate risk assessments. For example when talking about people with the provider and manager at the beginning of the inspection we were advised about a newly accommodated person using the service. We were advised they were on a short stay, but they had talked about their strong inclinations to self harm in some detail. Despite this information there was no risk assessment in place relating to these identified risks. In another example there were two loose canisters of oxygen in the lounge area. A member of staff explained a service user needed to have the oxygen near them, however we advised it was not safe as they were close to the kitchen hatch and in danger of being knocked over where they were placed. The member of staff moved the oxygen away from the thoroughfare. There was no risk assessment in the person's care plan for oxygen use, or a risk assessment relating to the use of oxygen in the home. When talking to one person they told us at times they did not feel safe, as they were concerned about the man staying at the service who shouted who had also once banged on their door, but was supported by staff to leave the area. In one person's records the skin integrity care plan recorded the person was vulnerable to pressure sores and skin tears. The risk assessment stated a body map should be completed daily. On the 9 May 2016 a body map showed the person had one bruise, two days later the person had 27 areas identified on a body map. The following day they had approximately 47 areas identified. Whilst it was recorded the person bruised easily there was no explanation or investigation into the increased number of bruises. We could see the nurse had been contacted when the person had developed skin tears, however we could not be assured the person was receiving safe care.

The lack of effective risk assessments in place to ensure the safety and welfare of people was a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection in December 2015 we found the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's needs were not always met by sufficient and consistent numbers of staff.

The provider told us since the last inspection 8 staff had left. They advised us they were recruiting new staff, but in the meantime they were using agency staff to fill the gaps. The provider told us the staffing levels were static with three staff working on the floor between the hours of 8:00am – 8:00pm and two staff working a night duty with one of these working a sleep in duty between 10:00pm – 6:00am. We were given copies of the duty rota from the 11 May 2016 – 5 June 2016. However, these were not accurate as the staff recorded on the duty rota for the days we visited were not accurately recorded as the staff who were actually working during the inspection. When we asked a member of staff a question about the duty rota, they pointed out three staff who had already left who were still identified as working in the home on the duty rota. The provider told

us the service was using an agency cook between the hours of 8:00pm – 1:00pm, as both cooks had left the service.

The provider had a policy on staffing levels which stated "It is the policy of the Home to maintain adequate staffing levels in accordance with the guidelines established by the Registration authority and appropriate Working Time Regulations'. The registration authority for the service is the Care Quality Commission and we do not set specific staffing levels, rather that providers are responsible for meeting all people's needs at all times. The provider used a dependency assessment, but it was not possible to establish how this in practice was used to determine staffing levels.

During the inspection we observed there were times when there were insufficient staff on duty to meet people's needs. On the first day of the inspection we had to alert staff twice to the fact that one person was trying to mobilise out of their chair and walk who was identified as at risk when mobilising alone. The member of staff in the lounge was positioned so they could not see this happening. They were providing one to one support to another service user who was also at risk if they mobilised alone. The member of staff left this service user and alerted a member of staff who had been supporting another service user in their own room. Later in the day a person sat in the lounge, and loudly asked for assistance to go to the toilet. It was 11 minutes until a member of staff was available to support the person to go to the toilet. On another occasion a lady was shouting in their room, which was usual for their behaviour we understood, but on this occasion we saw another service user come out of that person's room, which was not theirs. The person who was shouting was unable to tell us if they were distressed by this, but no staff were around to witness this interaction.

In the afternoon the care staff were responsible for preparing the tea time meal. Whilst this was not the main meal of the day it still took a staff member away from the care team. With one member of staff supporting a person on a one to one basis this meant there was only one member of care staff to support the other people in the home. A member of staff told us trying to support all people at times was difficult, with people identified as at risk if they mobilised on their own, one person who removed their clothes in the lounge on a regular basis, one person who wandered and one person who was cared for in bed. It was difficult to establish how people who required repositioning or mobilisation to the toilet at night could be supported by just one staff member working an awake shift, which was the planned cover for 10:00pm-6:00am.

The lack of planning to ensure there was always sufficient staff on duty to meet people's needs was a repeated breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection in December 2015 we found the provider was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the lack of effective recruitment procedures did not ensure people's safety.

