Lifestyle (Abbey Care) Limited

Lifestyle(Abbey Care) Limited Archery Bower

Inspection report

Abbey Care Village,
Scorton,
Richmond,
North Yorkshire,
DL10 6EB
Tel: 01748 811971
Website: www.abbeycarevillage.co.uk

Date of inspection visit: 22 July 2014
Date of publication: 28/01/2015

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

This was an unannounced inspection carried out on 22 July 2014.

Since May 2013 the provider had breached one or more regulations associated with the Health and Social Care Act 2008. At an inspection in August 2013 we found the provider did not have an effective system to assess and monitor the quality of service that people received. At the

Summary of findings

last inspection in March 2014 we found the provider still did not have an effective system to assess and monitor the quality of service that people received and they did not have appropriate arrangements in place for managing medicines. We told the provider they needed to take action and asked them to send us a report by 29 April 2014, setting out the action they would take to meet the standards. We did not receive a report of these actions. At this inspection we found improvements had not been made with regard to these breaches. We also found additional areas of concern.

Lifestyle (Abbey Care) Limited Archery – Bower provides nursing care and accommodation for up to 60 older people which includes a dementia care service. There were 26 people staying at the home when we visited. The home has four areas three were operational at the time of the visit and one unit was closed. Each unit has a lounge and dining room. All accommodation has en-suite facilities.

Although an acting manager had been in post for the last eight months, the provider had not ensured this person applied to be the registered manager. This is a breach of their conditions of registration and we are taking action separate to this process. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

We saw that people received appropriate assistance to eat and drink, and enjoyed their lunchtime meal. However, we found the provider's catering budget did not afford the opportunity to provide adequate fresh fruit and vegetables or for additional high calorific food to be made for people at risk of losing weight. Staff were not always identifying when people were losing weight. People's nutritional needs were not being met.

People's safety was compromised in a number of areas. During this inspection we found that people's needs were not always fully assessed and at times staff failed to identify when people who used the service were at risk, for example of losing weight. Care planning was not always personalised so we could not be sure care was centred on people's needs and preferences.

When we visited the home, people who used the service and their relatives told us they were happy with the service they received. People told us they were well cared for. We observed staff supporting people throughout the day and saw staff were caring, attentive and chatted to people when they provided assistance. Staff communicated with people in a respectful way.

People did not receive their medicines at the times they needed them and in a safe way. Medicines were not administered and recorded properly.

Staff were unclear about their roles and responsibilities in relation to safeguarding people. The management team had identified through recent safeguarding cases that staff did not understand safeguarding vulnerable adults procedures; Mental Capacity Act and Deprivation of Liberty Safeguards. Staff had not had the training necessary to deliver treatment to an appropriate standard.

Staff were not meeting the requirements of the Mental Capacity Act 2005, which meant people who lacked capacity were not being supported to ensure they received appropriate care. The provider had not made an application under the Mental Capacity Act Deprivation of Liberty Safeguards even though people's liberty may have been restricted.

Although the acting manager was trying to make improvements in the systems for monitoring the service, the overall leadership and management of the home was poor. The provider did not have a system in place to effectively monitor the quality of the service or drive forward improvements. Staff we spoke with said the provider had not checked how the home was operating or spoken to them about the service. People had asked the provider to go to their last two 'resident and relative' meetings but they had failed to attend. Annual surveys were not completed. The provider had not completed any records to show they had completed quality and monitoring visits.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the 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?

Inadequate

We found the service was not safe. Although people said they felt safe, we found risks to people were not appropriately managed. For example, some people had lost weight and steps were not always taken to ensure they received appropriate care at the appropriate time to manage the risk.

People were not appropriately supported to make decisions. Care plans did not contain enough information about what decisions people were able to make or how to support them to make decisions. Where people lacked capacity, the restrictions that staff and the provider had put in place may amount to a Deprivation of Liberty but had not made an application under the Mental Capacity Act Deprivation of Liberty Safeguards.

People did not receive their medicines at the times they needed them and in a safe way. Medicines were not administered and recorded properly.

However, we found there were sufficient staff to meet people's needs.

Is the service effective?

