Care Quality Commission

Capstone Care Limited

Walshaw Hall

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?	Requires Improvement

Overall summary

This was an unannounced inspection which took place on 24 March 2015 and 7 April 2015. The service was last inspected on 23 September 2013 when we found it to be meeting all the regulations we reviewed.

Walshaw Hall provides accommodation for up to 50 people who have personal care needs, including those with dementia. There were 44 people living in the service on the day of our inspection.

The service had 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.

During this inspection we found that a staff member failed to recognise that a safeguarding incident had occurred and did not report this to the registered manager.

Summary of findings

People were at risk of receiving unsafe care and support as risk assessments were not in place to show how identified risks were to be managed.

Correct recruitment procedures were not followed for volunteers. This meant that people who used the service were not protected against the risk of unsuitable people working within the service.

We found the management of medicines was unsafe and did not protect people who used the service. Care staff members handled medicines with their bare hands, medicines were not stored safely, inaccurate recordings of when medicines had been given and there was no robust system in place to account for controlled drugs.

People who used the service had access to hazardous substances. A clinic room and hairdresser's room containing sharp objects and hazardous liquids were unlocked.

We found the registered manager had identified a number of people for whom a Deprivation of Liberty Safeguards (DoLS) application was required. However, we found that no applications had been made and consequently people were being deprived of their liberty unlawfully.

People who required support to eat were left for long periods of time with their food in front of them before assistance was given. Those people who were supported to eat their meal were not given sufficient time to swallow their food.

People were not given a choice of what drink or biscuit they would like during the drinks service. Staff chose the biscuit and handed this to people with their bare hands.

We observed one staff member treat people in an undignified and disrespectful manner. A safeguarding alert was raised regarding this concern by the registered manager and the inspector.

Confidential information about a service user's medication was displayed on a notice board in a thoroughfare.

People were sitting in wheelchairs for long periods of time in the main lounge and library areas. The registered manager and staff members could not tell us why people had not been supported to transfer to a comfortable chair.

There was a lack of stimulation for people with dementia. Sensory equipment was stored in the attic area of the service and not made readily available for people to use.

Care records we looked at did not contain sufficient information to show how people who used the service were to be supported and cared for.

People's health and welfare was at risk due to the lack of risk assessments for choking, pressure ulcers and bed rails.

There were no robust systems in place to assess and monitor the quality of the service provided to ensure people received safe and appropriate care.

The registered manager lacked knowledge in key areas such as Deprivation of Liberty Safeguards (DoLS).

During this inspection we found the service was clean and people were able to personalise their rooms to their own tastes.

People told us their privacy and dignity was always maintained.

People knew how to make a complaint and told us they felt able to approach the staff with any concerns.

The registered manager had regular meetings for people who used the service where they were able to discuss anything about the service or their care.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of this report.

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?

The service was not safe. Medicines were not always managed safely.

Risk assessments were not completed for people who used the service.

We found the service was clean.

Inadequate

Is the service effective?

The service was not effective. This was because people's nutritional needs were not always met.

There was a lack of signage around the service to support people with dementia to be independent.

Bedrooms were nicely decorated and people were able to personalise them.

Inadequate

Is the service caring?

The service was not always caring. This was because people were not always treated in a dignified and respectful manner.

People's personal information was not kept confidentially.

People who used the service told us their privacy was respected.

Requires Improvement

Is the service responsive?

The service was not always responsive. This was because there was a lack of stimulation for people with dementia.

Care records did not contain sufficient information to show how people were to be cared for.

People who used the service told us they knew how to complain if they had any concerns.

Requires Improvement

Is the service well-led?

The service was not always well-led. This was because there was a lack of quality assurance systems in place to ensure the quality of the service.

The manager lacked knowledge in key areas and failed to identify issues and concerns around the service.

Policies and procedures had not been reviewed for some time.

We saw the service had regular meetings for people who used the service.

Requires Improvement

Walshaw Hall

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 24 March and 7 April 2015 and was unannounced.

The inspection team consisted of one adult social care inspector, a special advisor who was familiar with the care of people with dementia 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 service.

Before our inspection we reviewed the information we held about the service including notifications the provider had made to us. This helped to inform what areas we would focus on as part of our inspection. We had not requested the service to complete a provider information return (PIR); this is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.