We looked at the staffing recruitment records of five members of staff, but were later told one of these members of staff had left and not worked since the early part of February 2016. Two of these staff were identified as having information missing in the last inspection report. For these two members of staff we found there was still no photographic evidence available, despite the provider's checklist having a tick against this. One member of staff was on duty and told us they were struggling to find any photographic identification. For one of these members of staff there was only one reference and no details of any qualifications gained. The reason they had left their previous employment was not recorded. For the third member of staff we found there was no photographic identification and only one reference was available and there was no record of the staff member's qualifications. For the fourth member of staff we found there

had been no Criminal Record Bureau/ Disclosure and Barring Service check undertaken. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions. When discussed with the provider they showed us the matrix they had completed on all staff, as identified in their action plan. This identified the home had twelve staff who it recorded all had photo ID. The provider had taken a photo of each member of staff and put it in their staff folder. It recorded only one member of staff did not have an employment history. The form recorded five staff did not have a CRB check who had all been employed before the previous inspection. The provider told us they had been busy and they had not managed to find time to carry out the checks.

The lack of effective recruitment procedures did not ensure people's safety. This was a repeated breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found the provider was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as medicine practices were not safe. The provider had made sufficient improvements at this inspection and was no longer in breach of this regulation.

At this inspection we found the medicines management had improved. Medicines were kept in a locked room, with a refrigerator just for medicines. The temperature of the refrigerator was checked and recorded daily and was continually within normal limits. There was a disposal of medicines system in place and stock control was good. We observed two medicines rounds and found the staff knew people's medicine administration needs well. People's Medicines Administration Records (MAR'S) were complete and all but one included a photograph of the person to aid recognition for staff. These improvements ensured the management of medicines was safe.

Staff had knowledge of safeguarding people at risk and had received training to support this knowledge. When asked, staff were aware of the policies regarding safeguarding and which agencies should be informed if there were safeguarding concerns.

Requires Improvement

Is the service effective?

Our findings

Two people told us their meals were disappointing and the quality of the meals had recently declined.

At the last inspection in December 2015 we found the provider was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there was a lack of clear records relating to people's nutritional needs and intake.

People's nutritional care plans demonstrated a lack of planning and recording in how to meet people's nutritional needs. For example for one person there was a nutritional care plan, this gave little information other than they needed the support of one member of staff to meet their nutrition and hydration needs and their weight should be monitored monthly. A nutritional risk assessment had been completed which involved giving a score to seven questions, which determined the level of risk to the person. This also recorded a monthly weight record. This record showed that in two and a half months the person had lost 8 kg, which had not been identified in the risk assessment for the person. A separate weight chart had also been maintained which gave different recordings of the person's weight over this time period. However, this was a month and five days out of date to the weight recorded on the nutritional risk assessment. In the care records was a hand written note stating it would be helpful if the service user's meat was liquidised. This was not dated and we did not know who had written this. The information had not been added to the risk assessment or the person's care plan. The fluid charts for this person had been recorded sporadically. On some days they had been recorded twice, with different totals, on some days they had been recorded but not totalled and on other days they had not been recorded at all. We asked staff about the recordings and they were unable to find any other records. They advised the paperwork and recording of information had gone "Mad".

Five people had been prescribed 'Thick and Easy' which is a starch based fluid and liquid food thickener which is prescribed for people who have difficulty swallowing. The precise amount of thickener which should be added to fluids is determined by a Specialist Speech and Language Therapist (SALT), based on an assessment of the stage of difficulty in a person's swallowing ability.

The Medicines Administration Records showed that people had been prescribed Thick and Easy "as directed". These should have recorded the number of scoops to each 100mls of liquid. We spoke to two carers who had administered medicines on each of the days of our inspection. One told us "X has it when she has difficulty in swallowing". We asked what 'difficulty' meant and she replied "If she cannot swallow and splutters and coughs then we would add it, something like one scoop". Another carer told us regarding another service user "Has it naturally thicker" but was not sure if they had one or two scoops. We found that SALT had been consulted in all of the situations where Thick and Easy had been prescribed but this information was not clear to staff and it was not included on the handover sheet.