Inadequate

We found the service was not effective. Staff were not supported and did not receive appropriate training. This meant people were at risk of receiving care from staff who were not equipped with the right knowledge and skills.

Although people told us they were happy with the meals, we found people's nutritional needs were not always met. The catering budget was not sufficient to buy adequate supplies that ensured people had a nutritious and varied diet.

However, we found people received appropriate support with their healthcare and a range of other professionals were involved to make sure people's healthcare needs were met.

Is the service caring?

Good

We found the service was caring. We spent time in the communal areas and observed staff interactions with people who lived in the home. We saw staff were kind and considerate with people.

People we spoke with said they were happy with the care they received. People were complimentary about the quality of staff.

Staff we spoke with told us how they maintained people's privacy and dignity when assisting with intimate care, for example by making sure doors were closed and knocking before entering rooms.

Is the service responsive?

Requires Improvement

We found the service was not responsive. Care plans were not specific to the person and clear instructions for care delivery were not provided.

Summary of findings

People's needs were not always assessed so needs were not identified and managed. Care plans were not always specific to the person and clear instructions for care delivery were not provided.

The provider had not taken appropriate action to gather the views of the people using the service or others.

Is the service well-led?

Inadequate 

We found the service was not well led.

Systems to monitor the quality of the service were not completed in line with the required frequency and were not effective. For instance, we found a number of errors were being made in the administration of medication such as mislabelling medication, not signing for medicines given or not ensuring medicines were returned but the relevant audit had not identified these issues.

The provider had no systems in place to oversee that the home was delivering care and support effectively and in a way that met people's needs.

Lifestyle(Abbey Care) Limited Archery Bower

Detailed findings

Background to this inspection

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

The inspection team consisted of two inspectors, a pharmacist inspector, a specialist advisor and an expert by experience in older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Before the inspection we reviewed all the information we held about the home. We also looked at a provider information return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we used different methods to help us understand the experiences of people who lived at the home. We spoke with ten people three visiting relatives, and eleven staff including care workers, ancillary staff, the nurse in charge, senior care workers and the acting manager. We looked around the home and observed how staff interacted and how people were supported. We looked at five people's care records and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

We found the service was not safe. Our records showed there had been 11 incidents where abuse or allegations of abuse had occurred at the home in the last 12 months. This included medication errors, allegations of neglect, financial abuse and incidents between people who used the service. Some had been reported to the local safeguarding authority by the home and some by other agencies. One was raised by the Care Quality Commission (CQC) following an inspection. The acting manager said they recognised they had not always responded appropriately to safeguarding incidents but were taking action to make sure they reduced the risk of repeat events.

When asked if they felt safe all the people we spoke with said yes. People knew what to do if abuse or harm happened to them or if they witnessed it. They said they would talk to staff or the acting manager.

Staff we spoke with did not always have a good understanding of safeguarding of vulnerable adults. For example, three members of staff said they thought this related to the general safety of people who used the service and staff rather than it relating to abuse. Other staff understood what constituted abuse. All staff informed us that they would report any allegations of abuse. They were confident the acting manager would respond appropriately to any concerns raised.

Staff we spoke with said they were unclear about the Mental Capacity Act and DoLS authorisations. We asked the nurse in charge if anyone at the home was subject to a DoLS authorisation. They said they were unsure if anyone was, but as they had not received the relevant training the acting manager would be responsible for any applications.

We looked at people's care records. These showed that people needed support to make decisions. However, care plans did not always include information about what decisions the person was able to make. Neither did they provide information about how to support people to make decisions. The Mental Capacity Act 2005 and accompanying Code of Practice highlights that steps should be taken to assist people to make decisions and the decisions people can make should be recorded. This information was not available and is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Although people who used this dementia care service were not free to leave the home and were subject to constant supervision no one was subject to a DoLS authorisation. Staff were unaware that the restrictions they imposed on people's lifestyles could be deemed as a deprivation of liberty and that prior to preventing people carrying out everyday tasks they needed to risk assess the situation. The provider had not made an application for DoLS authorisations even though people's liberty may have been restricted. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We talked to staff and management about risk management. Staff said safety checks were carried out to manage risk and gave examples of these which included, fire tests, bed rail checks and water temperature checks. Staff said they also completed charts when they delivered care, such as turning people in bed, and food and fluid intake to show risks to individuals were being appropriately managed. However, when we reviewed some of these records we found they were not completed consistently.

