Warwick Park House Limited

Warwick Park Care Home

Inspection report

17 Butt Park Road
Plymouth
Devon
PL5 3NW

Tel: 01752772433

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection on 22 and 23 March 2016. Warwick Park Care Home provides nursing and residential care for up to 50 older people who require support in their later life or are living with dementia. There were 47 people living at the home at the time of our inspection. At the time of our inspection the provider was involved in a pilot project with the NHS and local hospital, to help rehabilitate people to return home following hospital treatment.

The home is on two floors, with access to the upper floors via stairs or a passenger lift. Some bedrooms have en-suite facilities, whilst other bedrooms have shared toilets, bathroom or shower facilities. There are two lounge/dining rooms, two conservatories, a patio seating area and garden.

There was a registered manager 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.

At the last inspection on 4 December 2014 we asked the provider to take action to make improvements to how they respected and involved people, social activities, and how records relating to people's care were documented. Improvements were also required to help ensure the management of medicines was safe, and there were enough staff to meet people's needs.

The provider sent us an action plan on 7 April 2015 confirming how improvements were going to be made and advising us these improvements would be completed by June 2015. During this inspection we looked to see if these improvements had been made. We found they had not all been completed.

People told us they felt safe living at the service, with one person telling us, "They check on me about every hour, so I know I'm safe enough". People were protected from abuse and harm because staff and the registered manager understood their safeguarding responsibilities. People were not always protected from risks associated with their care because staff did not always have guidance and direction about how to minimise risks relating to people's care.

People lived in an environment which had not always been assessed for risks which could cause people harm. For example, doors which should have been locked to prevent injury, for example a cleaning store was not. Overall, the environment was clean and free from odour; however there were some bedrooms which had a smell of urine.

There was not always enough staff deployed to meet people's needs. Some people did not receive the care they required because their call bells were not answered promptly. People who were unable to use their call bell had to wait for staff to hear them calling out, which meant they may not always receive support quickly. Staff told us staffing levels could vary at times, impacting on the quality of care people received. However,

people did not complain to us about staffing levels with one person telling us, "There is always plenty of staff around if I need anything".

People were complimentary of the food and of the recently employed chef, telling us, "Today it is meatballs, since that chef came we've had marvellous meals, everything is lovely and tasty. I look forward to everything he brings up. In fact if you want extra things he gets them". A member of staff explained, "We went through a few different chefs but the new one he's fantastic. Now he's here the kitchen is finally sorted. He's very approachable, nothing is too much trouble and he gives a lot of variety as well. He will go and chat with people and ask them what they would like if. He's jolly and boosts morale as well".

People's care plans did not always provide detail about how to meet their individual nutritional needs, so staff may not always know how to correctly support people. Documentation which was being completed to monitor how much a person was eating and drinking was inconsistently completed, meaning it was not clear if the person was eating and drinking enough.

People were not protected by the Mental Capacity Act (MCA) 2005 and associated Deprivation of Liberty Safeguards (DoLS). Staff and the registered manager had a limited understanding of the legislative frameworks and of their responsibilities, which meant people's freedom or choices may not always be supported or respected.

People received care from staff who had undertaken training to meet their needs. Staff told us they received enough training commenting, "There's always training courses going on". Nursing staff kept their training up to date to ensure their professional registration with the Nursing and Midwifery Council (NMC) was maintained. There was a management structure in place and staff told us they felt supported.

People told us staff were kind, telling us, "The care and attention is out of this world", "Everybody cares, from the maintenance man to the manager" and "The staff are a good crowd and a good laugh". We found interactions between staff and people varied. On our first day of our inspection there was little positive interaction. For example, staff were focused on carrying out their tasks and did not take time to engage with people. On the second day staff took time to speak with people, showed a tactile approach, and laughed and joked with people. We asked the registered manager about this who said the staff had been upset by the last inspection report which had contributed to their behaviour on the first day.

People's confidentiality, privacy and dignity were not always respected and staff did not always speak with and treat people in a respectful manner. For example, people's bedroom doors were open, so at times people were observed to be exposed lying in their beds. Staff used phrases in front of others to describe people such as, "She is very confused".

People's choices and wishes for the end of their life had not always been documented. This meant staff may not know how to meet people's individual needs. People did not always receive their medicine safely.