When people had fluid intake recorded there was no target intake which meant staff did not know what the person's daily needs were and therefore their fluid intake could not be monitored. In addition, when staff recorded food intake, it was written as 100% or 50% for example without an entry about how much 100% or

50% were. This meant it was not possible to accurately monitor people's food intake.

The lack of clear records relating to people's nutritional needs and intake was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The lack of effective planning to ensure people had their nutritional needs met was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in December 2015 we found the provider was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff were not receiving appropriate support or training. The provider had made sufficient improvements at this inspection and was no longer in breach of this regulation

A training matrix was available which demonstrated staff had undertaken training since the last inspection. Moving and Handling training had been recorded on the training matrix and had been delivered to eleven staff in February 2016. A record of staff supervision sessions was available which indicated regular supervision sessions had started in March 2016. The sessions for May had already begun, with most staff having received supervision. Staff reported they felt supported by the management team and felt equipped to carry out their roles.

At the last inspection in December 2015 we found the provider was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there was a lack of assessing people's capacity and ensuring their consent. This breach has now been met, but the provider could make further improvements in this area.

The training matrix recorded all staff had undertaken training on 'mental capacity' and 'deprivation of liberty'. Staff had a basic knowledge about mental capacity and how it affected people who lived at the home. 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. There were decision specific mental capacity assessments in all of the records of people who were in the home on a permanent basis. The records of one person on a short stay did not include a mental capacity assessment or records in relation to their behaviour. However, this had been considered as an application for a Deprivation of Liberty Safeguard had been applied for.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had an understanding of the Deprivation of Liberty Safeguards (DoLS). Applications to deprive people of their liberty had recently been made to the local authority responsible for making these decision.

One person regularly tried to rise from their chair and go for a walk. The staff member who was supporting them on a regular basis told the person to sit down. On four occasions we saw a staff member gently push the person on their arm whilst telling them to sit back in their chair. The provider may want to consider that staff telling people to sit down and staff gently pushing people to sit back down a potential form of restraint. Whilst it was clear the intentions of the staff involved were good in trying to ensure the safety of people, this

still could be considered restraint. It may have been more appropriate for staff to support this person to mobilise.

Where it was deemed appropriate people were referred to health professionals as necessary. People told us they had access to health professionals and the staff would support them to access these appointments. Details of the referrals and appointments were maintained in people's records.

Requires Improvement

Is the service caring?

Our findings

Two relatives we spoke with told us they were happy with the way their relatives were being cared for. One person spoken with told us, we were the first people to really talk to them. Another person told us the staff were kind but always too busy to talk. They told us staff were so busy they did not make their bed properly.

We found staff kind and caring. Their verbal interactions with people were respectful and they demonstrated they knew people well. However, we found care staff very busy and on the first day of the inspection the staff on duty struggled to take a proper lunch break as they were so busy supporting people. Staff on this day also stayed on after their shift had finished as they had not completed all their tasks. People could not be left during the lunch break as they would have been unsafe. This demonstrated the caring nature of the staff group.

Due to the fact staff were very busy they tended to work in a task orientated way. This meant they knew they had a list of tasks to complete and could not offer people choices and promote their independence as needed or as they wanted. For example two people who wanted to get up from their chairs to move around, but needed staff support to mobilise safely were often told to sit down. One person had to wait over ten minutes to go to the toilet, which was not respectful or caring towards this person. The staff were aware of this situation but were supporting other people so could not assist this person. One person showed us their bed, which we were told on a regular basis was not made properly, which they found upsetting. They told us the care staff were kind, but just very busy, so they did not like to bother them.

Whilst it was clear efforts had been made to try and include people's views, it was difficult to evidence how this was making a difference to people's care experience. For example people were being asked about the activities they were taking part in, which was good practice. However, we could not see this information was being used for the future planning of activities. When care records were audited this involved talking to the person, but there was no formal way of including and grouping these views for the development of the service. There had been two complaints by service users, but there was no investigation into these, which suggested people's views were not taken seriously.