We contacted the Local Authority safeguarding team, the local commissioning team and the local Healthwatch organisation to obtain views about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Healthwatch informed us they had not received any comments or concerns in the past 12 months regarding Walshaw Hall. The local safeguarding team informed us they had received one safeguarding concern in the past 12 months. The local commissioning team informed us they had undertaken a quality assurance inspection within the last 12 months. Issues raised with us by them prior to the inspection included concerns regarding consent and capacity requirements, religious needs not being met, care plans not being followed by staff, lack of procedures for covert medication, no training matrix in place and a lack of training of staff.

We spoke with three people who used the service and one relative. We also spoke with three staff members, the deputy manager and the registered manager.

During the inspection we carried out observations in all public areas of the home and undertook a Short Observational Framework for Inspection (SOFI) during the lunchtime meal period. A SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care records for six people who used the service and the medication records for a number of people. We also looked at a range of records relating to how the service was managed, these included training records, quality assurance systems and policies and procedures.

Inadequate

Is the service safe?

Our findings

We found the service was not safe. This was because staff failed to recognise a safeguarding incident, people had not been correctly assessed for the use of bed rails, correct procedures were not followed for volunteers, people did not have personal emergency evacuation plans in place, correct medication procedures were not followed and correct infection control procedures were not followed.

Records we looked at showed that people who used the service did not always have risk assessments in place. We saw one person had bed rails in place but with no risk assessment and we saw one person was identified as at risk of choking but no risk assessment in place.

We asked to see the risk assessments that were in place for the environment. The registered manager informed us they had recently completed environmental risk assessments for the service but these had not been put in place at the time of our inspection. The registered manager informed us they required dating and signing and they would soon be put in place.

These matters were a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our observations of a medicines round on 24 March 2015, we saw two of the senior care staff placed medicines into their bare hands prior to giving them to people who used the service. One senior staff member put two tablets in their hand prior to giving it to a person. We also saw the same person attempt to wake someone up to give them pain killers. We observed them pick the tablet up with their fingers and push it into a person's mouth prior to them being fully awake. This resulted in the person beginning to chew what was in their mouth, appearing unaware that this was medicine. The staff member then attempted to encourage the person to drink some water which resulted in the remains of the tablets coming out of their mouth with the water. At no point did the staff member ask if the person was in pain or needed pain killers that were as required (PRN) medicine.

We noted that the medicines were being administered whilst people who used the service were eating their lunch. We saw that staff were administering eye drops and other medicines whilst people were in the process of eating their meal. The registered manager told us that they would evaluate the current process and attempt to arrange for medicines to be undertaken at a different time where it would have less impact on people who used the service.

The storage and recording of the CDs used by the care home staff was satisfactory. We did see however that a senior care assistant transferred a CD from the box it was dispensed in into another box containing the same medication. This is poor practice. Medications should stay in the box they were dispensed in to ensure that, in the event of a medical alert/ recall, the actual medication dispensed can be accounted for.

During the inspection we witnessed a senior care assistant give the keys to the treatment room to a member of the domestic staff as they wished to clean the room. The CD keys were attached to the door key. Giving the CD keys to unauthorised personnel increased the risk of these powerful medicines being abused and placed people who used the service at risk of harm.

Appropriate arrangements were in place in relation to obtaining medicines. We saw that sufficient stocks of medication were maintained to allow continuity of treatment. When a medicine was received into the home staff recorded the quantity received onto the medication administration record (MAR). Staff also recorded how much medicine had been brought forward from the previous month. This helped ensure that the medicines could be accounted for as the stock of medicines could be checked against the amount recorded as being given; thereby checking that people received their medicines as prescribed.

We checked a random sample of MARs. They showed that staff were recording when they had given a medicine but the times they were actually given did not always correspond with the time written on the MARs. Inaccuracies in the recording of the administration of medicines could result in people being placed at risk of harm.

Appropriate arrangements were in place to safely dispose of medicines that were no longer needed.

We looked at the monthly medication audits and saw that not all aspects of medicine management were audited. The records we looked at only identified when medication

errors had occurred. Having a robust system of audit in place in order to identify concerns and make the improvements necessary helps to ensure medicines are handled safely within the home.