During the inspection we observed there were four occasions where staff assisted people to transfer using moving and handling equipment. The experience was positive for people on three of those occasions. But on the other occasion it was not a positive experience. The person told the members of staff they were in pain because their leg was hurting when they were being hoisted. The person told us the strap was too tight. Staff reassured the person and were very kind in their approach. However, we found they were using a small sling which staff acknowledged was the incorrect size. We asked to look at the person's moving and handling risk assessment but were told this could not be located. Staff and the acting manager checked the person's care file and the electronic file but were unable to find it. This meant the home could not show the person's needs were assessed or met. This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We reviewed the needs of a variety of people within the home and saw that three people had lost a significant amount of weight. In two of the three people's records staff had completed a MUST (Malnutrition Universal Screening Tool) but this was done incorrectly and had therefore miscalculated the amount of weight lost and risk. For example, one person's record showed a correct calculation

Is the service safe?

would have prompted an 'active response' such as a dietician referral. We reviewed the dietary monitoring records for people who were at risk of losing weight but found these were not always accurate as staff had not completed all the entries or been precise about the amounts of food and fluid an individual had taken during the day. This meant risks to people were not properly assessed or managed therefore people were not protected. This is a breach of Regulation 9 and Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At the last inspection we found the home had introduced a number of systems to improve the quality and safety of the service, which included developing risk assessments. At this inspection the acting manager said they had continued to improve systems to show risks were identified, monitored and managed but recognised they still needed to make further improvements before they could be confident the systems were working effectively.

We saw that the acting manager was identifying when repairs needed to be completed. However, the provider was not taking action in a timely manner to address the issues the acting manager had identified. For example, on 30 June 2014 the dishwasher, on one unit, had been noted to be broken; there was an intermittent fault on one high/low bed and the base doors on one of the unit's kitchenette were missing. No action had been taken to repair these faults. The acting manager had no contact details for any of the contractors, which she could either action repairs or ensure annual servicing was completed on time. This meant although risks were identified, the provider did not manage those risks which related to the health and safety of people who use the service and others. This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We have taken enforcement action because the provider was breaching this Regulation.

People we spoke with told us they felt there were enough staff available to give them the support they needed and no concerns were raised about the staffing levels. In two of the three units we observed there were sufficient staff to meet people's needs and keep them safe. In the third unit we observed lunch and saw people had to wait for their meal. During the meal time there were occasions when staff were unable to observe other people in the unit. Staff told us the unit would benefit from an additional member of staff but said the current levels kept people safe. Staff we spoke with felt staffing levels were sufficient to meet people's needs.

The home is registered to provide accommodation for up to 60 people but at the time of the inspection only 26 people were using the service. Two staff said they hoped staffing levels increased when the number of people living in the home increased. At the last inspection we were given assurance that staffing levels would be reviewed in accordance with dependency levels and any increase in occupancy. The acting manager said this assurance still applied.

Two staff said they went through a robust recruitment process before they started working at the home. They were interviewed and asked questions about their relevant experience. They said a number of checks were carried out before they could start work which included obtaining references and a criminal records check.

At our inspection in March 2014, we were concerned because the provider did not have appropriate arrangements in place for managing medicines. We told the provider they needed to take action. At this inspection we found the provider still did not have appropriate arrangements in place and administration of medication practices were still concerning.

Medicine stocks were not properly recorded when medicines were received into the home or when medicines were carried forward from the previous month. There were some gaps on people's medicine records where the records had not been signed to show that the medicine had been taken as prescribed. If the dose had been omitted staff had not recorded the reason for this. For medicines with a choice of dose, the records did not always show how much medicine the person had been given at each dose.

The records which confirmed the application of creams and other topical preparations were incomplete. Incomplete record keeping means we were not able to confirm that these medicines were being used as prescribed.

When we checked a sample of 'boxed' medicines alongside the records we found that more of the medicine remained than the administration records indicated so we could not be sure if people were having them administered correctly.

Inadequate

Is the service safe?