Care records were stored so people's confidentiality was maintained. However, the day to day records of people were held in the communal lounge, which could have compromised some people's privacy. When we spoke with the provider at the beginning of the inspection, they advised us one person "May pee anywhere". Whilst we understood the reason for this it could have been vocalised in a more respectful manner.

Inadequate

Is the service responsive?

Our findings

At the last inspection in December 2015 we found the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not receiving personalised care to meet their individual needs.

People did not have personalised care plans to ensure they received care which was specific to their individual needs. Some care plans were brief and did not give sufficient detail to ensure staff knew how to care for people. For example one person who had come for a short stay only had 2 of the twelve sections of their care plans completed. The 'personalised short term respite care plan' was blank. In the handover book it recorded this person needed, 'A behaviour chart as behaviour keeps changing'. However, no behaviour chart had been put in place and their care plan did not reflect the person's behaviour kept changing. Whilst the care plan was brief for this service user the words used to describe their behaviour included, 'Aggressive and non-compliant', which did not reflect the person was receiving responsive care to their needs. This person had also been vocalising ideas of hurting themselves. This had not been included in their care plan so staff did not know how to support this person with these identified needs. During the inspection this person expressed to staff "There is nothing to do" and asked about their shoes and coat. A member of care staff told the person, they needed to join in more. Later in the day the person was asked if they wanted to join some other people at the table who were doing some drawing and colouring with felt tips. It was clear the person did not want to, but the staff member continually asked the person. No other activity was offered to this person.

We found other people's care records did not give clear guidance on how people should have individualised needs met. People's mobility and moving and handling records were not personalised to ensure staff knew how to support people. For example we saw a member of staff pulling a person behind them in a wheelchair. This meant the person was not able to see where they were going and the member of staff could not see if the person was at risk of collision with a door frame or other obstruction. This was not an appropriate way to move the person safely, but there was no instruction in their care plan.

We saw people being supported to mobilise in ways which were not safe. People's care plans gave little information in these circumstances on how people should be supported. For example we saw a carer trying to transfer a person from a wheelchair to an armchair. The member of staff did not have a good understanding about how to support the person to achieve this. The person had their arms and then legs crossed in an extremely unstable manner and at one point both of the person's legs were against the leg of a chair and they were unable to move. This process took several minutes during which time the person was at risk of falling. The person's care plan which was not named, identified the person had poor mobility. The manual handling risk assessment and person's risk assessment for falls identified the person needed a wheelchair for longer distances. However, there was no information on how to support the person to move from the wheelchair to a seat. This person had had three falls in May 2016.

In another example two members of staff tried to support a person to move from the dining table to a more comfortable chair. Both care staff tried to support the person by placing their arms under their arms in a

modified drag/support lift which was not a safe moving and handling practice. Staff did not move the person but went to get a wheel chair. There was no specific information regarding how to support this person with their mobility in their care plan or risk assessment.

More activities had been introduced into the home, which tended to be group activities. These tended to rely on the availability of the staff. However, the activities offered and who had taken part had been recorded. The people who had joined in had their level of engagement recorded and whether they had enjoyed the activity.

The handover sheets which recorded information on each person to give to the next shift of staff was basic. This detailed very little personal information and tended to state what tasks staff had undertaken. We were shown a copy of a shower schedule which recorded when people were to have a shower. The daily handover sheet seen, supported this was used as a working document. This demonstrated people were not supported to have a choice but had a shower when staff had allocated time for this task. We were also saw records which gave both day and night staff a list of tasks to carry out when on shift, which had approximate times next to them. This again suggested the home was run to the routines of staff and not to meet the individual needs of people. The night records recorded when people were supported with personal care and 'were in the lounge'. The records showed that for eight people for five of the six previous days they were supported with personal care between 06:00am and 06:15am and 'in the lounge' at 07:00am. There was no evidence this was people's choice or how people's individual privacy was assured as there was no information relating to this in their records.

The care and treatment of people was not always person centred and did not always meet people's needs in an appropriate way. This was a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in December 2015 we found the provider was in breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider did not have an effective complaints procedure.