We found there was a medicines policy in place date May 2013 and no evidence of this being reviewed to ensure best practice guidance was followed.

The registered manager told us that the medicine training was completed on-line and that once staff had passed this the deputy manager undertook competency assessments prior to senior care staff administering medicines. The area manager was responsible for assessing the competency of the deputy manager.

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

The service had a clinic room specifically for district nurses and visiting doctors to use whilst they were in the home. We found this room was unlocked and accessible by anyone and therefore people who used the service had access to the containers which contained sharp instruments such as needles. Cupboards were unlocked which contained dressings and various lotions. On the second day of our inspection the registered manager informed us that a lock had been fitted to this door. We saw that this was in place.

The service also had a hairdresser's room which was unlocked. There was an unlocked storage cupboard containing hazardous substances which were accessible to people who used the service some of whom may lack the capacity to understand they were hazardous. We also found an electrical socket was damaged and held together with tape.

These matters were a breach of Regulation 12 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2014.

During our inspection we looked at infection control and how this was being managed within the service. We found an infection control policy was in place dated May 2013 but there was no evidence of this being reviewed to ensure that best practice guidance was followed.

We looked in a bathroom and a shower room. Both rooms contained an amount of communal toiletries. Toiletries should be personal to each individual to demonstrate choice and help prevent any possible spread of infection. We also found in each bathroom/shower room there was only one set of dressing protectors (in particular for people with dressings on their legs). This meant there was a risk of cross infection.

We noted that in the shower room and the bedrooms we looked at there was insufficient hand washing facilities for staff to use after undertaking personal care. We found paper towels and liquid hand wash were not always available. This meant there was a risk of cross infection.

These matters were a breach of Regulation 15 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the registered manager to enquire who the infection control lead was in regards to infection prevention and control. The registered manager informed us that they did not have an infection control lead within the service. We advised the registered manager that as described in the Code of Practice for health and adult social care on the prevention and control of infections and related guidance, it is necessary for a lead person to be identified within the service. It was suggested that the registered manager referred to the above guidance and ensured that this was followed. On the second day of our inspection we found that the manager had taken action and had a named person responsible for infection control.

People who used the service told us they felt safe. One person told us "It is good, there is no bullying." We asked people if they knew who to tell if they did not feel safe. One person told us "I would tell any member of staff who would tell the person in charge" and another said they would tell their relative. One visitor told us they would not know who to tell if their relative did not feel safe.

Records we looked at confirmed staff had completed safeguarding training. All the staff we spoke with confirmed they had completed this training and they knew what action to take if they thought a person who used the service was being abused or at risk of harm.

However, on the second day of our inspection a safeguarding incident occurred which was immediately reported to the registered manager by one of the inspectors. A staff member who had received safeguarding training, witnessed part of this incident failed to recognise this was a safeguarding concern and consequently did not report this to the registered manager immediately.

Inadequate

Is the service safe?

The service had a whistleblowing policy in place dated May 2014, which gave staff clear steps to follow should they need to whistle blow (report poor practice). Within the policy the telephone number for the Care Quality Commission (CQC) was detailed along with the number for Public Concern at Work (whistleblowing charity). Staff we spoke with told us they were aware of the whistleblowing policy and knew what to do if they had any concerns. They told us they would approach the manager or another member of the management team and felt confident to do so.

We looked at personnel files held for two staff who were employed in the service. We saw there were recruitment and selection procedures in place. All the staff files we looked at provided evidence that the manager had completed the necessary checks before people were employed to work in the home, with the exception of volunteers.

The registered manager informed us that a volunteer staff member was in place in the service. However we found that the correct vetting procedures had not been followed for volunteers. A Disclosure and Barring Service (DBS) check had not been undertaken by the service prior to them volunteering. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. This meant that people who used the service were not protected against the risk of unsuitable people working within the service.

The service had a contingency plan in place in case of emergency, including fire, flood, storms and technical or mechanical failures. Control measures were in place for staff to follow a three stage plan, ranging from what should be done within the first eight hours to three days. The contingency plan also identified the minimum amount of staff that should be on duty throughout a 24 hour period.

Records we looked at showed that wheelchairs were to be inspected on a monthly basis to ensure these were safe for use. We found that the wheelchair audit had been developed and commenced in March 2015.