We found changes to people's medication were not clearly recorded. For one person we saw incomplete records for the administration of two inhalers. When we checked the professional visit records we saw that one of these inhalers had been noted as discontinued in April 2014. On the medication administration records this was still signed for as administered at the bedtime dose.

Two people had medicines administered 'covertly', crushed and mixed with food. This was documented in their care plan and guidance had been sought from the pharmacist to make sure that these medicines were safe to crush before administration. However, for two medicines the advice from the pharmacist was that crushing was not advisable and an alternative dosage form should be used. Care staff told us during the visit that these were currently being crushed before administration. This meant that the home could not confirm that this medicine was safe to administer in this form. Medicines were not safely administered.

We looked at the guidance information kept about medicines to be administered 'when required'. Although there were arrangements for recording this information we found this was not kept up to date and information was missing for some medicines. This meant there was a risk that staff did not have enough information about what medicines were prescribed for and how to safely administer them. For one person we saw that two strengths of the same medicine were available and the information did not clearly state which strength should be administered. This placed the health and welfare of people at unnecessary risk. This is a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We have taken enforcement action because the provider was breaching this Regulation.

Medicines were kept securely in locked cupboards. Records were kept of room temperature and fridge temperature to ensure they were safely kept. We saw that eye drops for one person with a short shelf life once opened were still being used past the recommended date of expiry. This meant that the home could not confirm that this medicine was safe to administer.

Medicines that are liable to misuse, called controlled drugs, were stored appropriately. Additional records were kept of the usage of controlled drugs so as to readily detect any loss. Everyone had their medicines given to them by the staff. We saw a nurse giving people their medicines. They followed safe practices and treated people respectfully.

Inadequate

Is the service effective?

Our findings

We found the service was not effective. Over the last eighteen months regular appraisals and clinical or general supervisions had not been carried out for any staff. Staff told us they had not received an annual appraisal but had received supervision with the acting manager although this was not always on a regular basis. They said they did have opportunities to talk to the acting manager if they wanted to discuss anything, but this was often on an informal basis. Staff said they did not have opportunities to talk to senior managers who were also the registered providers.

The acting manager told us they had identified that some staff had not received all the necessary training and not all of the relevant staff had completed refresher training for instance in infection control, moving and handling and fire safety. This meant staff did not have up-to-date knowledge and were not fully informed of current practice which puts people at risk. This is a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The records indicated that out of the 33 nurses, care staff and management team that were included on the training matrix only 14 had completed, risk, restraint and capacity training. Thirteen had completed Mental Capacity Act and DoLS authorisation training. The lack of effective training meant staff were not fully informed of current practice in relation to the Mental Capacity Act and DoLS authorisations which puts people at risk. This is a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff we spoke with said they had received safeguarding of vulnerable adults training. Records we reviewed confirmed this and most had received refresher training. However, the acting manager told us they had recognised through some recent safeguarding cases that the staff team did not fully understand their role and responsibilities in relation to three key areas; safeguarding vulnerable adults; the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) authorisations. The acting manager said they had identified the current training programme was not effective and were in the process of developing a training package which would extend staff knowledge to help make sure everyone understood their responsibilities. The lack of appropriate training meant staff were not fully informed of current practice which puts people at risk. This is a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found the provider needed to take action to ensure nursing staff received sufficient training and to ensure these staff remained competent to administer nursing care, for instance, percutaneous endoscopic gastrostomy (PEG) feeding, subcutaneous fluids and medicines in general. We found that the lack of training had contributed to staff being unable to administer medicines safely, meet the requirements of the Mental Capacity Act 2005 and DoLS authorisations, and recognise when people were losing weight and when they needed to seek support from other healthcare professionals.

Steps were being taken to improve the training and supervision programme. The acting manager said they had started providing more structured supervision so once this was fully implemented staff would receive formal support on a regular basis. They were also taking steps to make sure staff received refresher training and appropriate training which included condition specific training such as working with people who had a dementia type condition.

During the day we noticed people were offered plenty to eat and drink. At lunchtime people were given a choice of two meals and said they had enjoyed their food. One person said, “The foods pretty good and I get enough to keep me going.” People received appropriate support from staff when they needed assistance to eat and drink although when some people had finished their lunch they were not given the choice of moving from the dining room to the lounge for quite a long time. Most people ate their meal in the lounge or their room; only five people ate in the dining room. In one of the units when one person sat down to eat at the dining table there was no table cloth, drink, cutlery or napkin. Menus were not displayed in the home so people did not know what they were eating until it was served.