The provider had started to record complaints and had received two complaints, both from people living at the home. However, neither of these had been investigated thoroughly. One of these complaints made complaints about several aspects of the service provided. Against the action part of the record the provider had recorded 'X (service users first name) has an infection'. This was not an appropriate investigation to close the matters to the satisfaction of the complainant. The second complaint regarded the behaviour of a person at the home. The investigation made no attempt to give feedback to the complainant. The providers own policy stated, 'All complaints will be dealt within 7 days of receipt. The outcome may be an informal resolution where both parties are satisfied without any administrative action being required. For some serious cases the Proprietor will seek a formal resolution which may result in disciplinary action being taken and external regulatory bodies being notified'.

The lack of an effective complaints procedure was a repeated breach of Regulation16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in December 2015 we found the provider was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as accurate records and an effective system to monitor the service to drive improvement had not been developed.

Since the last inspection the provider has recruited a manager who has submitted an application to become registered with the Commission. Staff told us they had confidence in the management team, but did at times feel communication was one way. A Member of staff gave us an example stating providers had changed to 12 hour shifts, which they said had meant some staff had left as they could not work these hours. The member of staff advised they had been told this was a decision made by CQC, which was not accurate.The provider told us after the inspection that they had no record of having told staff this was a decision made by CQC. We were concerned the time pressures on staff also meant at times they did not support people in the most appropriate manner. This report has raised concerns about the poor techniques of moving and handling which could have possibly led to people being injured. There was a risk that without the provider identifying the shortfalls in staffing and connection to poor moving and handling techniques that this could become an acceptable culture within the home.

We found since the last inspection the provider was much more organised in their approach and was able to locate information and policies and procedures easily. They had employed a consultancy company to try and support them with their action plan. A lot more quality audits had taken place and these had been recorded. These included, meal time audits, laundry audits, kitchen audits, medication audits and provider monthly audit and daily reports. The provider was working with the fire authority and had made some necessary improvements to the fire safety in the home. The fire officer was pleased with the progress and was monitoring the last phase of these improvements. Regular staff meetings had taken place and surveys had been sent to relatives and staff. These had been analysed and whilst most were positive no action plan had been developed to address the areas listed for improvement from staff responses to the survey, for example, better handovers, food menus, activities and more compassion. Relatives had noted more staff on a Sunday would be an improvement. The provider had reorganised the lounge/dining area by removing the medicines trolley which made more of the space available.

Care planning audits had taken place but these had not identified the findings we had when we looked at care records We found care plans were not providing sufficient information to ensure staff had adequate information to be able to meet peoples individualised needs. We also found records were not accurate to ensure the provider could evidence people were being well cared for. For example, records did not always evidence people had received topical medicines when they were due. Records of people's nutritional intake were inadequate to ensure people were receiving adequate nutritional intake. The investigation into complaints was not effective.

When people sustained injuries, records were not made of how these had occurred. There was no investigation to ensure there could be learning and the injury being prevented from happening again. We found incident and accident records were confused. We found examples of where there had been injuries

but no body maps, or there would be body maps but no records of injuries.

We were concerned some injuries appeared to have happened when staff were assisting people to mobilise and staff could have caused these injuries through inappropriate moving and handling techniques. For one person we saw the person had sustained two injuries when staff had been assisting the person to transfer over a seven day period. On both occasions the person had sustained skin flaps.

The training matrix showed eight staff still working in the home had received training on moving and handling. However, this had not been reviewed to see if the training was effective and ensured staff knew how to support people with moving and handling. The provider was unable to explain why injuries had occurred and could not demonstrate they had investigated these. One record showed a member of staff had applied a treatment that was usually undertaken by a registered nurse because of the risks associated with causing further skin damage and pain. The provider did not use a validated pain assessment therefore it was not possible to know if staff always recognised a change in the presence, severity or frequency of any pain that people experienced. Pain in people with cognitive impairment for example in people living with dementia is difficult to ascertain and it will commonly be hard for them to verbalise. For these reasons a system that identifies pain should be available to all people who live with dementia and similar conditions.

The failure to ensure accurate records and effective systems to monitor the service to drive improvement was a repeated breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

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