People were not involved in the creation and implementation of their care plan, so people's care may not be delivered in line with their wishes and preferences. People's care plans did not always give staff guidance and direction about how to meet people's needs.

People's changing care needs were referred to health services in a timely manner to help ensure they received responsive care and treatment. One person told us, "When I first came out of hospital I couldn't eat anything, and now I can walk out into the garden for a smoke on my own, so I'm progressing". The registered manager and nursing staff worked in partnership with external professionals to help ensure people's health

care needs were met.

People told us there was not always enough to occupy their time, commenting "It's ok in here but there's not much to do" and "I am bored silly". There were no activities for people on the first day of our inspection, but on the second day a spontaneous game of catch was organised by staff which people enjoyed.

People were asked their views and opinions by completing questionnaires, one person told us "They used to do tea at 4pm or 4.30pm, but they listen to what we say to them and now it's a bit later". People told us if they had any complaints to make they would feel confident to do this. One person told us, "I have no complaints about the staff; they look after me in the way I would like". The registered manager had a complaints policy which was followed when a complaint was raised. Complaints were used as a learning opportunity, and the registered manager apologised and was honest when something had gone wrong. This reflected the provider's responsibilities under the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

The provider did not have effective processes in place to monitor, assess and improve the service provided to people. Required improvements were not identified quickly to help ensure action was taken promptly.

We found breaches 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always protected from risks associated with their care and documentation relating to this did not reflect people's individual needs.

People were not always protected from risks associated with the environment.

People did not always live in an environment free from odour and infection control practices were not always followed.

There were not always enough staff to meet people's needs.

People did not always receive their medicine safely.

People told us they felt safe.

Staff knew what action they would take if they suspected abuse was taking
place.

Is the service effective?

Requires Improvement

Aspects of the service were not always effective.

People liked the food, but people's care plans did not always provide detail to staff about how to meet people's individual needs.

People were not protected by the Mental Capacity Act (MCA) 2005 and associated Deprivation of Liberty Safeguards (DoLS), which meant people's freedom or choices were not always supported or respected.

People received support from staff who had the necessary knowledge, skills and training to meet their needs.

People's changing care needs were referred to relevant health services in a
timely manner.

Is the service caring?

Requires Improvement

Aspects of the service were not caring.

Staff did not always speak with and treat people in a respectful manner.

People's confidentiality, privacy and dignity were not always respected by staff.

People's choices and wishes for the end of their life had not been considered or communicated to staff. This meant staff may not know how to meet people's individual needs.

People told us staff were kind.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive.

People were not involved in the design and implementation of their own care plans which meant care planning documentation was not reflective of their
wishes.

People's care plans were not individualised and did not provide guidance and direction to staff about how to meet people's care needs.

People told us there was not enough to occupy their time.

People told us if they had a complaint they would feel confident to speak with staff. The provider had a complaints procedure in place which they followed to help ensure people's complaints were investigated and responded to in a timely manner.

Is the service well-led?

Requires Improvement

Aspects of the service were not well-led.

The provider did not have effective processes in place to monitor, assess and improve the service provided.

There was a management structure in place and staff told us they felt
supported by the registered manager.

The registered manager worked in partnership with external professionals to help ensure people's health care needs were

met and a co-ordinated approach was taken.

Warwick Park Care Home

Detailed findings

Background to this inspection

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

We visited the home unannounced on 22 and 23 March 2016. The inspection team consisted of three adult social care inspectors, a specialist nurse advisor of older people's care, a pharmacy inspector, and an expert by experience – this is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection we reviewed information we held about the home. We reviewed notifications of incidents the provider had sent us since the last inspection. A notification is information about important events, which the service is required to send us by law. We also looked at the provider's action plan they sent us following our last inspection. We also contacted health and social care professionals.

During our inspection we spoke with 16 people living at the care home, three relatives/visitors, 10 care staff, three nurses, two cleaners, a housekeeper, the laundress, a chef, a kitchen assistant, a maintenance man, and the registered manager.