People who used the service did not raise any concerns about the quality of meals and some said the food was good. However, we received a mixed response when we spoke with staff about the choice and quality of meals. Some staff told us the meals were suitable and satisfactory whereas others said they were not.

Inadequate

Is the service effective?

From discussions with staff we found that the catering budget was insufficient. Staff told us there was not an adequate supply of provisions. Also the catering staff were unable to ensure people could receive high calorific meals or increase quantities of food. Staff had not been able to purchase moulds and adaptions to enable them to ensure those people who received pureed diets were presented with appealing foods. One member of staff said there were not enough sandwiches at suppertime. Another member of staff said only the same plain biscuits were provided. Staff we spoke with said there was not always fruit available for people to eat and none of the vegetables were fresh. They said this resulted in people having limited choice.

The care records of one person who had lost a significant amount of weight stated they enjoyed 'finger food'. We did not observe finger food being provided during the meal time. Staff said generally finger food was not provided but they often cut up items into chunks, however, this was not always possible because of the menu options. This meant the home could not confirm there were suitable foods in sufficient quantities available to meet people's needs. This is a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At lunch, one person had mashed potato, cauliflower, cabbage and chicken casserole which was chunks of chicken in a sauce. Their care record stated they should have a moist diet but it was not clear what this meant. When we asked staff, they were also unclear so we could not be sure the person had received suitable foods to meet their needs. This meant staff could not demonstrate they had assessed the person's needs and planned the delivery of their in line with the need.

Recently the provider had changed some of the arrangements for purchasing provisions. They had asked for milk and bread to be paid from the catering budget instead of the provider making a direct payment for these items, however, there was no increase in the budget. This had resulted in a further reduction in the range of foods and ingredients that could be obtained.

New improved menus with more variety had been devised and were due to be introduced in the next couple of weeks. However, concerns were raised that these would not be provided because the budget was limited. The acting manager told us the current budget was insufficient to enable the catering staff to provide meals shown on the menu but agreed to review this with another member of the management team.

Staff we spoke with said good systems were in place to ensure people received appropriate support with their healthcare. Care staff said they always reported any concerns to the nurse in charge or the acting manager who is also a nurse. The nursing staff said they always contacted other health professionals when appropriate. They said they had a good relationship with the local GP surgery. Care records showed people received visits from a range of healthcare professionals such as GPs, district nurses, chiropodists and opticians.

The home is divided into four smaller units. Each unit has a lounge, dining area and communal bathrooms. People told us they were comfortable in their environment and could choose where to spend their time. They said they also chose where to see any visitors. One person said, "It's a very pleasant home." We observed people making use of communal areas and spending time in their room if they wished. We looked around areas of the home and found the design and layout of the premises were suitable and met people's needs. People had personalised their rooms.

Good

Is the service caring?

Our findings

We found the service was caring. People we spoke with said they were happy with the care they received. A comment included: "The staff are nice, pleasant and polite and will sit and talk to me. What more can I ask for at my age?" Several people told us the staff were caring. People told us staff treated them with dignity and respect when helping them with personal care tasks. A comment included: "They are all very lovely and always give me plenty of time and reassurance when they help me."

People we spoke with said they could make day to day decisions such as choosing what time to get up, what time to go to bed and where to eat their meals. A comment included: "I enjoy eating my meal and watching TV at the same time so I stay in the lounge."

Visitors told us the staff were caring. One relative commented: "The care here is superb. It's a relief to me he is settled." Another relative said the home contacted them if they had any concerns about their relative. They were happy with the standard of care and were very complimentary about the quality of staff.

Staff we spoke with said people were well cared for. They told us how they maintained people's privacy and dignity when assisting with intimate care, for example by making sure doors were closed and knocking before entering rooms. Staff said they encouraged people to make day to day decisions and gave examples of how they did this. For example showing people different items of clothing, asking what they would like to wear and by offering a range of drinks.