Mechanical hoists (including bath hoists) throughout the service were inspected on a regular basis by an external company. The last dated inspection was 8 January 2015 and it was deemed that all equipment was safe.

On numerous occasions throughout our inspection we saw that wheelchairs and hoists were stored in the library area of the service. We found that where these were placed could restrict the access in and out of the library due to the amount of space near the doorway. This could result in people falling.

We saw that all the gas and electrical equipment had been serviced and checked within acceptable frequencies. This included electrical installations, gas appliances and portable electrical equipment.

People who used the service told us they felt there was always enough staff on duty and they did not have to wait long if they used their buzzer or asked for something. One person told us “They work hard but an extra body would do no harm.” One staff member told us they felt there was not enough staff on duty on a daily basis and they were only able to complete routine tasks and were not able to spend quality time with the people who used the service.

On the day of our inspection we found a total of 9 care staff on duty, 3 cleaning staff, a maintenance person and an administration person. We also noted there was an activities co-ordinator on duty during our inspection. The service also employed laundry staff and kitchen staff, including a dining room assistant. The manager and deputy manager were also available to assist throughout the day. We looked at the rotas for a two week period and found that staffing levels were similar to those on the day of our inspection.

We observed the lunchtime period and saw that people who required assistance with eating their meal had to wait long periods of time before a staff member was available to assist them. We found that two staff members were busy doing medicines and two staff members were serving vegetables at a time when people required assistance.

During our inspection we did not observe staff spending time chatting to people who used the service and found that the majority of interactions were taking place during task orientated routines. We spoke with the registered manager to enquire how they assessed their staffing levels and were informed that they informally assessed this through discussions with the deputy manager and staff.

People told us they felt they were cared for by staff members who knew what they were doing. One person told us “They know what they are doing”.

Inadequate

Is the service safe?

We looked at all the records relating to fire safety and found that people who used the service did not have a Personal Emergency Evacuation Plan (PEEP) in place. This meant that people who used the service may not be evacuated safely in the event of an emergency situation. We discussed this with the registered manager on the first day of our inspection and were told they would ensure these were implemented as a matter of urgency. On the second day of our inspection, the registered manager had made steps to put these in place.

We also found that some doors throughout the service including bedrooms doors were wedged open. This presents a significant risk in the event of a fire. **We recommend the service consider contacting the local fire authority for further advice on this.**

We looked at all the maintenance records relating to fire safety and found that regular fire drills took place within the home and fire escapes were checked on a regular basis. We found there was a risk assessment in place dated February 2015. This was completed by an independent company that the service contracted to also undertake regular servicing and checks of the fire systems in place.

We found that all staff members had undertaken fire safety training recently as part of their training. The registered manager informed us that all mandatory training is refreshed within a 12 month period.

People told us they felt the home was clean. One person told us “My room is clean enough to eat off the floor.”

We found the home was clean. We spoke with two housekeeping staff whilst they were cleaning a bedroom. They were able to describe their rota for cleaning rooms, each room having a daily clean and more intense clean every other day and a regular deep clean.

We saw records to show that the services’ water system was tested by an independent company to check for the presence of legionella. There was also a system in place to ensure that shower heads were cleaned on a monthly basis. The registered manager had undertaken a course on legionella and was knowledgeable in this area.

Inadequate

Is the service effective?

Our findings

We found the service was not effective. This was because the registered manager did not fully understand issues around consent and capacity, people were not supported in a timely manner to eat their meal, people's mealtime was interrupted to administer medicines and people who could not eat independently were left for long periods of time with their food going cold. There was also a lack of pictorial signage to support people with dementia to be as independent as possible.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA 2005) sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected. The Deprivation of Liberty Safeguards (DoLS) provides a legal framework to protect people who need to be deprived of their liberty to ensure they receive the care and treatment they need, where there is no less restrictive way of achieving this.

The registered manager informed us that they had been on training in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). They had identified all the people within the service that they felt required a DoLS application being made for them although no applications had been made at the time of our inspection. This meant that people did not have access to independent representation and may be being restricted without the correct procedures being followed.

We asked the manager if there was anyone living in the service for whom a best interests meeting/decision had been made. The registered manager gave us the details of one person who they had held a best interest meeting for and a best interest decision had been made by the registered manager and staff. However, we found that the person had capacity but struggled with communication and therefore we questioned the manager as to why a best interest decision had been made. The registered manager could not explain why this had been put in place and was unaware that this person was able to communicate in non-verbal ways.