We observed care and support in the lounge and dining rooms, and watched how people were supported during lunch. We also 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 spoke with people in private and looked at 14 care plans and associated care documentation. We pathway tracked three people who lived at the home. Pathway tracking is where we follow a person's route through the service and capture information about how they receive care and treatment. We also looked at 11 medicine administration records (MARS), as well as documentation relating to the management of the service. These included policies and procedures, audits, staffing rotas, training records and quality assurance and monitoring paperwork. We assessed and reviewed the safety and cleanliness of the environment.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in December 2014 there were not enough staff to meet people's needs and medicines were not being managed safely. The provider sent us an action plan detailing how they would make improvements. At this inspection we found that improvements had not been made.

People's needs were not always met because staff were not always available. Particularly during the morning staff were focused on personal care tasks, and did not have time to stop and have meaningful conversations with people.

One person, who was cared for in bed had been incontinent. The person called out for help at 10.30am, however there was no staff around to hear them. We spoke with a member of care staff at 10.40am and again at 10.55am to inform them the person required assistance. However, staff did not assist the person until 11.00am. The registered manager said they were disappointed about this, but told us the reason for the delay was because there had been an emergency and staff had been busy elsewhere. Another person rang their call bell at 9.40am to request to get up; however, their call bell was not answered. The person's call bell continued to ring until we informed a member of staff at 10.00am.

Whilst some staff told us there was no problem with staffing levels, others commented, "Staffing levels can be short. Especially due to sickness and people having high care needs. It can impact on waiting times and we can't get to people as quickly as we should" and "We need more staff to achieve person centred care. It's not achievable if we are short staffed". Our SOFI showed staff looked busy, stressed and disorganised. The registered manager had a staffing dependency tool which was used to help ensure there was enough staff to meet and respond to people's needs. However, the tool was not effective in ensuring people's needs were being met by sufficient numbers of staffing.

People's individual needs were not always being met because there were not always sufficient numbers of staff deployed. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were cared for in bed did not always have the capability to use a call bell and/or did not always have a call bell in reach to alert staff when they required support. So people had to call out for assistance or wait for staff to visit their bedroom, meaning people were at risk of not receiving the care or support they needed. For example, one person was calling out for assistance. When we entered their bedroom we found their call bell was out of their reach. We were told by staff, that the person was unable to use a call bell. However, when the call bell was provided, the person pressed it independently.

People did not always receive their medicines safely. Gaps on people's medicine administration records (MARS) meant it was not possible to check people were getting their medicines as prescribed, this included antibiotics. People's medicine records did not record their allergies, so this meant people could be given a medicine they may be allergic to because information was not immediately available.

Soluble medicines that needed time to dissolve were left in people's bedrooms. However, we were told by a nurse that sometimes the staff threw them away. This meant people may not be receiving the medicine they need.

People did not have records in place to provide guidance and direction to staff about where to apply their topical medicine (cream). This meant there was a risk people's cream was not being applied correctly or in line with prescribing guidance.

Medicines prescribed to be taken when required, such as, to help control people's pain were not always given. For example, one person was heard to be shouting for staff because they wanted to take their painkillers at 11.50am, but were given their medicine half an hour later when the medicine round took place. This meant people may not always get their pain relief when they needed it, but instead received it when the medicine round took place.

Medicines were not always stored safely or securely. The fridge did not store medicines at the correct temperature to ensure they were effective. Liquid medicine that should have been stored in the fridge after opening was stored at room temperature.

The stock control of people's medicines was not safe or effective. For example, medicines that expire more quickly after opening did not have a date of opening recorded on the bottle, which meant the medicine may not be suitable for use or may not be as effective. We found medicine, which was prescribed to control a person's epileptic seizures was not in date, which meant if the person had a seizure, the medicine may not be effective in controlling it.

The storage of medicines was not always being managed to ensure it was in line with prescribing guidance. Medicines were not always stored safely or securely. For example, folic acid 2.5mg/5ml liquid that should have been stored in the fridge after opening was stored at room temperature. Medicines stored in the fridge were not always stored at the correct temperature to ensure they were effective. For example, refrigerated medicines which should be stored between two and eight degrees centigrade showed they had been stored above eight degrees centigrade.

People received their medicines by staff who followed correct medicine administering procedures. For example, people's MARS were signed after the person had taken their medicine, to ensure records were accurate. People were asked if they were ready to take their medicine and people were provided with a drink to take their tablets.