We observed staff treating people with dignity and respect. Staff were caring, attentive and chatted to people when they provided assistance. Staff communicated with people in a respectful way. Some staff had worked at the home for a long time so knew people very well. Staff used people's names when they spoke with them and talked about their family members. One person's care records stated they liked to be called by a different name. We saw staff respected this and called the person by their preferred name.

People were supported to maintain relationships with their family. No information was available to highlight how people could contact advocacy services and staff were unaware of what local services were available.

Requires Improvement

Is the service responsive?

Our findings

We found the service was not responsive. During the inspection we reviewed care records and found staff had not always appropriately assessed people's care needs. For example, three people's capacity assessments were not completed in respect of any specific decisions yet records showed staff were making decisions on their behalf. Staff had completed capacity assessments for two people but these were incorrectly filled out. The care records showed each individual could make some decisions and could express their views at times. But capacity assessments indicated that the individual could not take any information on board; could not retain any information; could not make a decision about anything and could not express their opinion. It was unclear which record was correct and whether the people concerned could make decisions or give consent care and treatment. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Care plans were not always specific to the person and clear instructions for care delivery were not provided. For example, the care plans for two people who had lost weight stated "to make best opportunities with her diet". This did not provide staff with clear guidance about what the 'best opportunities' were or how the person's nutritional needs should be met. One person's evaluation stated "food intake seems mood dependent". But there was no information explaining what this meant or if follow up action was required. There was no evidence that a mood assessment had been completed. This might result in people receiving care that is not personalised and centred on their needs, choices and preferences. This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Some people's care records provided conflicting information so it was not clear if their needs had been appropriately assessed and met. For example, one person who was at risk of developing pressure sores had different guidance in their care plan and care plan evaluation. This meant the person's care needs could be over looked. This is a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

In two of the care records we looked at DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) forms were in place. The care records indicated they had been assessed by the staff as lacking the capacity to consent. We found no information was available to show why the decision to have a DNACPR was needed. The reason for the decision recorded on the form was that they had a dementia type illness. This justification for a DNACPR was not in line with the General Medical Council code of practice. We did not see information in the file to indicate if a family member had been made involved or aware of these decisions. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

In the care records we looked at there was no information to show that staff had made sure 'best interest' arrangements were in place. People's lifestyles were restricted in that they were only allowed to leave the building if accompanied by either staff or a family member; their healthcare was monitored and they were accompanied when attending to personal care tasks. One person was being given medicines covertly, crushed and mixed with food, so without their knowledge. There was no evidence that a multidisciplinary team or family had considered the decision to make sure this was being done in the person's best interest, which is a formal 'best interest' process. The staff we spoke with were unfamiliar with 'best interests' decisions.

We saw in people's care record family members had been asked to sign care plans but there was no information to show they had the authority to do this or that the person, where able, had agreed to this occurring. We found that staff had taken no action to determine if the person wanted their family member to act on their behalf. For those people who lacked capacity they had not taken action to determine if the family member had the legal authority to make decisions on behalf of their relative. So no information was contained on file to indicate if this relative had been appointed as a deputy via the Court of Protection or was named in a last power attorney for finance and/or care and welfare. At the time of the inspection there was no activity worker employed. On the day of the inspection a care worker was helping one person do a jigsaw, otherwise we did not see any other activity taking place. Care staff were observed sitting with people and chatting which they clearly enjoyed. Care staff said they often spent time with people. Staff said they played games such as dominoes, puzzles and did people's hair and nails. One person who

Requires Improvement

Is the service responsive?

used the service said, “I sometimes go out for a walk with a member of staff to the village which is nice.” Some people had morning papers delivered. People told us there were regular visitors at the home.

The acting manager said they had not received any formal complaints in the last few months. People we spoke with said they had not raised concerns because they were happy with their care. However, they said they would talk to the acting manager or staff if they needed. The meeting minutes for people and their relatives we reviewed showed that people who attended had a chance to talk about the service with the acting manager. Minutes showed at the last three meetings relatives had asked the provider to attend the meetings but to date this had not occurred. We found no evidence to show that the provider had taken any other action to gather the views of the people who used the service or others. We found that annual surveys were not completed and that they used no other system to enable them to determine that the service was meeting people’s needs, run in line with their wishes and valued their opinions.