This matter was a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they liked the food on offer. One person told us "I like it" and if there was something on the menu they did not like they were offered an alternative.

We found the menu was on a four week rotation and corresponded with the food being served on the day of our inspection. There was a range of choices all of which were of good nutritional value. We saw that regular temperature checks of fridges and freezers were undertaken. We saw that provisions were delivered on a regular basis, mainly on a Monday and Friday, with bread and milk being delivered daily. We saw that kitchen staff ensured stock rotation and appropriate levels of stock were in place.

During the lunchtime meal service 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 noted that tables were laid with napkins and flowers and that music was playing on the radio.

We saw that most of the main course came ready plated and vegetables were being silver served in order to provide people with a choice. However, the consequence of this was that people had finished their food before the vegetables arrived.

We observed one person was asleep at the dining table and food was placed in front of them by a staff member. Nobody returned to support this person eat their lunch until 25 minutes later, at which point the food was likely to have been cold.

We observed another person being assisted to eat their meal by a staff member for a short period before they moved away to do something else. We observed another staff came over to assist and again left shortly after. Staff did not return to assist this person until 35 minutes later at which point the food is likely to have been cold.

We observed that one person had finished their lunch and a staff member approached and asked if they would like some more. However, the staff member did not wait long enough for the person to answer and walked away without giving the person more food.

We saw another care staff member assisting someone to eat their lunch although noted that they did not give the person enough time to finish eating what was in their mouth before attempting to give them some more. We saw that this person had food around their mouth and no

attempt to clean it off was made by the staff member. We also observed that people were interrupted when eating so that eye drops and other medication could be administered.

We saw that a care staff member was going around the dining room asking people what they would like for the lunch the next day. We heard many people stating that they did not know what they wanted for their meal the following day. Taking into consideration that a large proportion of people living in the service had dementia or confusion it might have been advantageous to ask people who used the service at a more appropriate time such as the following day and it would be good practice to use pictorial aids.

We noted that none of the staff members told the people who used the service what was on their plate as they were serving them or asked them if they still wanted the same meal they had chosen the day before.

We discussed some of the above issues with the registered manager who agreed that these issues needed to be addressed.

We spoke to people to ask what times during the day they were offered other drinks or food. One person told us they were offered drinks at 10:30am, 2pm, 6pm and 9pm. We also observed drinks being served with the lunchtime meal. We saw that fresh fruit was available in the dining room and observed staff members offering this to people who used the service during the lunch time period. However, we did not observe drinks of water or juice being made available for people to help themselves throughout the day.

In the afternoon we also observed the staff giving out drinks and biscuits. We noted that staff did not ask people what they would like to drink and saw that staff chose the biscuit, picked it up with their bare hands and passed it to people who used the service. This meant that people's choices were not respected and there was a possible infection control issue.

These matters were a breach of regulation 9 (3) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with confirmed that they had received an induction when commencing employment at Walshaw Hall. The registered manager told us that all staff had to complete this induction training along with other training.

The registered manager informed us that they were responsible for delivering a large portion of the training for staff. Other forms of training included booklets and DVD's. The registered manager informed us that they were looking to source external courses with the local authority for future training needs.

We look at the training matrix for all the staff employed by the service. We found that staff had completed training on a range of topics, such as infection control, food hygiene and fire safety. However, the registered manager informed us that all staff required updated moving and handling training. The registered manager told us that they had been having some difficulty in locating a course for all of the staff. However, during our visit of 7 April 2015 the registered manager informed us they had located moving and handling training and records we looked at showed that all the staff had been booked onto a course in the near future.

The registered manager informed us that a doctor visited the home on a regular basis and would see anyone who used the service if they were unwell. We also found that a district nurse visited the service on a regular basis for those people who required nursing care that the service could not provide, such as for dressings and injections.

We noted there was a lack of appropriate signage for people with dementia. This included a lack of pictorial signs to identify toilet and bathroom facilities as well as a lack of photograph's or other identifying features on bedroom doors. The use of pictures and other visual aids can be helpful in promoting the independence and orientation of people with dementia related needs.