People did not always receive their medicines safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always live in an environment which was free from odour. Some people's bedrooms had a malodour because of continence needs. Cleaning schedules showed carpets had been cleaned, however we were told it was difficult to clean some people's carpets as they did not wish this to happen.

Staff had received infection control training, however did not always put their knowledge into practice. For example, the sluice room was left unlocked and was cluttered, meaning there was a risk of cross infection. Action was taken to rectify this by the second day of our inspection; however the door still remained unlocked. Laundry bags were colour coded to help prevent the spread of infection and the laundress spoke confidently about the importance of ensuring soiled laundry was kept separately.

Infection control practices did not ensure the prevention, detection and control of the spread of infections. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
People were not always protected from risks associated with their care. One person had been identified as not eating and drinking enough. However, documentation regarding this was incomplete and did not demonstrate what action was being taken, to help ensure this person's needs were being effectively met. People who were cared for in bed had risk assessments in place to help prevent isolation. However, from our observation and from reading the daily records of two people, there was no evidence to demonstrate the risk assessments were being followed.

People's risk assessments were not always in place as necessary, followed, updated, and reviewed effectively. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had risk assessments in place relating to their skin and these detailed people's current care needs, the action required of staff and were reviewed when changes occurred. This helped to prevent and minimise people's skin from becoming damaged. People who were at risk of falling had risk assessments in place to reduce the likelihood of them causing themselves injury. The registered manager reviewed falls and accidents on a monthly basis to help identify themes and to take preventative action.

People were not always protected from risks associated with the environment. For example, hot water was not always regulated to ensure that it did not scald people; although action was being taken to address this at the time of our inspection.

Doors which should have been locked to stop people from entering them were not always locked, for example the sluice room, the kitchen and a room which stored cleaning products. Some bedroom doors were manually propped open with door wedges, and some instant release fire mechanisms which should close doors in the event of a fire, were not working. This had not been considered in line with fire regulations and the home's fire risk assessment. The registered manager told us the fire risk assessment which was dated 2011was in the process of being updated.

Risks had not always been assessed and monitored in respect of the environment. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's personal evacuation needs had been documented which meant in the event of a fire emergency services would know what level of care and support people may need. Records were in place which showed the fire system had been checked to make sure it would sound in the event of a fire. Manual handling equipment, such as hoists had been serviced regularly to ensure they were safe for people and staff to use.

People told us they felt safe with one person commenting, "They check on me about every hour or so, so I know I'm safe enough" and another telling us, "It's safer than being in a hotel and I know everybody here".

Staff told us what action they would take if they suspected abuse was taking place. Staff told us they would have no hesitation in reporting it to senior staff or to the registered manager. The registered manager was knowledgeable, and aware of the local authority safeguarding process.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act (MCA) 2005 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. Some people were living with dementia. People's care plans did not always contain guidance and directions for staff about how to support people when they did not have the capacity to make decisions for themselves. For one person who had been living at the service for five weeks and was reluctant to receive support, a mental capacity decision assessment was in their care plan; however it had not been completed. A member of staff told us they had to make best interests decisions when the person declined any intervention with their personal care, however, there were no records of these conversations.

People who may be deprived of their liberty had not been assessed, which meant their human rights may not be protected. The deprivation of liberty safeguards (DoLS) provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The registered manager and staffs understanding of the legislative framework was limited, with one member of staff describing DoLS as "Anything that isn't person centred" and another who told us it was related to the resuscitation of people. Some people were not free to leave because of their mental capacity; however the registered manager had not made DoLS applications. People's consent was obtained prior to staff assisting them or before receiving care and treatment.

The legislative framework of the Mental Capacity Act (MCA) 2005 and associated Deprivation of Liberty Safeguards (DoLS) were not being followed. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans did not always provide detail to staff about how to meet people's individual nutritional needs. Food and fluid charts which were in place to monitor how much a person was eating and drinking were not always completed, or reviewed to ensure a person was eating and drinking enough. For one person whose care plan stated they were at nutritional risk, their charts had been inconsistently completed and there was no information in the person's care plan about how much they should be eating or drinking.

People's weight was being monitored and recorded, however documentation was not always fully completed. For one person whose care plan stated they were at high nutritional risk, the person's malnutrition universal screening tool (MUST); a tool which is used to measure a person's weight by a calculation of a person's BMI had not been fully completed. This meant the response, by staff to this person's care may not have been correct due to incomplete information.