We looked around the home and found communal areas provided a comfortable environment and were in keeping with the features and character of the Victorian building. The bedrooms that we looked at were clean, tidy and personalised. We were told that everyone was able to personalise their room to their own tastes if they wished.

Requires Improvement

Is the service caring?

Our findings

We found the service was not always caring. This was because people were not always treated respectfully.

During our inspection on 7 April 2015 we observed a staff member treat people in an undignified and disrespectful manner. We saw a staff member speak inappropriately to a staff member about a person and manhandle another person as they were 'in the way'. This matter was reported to the registered manager and action was taken to address this concern. This matter was referred to the local authority safeguarding team as a matter of concern by the registered manager and the inspector.

However, people who used the service told us that the staff members were kind. One person told us "They are very good" and another told us "They are very respectful." All the people we spoke with felt the staff members listened to them. During our inspection, we observed staff reassuring people in a sensitive and appropriate manner.

People we spoke with told us their privacy and dignity was always maintained by the care staff. One person told us "My privacy is respected extremely well." Another person told us that one person had come down the stairs that morning and was partially dressed. They reported that staff acted quickly and supported them to go back to their room to dress in order to maintain their dignity.

However, we observed that four people had been sitting in wheelchairs for long periods of time in the main lounge and library. Most of these people had been sitting in their wheelchairs from before lunchtime. We asked the registered manager why people were left in wheelchairs but no explanation was forthcoming. Whilst we did not look at people's records to see if they preferred to remain in their wheelchair, this did not promote the health and well-being of people as they were potentially at risk of pressure ulcers and poor posture.

We spoke with the registered manager to enquire if anyone who used the service had an advocate. The registered manager informed us that she was not aware of anyone having used the advocacy service although they advertised this in communal areas of the service.

Requires Improvement

Is the service responsive?

Our findings

We found the service was not always responsive. This was because care plans did not contain sufficient information.

We looked at the care records of three people who used the service. They did not contain sufficient information to show how people were to be supported and cared for. We also looked to see if the care plans in place were person centred. We found that they did not reflect people's preferences for example what they liked to wear, liked to do, gender preference for care etc. There was also limited information available about people's likes and dislikes. This meant that the care and treatment provided may not be appropriate or meet people's needs.

Inspection of care records provided evidence that not all care plans were kept up to date. We saw one example where there was no up to date pressure ulcer prevention plan, despite the provision of different equipment following a recent deterioration in their pressure ulcers being noted. Similarly the person's pressure ulcer assessment was last updated in December 2013.

We saw a care plan with conflicting information and risk assessments concerning whether or not bed rails should be used. The inappropriate use of bed rails creates a preventable risk to the person, who may injure themselves trying to get out of bed.

Discussion with staff identified someone who needed 'thickeners' added to their drinks to reduce their risk of choking. There was no corresponding written assessment or care plan which addressed this for the individual concerned. We saw that another person did have a written risk assessment and care plan which identified the need for the use of thickeners. However, the record relating to their fluid intake indicated they were being given fluids of a different consistency to that identified as necessary in the care plan.

Accurate care plans must be in place to ensure the correct care is given and that it is consistent and appropriate.

These matters were a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke to people about the activities on offer within the home. One person who used the service told us they had been on a trip to Blackpool to visit the illuminations and had their tea out. Another person told us that they occasionally joined in with activities but did not want to do so on the day of our inspection.

The service had an activities co-ordinator who was on duty on the day of our inspection.

We saw a notice board in the entrance area of the service that detailed all the activities that were occurring throughout the week. These activities included sing-along's, reminiscing reading, violinist, film afternoons, communion every Saturday for people who wished to practice their religion in this way and animal therapy.

We spoke with the registered manager about the lack of stimulation for people with dementia and that we had not seen activities for these people to engage in on the day of our inspection. The registered manager told us that the service did have sensory equipment and things that could be used to engage with people with dementia but they were stored in the attic. We asked why these were not readily available for people to use all the time and were told that the provider has requested for them to be kept in the attic so that they do not make the environment untidy.

We saw that people who used the service had religious care plans in place. On person told us they used to go to church regularly prior to moving into the service and they now get visits from the Methodist church.

Records we looked at showed that every Saturday, within the service, communion took place. The registered manager informed us they were looking into arranging services for people who were of Methodist/Christian and other faiths in the near future.

All the people we spoke with told us they knew who to approach if they wanted to make a complaint. One person told us "I would go to the person in charge, but I have not had to."

We asked people who used the service if they have ever had to make a complaint. One person told us "A few of our phones are not working due to the workmen. It's been a week now, it's a nuisance but they have told me they are going to be fixed." We spoke to the registered manager regarding this. They told us there had been a fault with the telephone provider and not due to building work that was being undertaken. They reported to us that all people's phone lines were currently working.

Requires Improvement

Is the service responsive?

The service had a complaints policy in place dated October 2014 and a copy of this was displayed on the notice board in the main area of the service.

Requires Improvement

Is the service well-led?

Our findings

The service was not always well-led. This was because there were no robust quality assurance systems in place to effectively monitor the service, some policies and procedures had not been reviewed for some time and contained out of date information and the registered manager lacked some knowledge in key areas.

The service had a manager who registered with us on 6 November 2013. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We looked at the quality assurance systems they had in place within the service. We found that there were audits in place for infection control, health and safety, care plans and medication but found these were the only audits in place. The meant the service had no robust system in place to monitor the quality of the service provided to ensure people received safe and effective care or that highlighted the issues we found during our inspection.

We looked at a number of policies and procedures the service had in place including safeguarding, recruitment, infection control, and found that most of these had not been reviewed for some time. We found the recruitment policy contained incorrect, out of date information. We made the registered manager aware of this and they updated this one policy during our inspection. This meant that staff may not have had the correct or up to date information they needed to undertake all their duties.

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

Throughout our inspection and discussions with the manager, we found they lacked sufficient knowledge in key areas such as best interests, medicines and DoLS. They also failed to identify or rectify issues and concerns around the service, such as people not being supported to eat in a timely manner, staff handling medicines and people being left in wheelchairs for long periods of time.

The manager failed to ensure that systems were in place to help protect people against the risks of inappropriate or unsafe care.

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

We checked our records before the inspection and saw that accidents or incidents that CQC needed to be informed about had been notified to us by the registered manager.

There was a recognised management system which staff understood and meant there was always someone senior to take charge. When the registered manager was not on duty the deputy manager was in charge. People who used the service told us they knew who the registered manager was and they felt able to approach them. All the staff we spoke with told us they felt able to approach the manager with any concerns or issues they may have.

The registered manager informed us that staff meetings were held every two months. Records we looked at showed that these were regular and that the registered manager would send out memorandums in between staff meetings if there was any information they felt the staff needed to know.

One staff member told us they had not been able to attend the recent staff meeting, although the registered manager had ensured they had received a copy of the minutes from the meeting so that they were aware of items that had been discussed.

Records we looked at showed that the service had received 'thank you' cards from relatives. One relative had written "Thank you for all the care and love you gave to my [relative]."

The registered manager told us they sent out questionnaires to relatives as a means of gaining feedback about the service. They told us they had recently sent some out and were awaiting more to come back before they collated all the information and analysed this.

We saw that questionnaires were also given to people who used the service. This information was also collated and a graph of results produced. However, the one we looked at did not have a date on so we were unclear when this had taken place.

Requires Improvement

Is the service well-led?

Records we looked at showed that the registered manager held meetings for people who used the service on a monthly basis. Minutes of the last meeting showed actions that had been taken since the last meeting and new items that had been discussed.

One person told us “We said that tea time was too early at 4pm and they changed it to 4:30pm.” Another person told us they were able to discuss what trips they would like to go on during this meeting, or discuss any complaints they may have had.

The registered manager also informed us that they invited relatives into the service for a meal on occasions and invited them on excursions that had been arranged so that they could spend time with their relative. Visiting was not restricted.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The registered provider did not maintain standards of hygiene appropriate for the purposes for which they were being used.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Where meeting a service user's nutritional and hydration needs, there was no regard to the service user's well-being.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance There were no systems and processes in place to ensure the service was assessed, monitored or improved. Complete and contemporaneous records including a record of the care and treatment provided to the service user were not maintained securely.

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	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users must be protected from abuse and improper treatment in accordance with this regulation.

The enforcement action we took:
A warning notice was issued.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users.

The enforcement action we took:
A warning notice was issued.