People's individual needs may not always be met in respect of nutrition and hydration. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were at risk of choking had care plans and risk assessments in place to provide guidance and

direction to staff. External health professionals, such as speech and language therapists were consulted and their advice followed. In response to people's feedback, the registered manager had recently employed a new chef and people were highly complimentary
of the menu changes which had taken place. People told us, "The food is that good I've had two dinners today, and a pudding", "The food is good, it's fresh and there is plenty of it", "They offered me fish finger butties one day which is my favourite", "The food here is beautiful, you can have whatever you like" and "The food is very good, but I didn't fancy what was on offer today so they made me cheese on toast".

Food was plentiful, looked appetising, was freshly prepared and there was lots of choice on offer. The chef told us, he spoke with people about what they would like on the menu and told us, "For some people, the food may be all they have to look forward to, so it's got to be appetising and tasty". They also explained, "I like to get to know people and what their likes and dislikes are…in general if they want it, I get it and make it for them".

The chef had a caring attitude towards the people living at the service and would get food in stock that they asked for, such as haggis and black pudding. Some people, because of their individual health needs required a pureed diet but the chef told us he tried to ensure their food always looked appetising.

People confirmed and records showed they had access to external health professionals, such as GPs and district nurses.

People were supported by staff who had received an induction to the organisation and were enrolled on the care certificate. The care certificate is a national induction tool which providers are required to implement, to help ensure staff work to the desired standards expected within the health and social care sector. Staff told us there was good access to ongoing development and they were supported and given opportunities to attend training, such as dementia and moving and handling.

Nursing staff knew about the Nursing and Midwifery Council (NMC) revalidation process and there was documentary evidence to show a member of the Royal College of Nursing (RCN) had visited the home to speak about the revalidation process. The revalidation process is to ensure nursing staff are appropriately qualified and competent to practice as a nurse. Nursing staff had undertaken training in areas such as the verification of death and skin care.

Staff told us they felt supported, attended staff meetings but did not receive formal one to one supervision or appraisals. The registered manager clarified, rather than one to one meetings, group supervision was carried out as part of the staff meeting. Supervision is a process by which a person reflects on their work performance and identifies training and development needs.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in December 2014 people were not always respected and involved in their care. The provider sent us an action plan detailing how they would make improvements. At this inspection we found improvements had not been made.

During our first day of inspection there was very little positive interaction between staff and people. Staff did not have time to speak with people and were focused on their care and domestic tasks. Our SOFI showed staff often did not acknowledge people. For example, walking through the lounge and not engaging in conversation. One person had become upset after their relative had left. The person began to cry and was seeking reassurance, however staff walked past, not noticing they were upset for over 45 minutes. After this time, a member of staff did notice and dried the person's eyes. They asked what was wrong offering to take the person to their bedroom, and asking what would make them feel better. The person was visibly reassured by the kindness shown.

People were not always treated with respect and patience. One person was calling out for their lunch so we alerted staff. The member of staff said in front of the person, "She is very confused". When we left the room we heard the person ask the member of staff for another cup of tea. The staff member impatiently responded by saying "You've already got one", the person replied "Don't shout at me".

People who were cared for in bed and were unable to use their call bell were not frequently checked to help ensure they were not distressed. For example, two people called out for 20 minutes requesting help and acknowledgment. One person commented, "The staff make me feel as though I'm being a nuisance".

People's privacy and dignity were not always promoted. For some people their legs or bodies were left exposed whilst their bedroom doors were open and one person was sat on a toilet with their bathroom and bedroom door open. We saw some staff knocked on people's doors prior to entering, but this did not occur at all times.

People's choice and independence was not always promoted. For example, when tea and coffee was served, people were not offered which biscuits they would like; these were chosen by the member of staff. One person had requested a different drink to tea and coffee but was told this was not possible. A short while later, the person asked a different member of staff who made it for them.

People were not always treated with respect and consideration, and their privacy and dignity was not always maintained. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's end of life care wishes were not always recorded, so staff may not know what to do or decisions to make at the end of a person's life, to help ensure they received the care they wanted. Nursing staff had received training in respect of the verification of death, which helped to ensure a co-ordinated approach was achieved with external agencies, such as GPs at the end of a person's life.

People's care records were not always complete, contemporaneous, or an accurate record of the decisions taken regarding their care. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans did not always include a personal history so staff were aware of what a person achieved in life prior to getting older and moving into the service. A person's history helps to enable staff to have meaningful conversations with people and tailor social activities to
people's past interests and memories. This is particularly important when supporting people who are living with dementia.

Staff were focused on completing tasks rather than listening to and involving the person. For example, one person requested to get up at a certain time, however, their request was not acknowledged as staff were busy supporting others.

We spoke with the registered manager at the end of our first day about the lack of positive interactions between people and staff. The registered manager told us staff found the inspection process difficult and were upset with the last inspection report, but told us she would speak with the staff team.

During our second day of inspection, interactions between staff and people had improved. There was a calmer atmosphere with staff taking time to speak with people. Kindness was shown, staff were observant to people's needs, and they used appropriate humour in conversations, which made people laugh. One member of staff had noticed one person did not look comfortable sitting in their chair. The member of staff patiently tried to work out what was wrong by asking questions, and reassured them they would get staff to help assist them back to their bedroom.

People told us staff were kind their comments included, "I find all the staff are very helpful, very kind and very helpful", "The care is very good, when I first came here I wasn't too good, their attitude, and the way the staff work as a team helped…they're always very helpful, nothing is too much trouble", "All of the staff are very kind" and "The staff are angels without wings".

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in December 2014, people were not protected from the risks of unsafe or inappropriate care because accurate and appropriate records were not maintained. People also told us there was a lack of meaningful social activities. The provider sent us an action plan detailing how they would make improvements. At this inspection we found that improvements had not been made.

People's care plans were not always descriptive about how people's needs should be met. For example, one person's care plan detailed they were unable to express their "needs or expectations"; however, there was no information about what this meant for staff, or how the person should be supported because of this. People's care plans did not reflect a personalised approach to care; they were mainly based on health and nursing care rather than the individual person, such as their likes and dislikes, choices and preferences. An external health professional told us, they felt documentation was not always in place relating to people's care and associated risks and that they had raised this with the registered manager.

People's care plan and records did not always provide clear guidance and direction for staff. This meant people's care may not meet their needs or be in line with their wishes. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care records were not always accurate and did not always provide clear guidance and direction for staff. This meant people's care may not meet their needs or be in line with their wishes. For example, one person's care plan stated they were at high risk of skin damage. Their care plan stated, "re-positioned at regular intervals during the night". However, there was no definition of what "regular" was. We spoke with the registered manager who confirmed this meant "every two hours. However, the re-positioning charts put in place to record and monitor when they had been re-positioned, to reduce the likelihood of their skin breaking down showed the person had not been re-positioned every two hours as required. For example, on 21 March 2016 they had been re-positioned at 3am, 7.45am, 8am, 7pm, and 11pm.

People's care records were not always accurate and did not reflect the care being provided. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us there was not always enough to do, comments included, "I don't know about activities, I don't like the lounge, but one of the girls has offered to take me to the Kentucky Fried Chicken, cos she heard I like that!", "I am bored silly…this is one of the loneliest places I have ever been, especially this room" and "It's ok in here but there's not much to do". One person told us they did not like to sit in the lounge because they did not like the atmosphere, they told us "People (who lived at the service) swear and use bad language".

People were not offered any social activities on the first day of our inspection. People spent time in their rooms or in the lounge with the TV on. People were not asked what TV channel they would prefer to watch; the same TV channel remained on through-out the day. The registered manager acknowledged that improvements were required in respect of social activities and they were looking at better ways of achieving

this.

On the second day of our inspection, throwing games in the lounge were facilitated by a member of staff. People were encouraged to join in and their contributions were praised and valued. The hilarity between people and staff showed enjoyment was being had. A member of staff was asked to pop out and purchase some sweets as prizes; these were handed out and enjoyed by people in celebration of their achievements.

Staff told us, if a person's health needs changed they would promptly speak to the necessary external agencies, such as GPs, district nurses, speech and language therapists (SLT) or dieticians. Staff felt there was a good knowledge base within the team, they knew people well and were quickly observant of any changes. One member of staff commented, "I would involve a GP if someone fell ill. If there was an accident I would complete accident forms and refer to whoever needed to be informed. If someone had chest pains it's always 999".

People told us, if they had any concerns or complaints, they would speak with the registered manager, staff or their relatives. One person described how a member of staff had been unkind to them, so they had reported it and action had been taken. People had a copy of the complaints procedure which was kept in their care plans. However, the complaints procedure may not have been in a suitable format for everyone. For example, people with visual impairments or dementia. Complaints had been investigated in line with the provider's policy; however, it was not clear if the person had been satisfied with the outcome. The registered manager told us this would be documented in the future.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in December 2014 the quality monitoring system was not effective in identifying areas that required improvement. The provider sent us an action plan detailing how they would make improvements. At this inspection we found that improvements had not been made.

People did not always receive a high standard of quality care. The provider did not have effective monitoring systems and processes in place in respect of the planning of people's care and meeting people's individual needs, staffing, infection control, the management of medicines, the environment and the implementation of the legislative framework The Mental Capacity Act (MCA) 2005 and associated Deprivation of Liberty Safeguards (DoLS).

Although the provider had some systems to monitor the service, such as medicine, staffing levels, care plan and infection control audits, these had not been effective in identifying areas requiring improvement. For example, care planning audits had not identified people's care records were not always accurate and did not reflect the care being provided.

The systems in place to assess and monitor the quality of service people received were not effective. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of our inspection the atmosphere in the home was tense and staff were reluctant to speak with us. The registered manager told us this was because staff had been upset by the last inspection report. We spoke with the registered manager about their responsibility of helping staff understand the inspection process, and the consequence that staffs negative behaviour could have on people and on the outcome of an inspection. The registered manager told us she would speak with staff about their behaviour before we returned on our second day.

People spoke positively about the registered manager and told us, "The manager's very nice" and "All the girls and management are more than attentive". A relative told us, "I live away but I'm always kept informed about my relative".

Staff felt the service was well managed, and commented, "There have been a lot of changes and it's a lot better. There's more management than there was before" and "She (the registered manager) is fair, hard going when it needs to be done. She makes sure we are doing what we're supposed to be for the residents".

The registered manager had apologised to people when things had one wrong. This reflected the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

The service had been awarded the Dementia Quality Mark by the local authority in 2015. The aim of the Dementia Quality Mark is to ensure services provide good quality dementia care. The registered manager

worked in partnership with external professionals to help ensure people's health care needs were met and a co-ordinated approach was taken.

People were asked their views and opinions. For example, a recent questionnaire had been completed to find out what people thought of the food and the menu was being adapted. One person told us, "They used to do tea at 4pm or 4.30pm but they listen to what we say to them and now it's a bit later"

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with respect and consideration, and their privacy and dignity was not always maintained. Regulation 10 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 The legislative framework of the Mental Capacity Act (MCA) 2005 and associated Deprivation of Liberty Safeguards (DoLS) were not being followed. Regulation 11 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations 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 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 (1) (a) (b) (c) (2) (3) (b) (i) of the Health and Social Care Act 2008 (Regulated Activities) Documentation required to support people in relation to their nutrition and hydration was inaccurate leading to people's individual needs not being met. People's care plan and records were not always reflective of the care being delivered and did not always provide clear guidance and direction for staff. This meant people's care may not meet their needs or be in line with their wishes.

The enforcement action we took:

We issued a warning notice to be met by 18 June 2016.

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 Regulation 12 (1) (2) (a) (b) (g) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Infection control practices did not ensure the prevention, detection and control of the spread of infections. Medicines were not managed properly or safely. Risk assessments were not always in place to mitigate risks and to help ensure people were protected from risks associated with their care.

The enforcement action we took:

We issued a warning notice to be met by 18 June 2016.

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 Regulation 17 (1) (2) (a) (b) (c) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The systems in place to assess, monitor and improve the quality and safety of the service people received were not effective. People's care records were not always complete, contemporaneous or an accurate record of the decisions taken regarding their care. Risks had not always been assessed, monitored and mitigated in respect of the environment.

The enforcement action we took:

We issued a warning notice to be met by 18 June 2016.

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 Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's individual needs were not always being met because there were not sufficient numbers of staff deployed.

The enforcement action we took:

We issued a warning notice to be met by 18 June 2016.