Inadequate

Is the service well-led?

Our findings

We found the service was not well-led. At our inspection in August 2013 and March 2014 we were concerned because the provider did not have an effective system to regularly assess and monitor the quality of the service. We told the provider they needed to take action. The provider was told they must send a report that detailed what action they were going to take to meet the required standards but they did not do this. At this inspection we found the provider still did not have appropriate arrangements in place. This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

In the last inspection report we said, 'Staff still had the perception that improvements were because of efforts made by individual local staff, rather than an effective approach to quality and governance by the provider'. It was evident at this inspection this perception had not changed. Staff we spoke with said the acting manager worked very hard and had introduced changes which had improved the service. One member of staff said, "She's a brilliant manager and has been great for this place." However, staff felt the provider did not fulfil their responsibilities. One member of staff told us the staff team were concerned about the service and didn't feel the owners cared about the service.

Since the last inspection, the provider had not completed any records to show that they had completed quality and monitoring visits. Staff we spoke with said the provider had not checked how the home was operating or spoken to people who used the service, staff or others. The acting manager did not send information to the provider regarding the output of her audits or other additional information about the home such as the receipt of complaints and the analysis of incidents. The acting manager had limited monies available to complete repairs, which meant that for even minor issues they needed the provider to authorise the repair. This lack of access to the provider was leading to items being left unrepaired for long periods of time.

From a review of the catering arrangements we found that the provider had named the catering manager as the business account holder for the company who supplied the goods. We found that to do this the catering manager had to use their own personal bank account and at times the provider did not ensure that there were adequate funds in the catering manager's personal account. The provider had told staff that the catering budget was £2.75 per person per day and we confirmed this allowance had not changed for at least four years. We found no evidence to show how this figure had been reached. The acting manager could not provide any information to clarify why this figure was adopted and why no action had been taken to increase it in line with inflation.

Although an acting manager has been in post for the last eight months, the registered provider had not ensured this person applied to be the registered manager. This is a breach of their conditions of registration and we are taking action away from this process to address this matter. We also noted that the CQC registration certificate on display was out of date and did not therefore reflect the current conditions imposed on the service.

We asked to look at the arrangements for monitoring the quality of the service. The acting manager said they had improved the monitoring of the service but recognised this was an area they still needed to develop. At the time of the inspection they had not fully implemented their quality assurance system. We asked the acting manager if audits or reviews were carried out by the home on a regular basis to assess areas such as care planning, quality of the care records, medication and risk assessments. They said they had started to carry out more audits but had recognised the tools they used needed to be improved and at times they were not being completed in line with the required frequency. We reviewed the audits and system, which confirmed there were gaps in the frequency of completion. We also found that the system was not always effective. For instance, we found a number of errors were being made in the administration of medication such as mislabelling medication, not signing for medicines given or not ensuring medicines were returned but the relevant audit had not identified these issues.

From a review of the care records we found that routine action was not taken to establish whether any lasting power of attorney for either finance or care and welfare were in place. We saw information contained throughout one set of care records indicated that a care and welfare lasting power of attorney was in place only to find from discussions with the acting manager that in fact it was not. This had not been identified as an issue within the care plan audit.

Inadequate

Is the service well-led?

At the inspection we found multiple breaches in the regulations which evidences that the provider was not monitoring the quality and safety of the service provided. This is a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People we spoke with did not raise any concerns about the management of the home. People told us they would speak with staff if they had any concerns.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 (1)(a)(b)(i)(ii) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Care and welfare of people who use services.** The registered person did not take proper steps to ensure each service user received care that was appropriate and safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **Regulation 14 (1)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Meeting nutritional needs.** The registered person did not protect service users and others against the risks of inadequate nutrition by means of the provision of a choice of suitable and nutritious food in sufficient quantities.

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 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Consent to care and treatment.** The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **Regulation 20 (1)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Records.** The registered person did not ensure each service users were protected against the risks of unsafe or inappropriate care arising from a lack of proper information.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Regulation 23 (1)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Supporting workers** The registered person did not have suitable arrangements in place to ensure that staff were appropriately trained to deliver safe care and support to people.

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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **Regulation 10 (1)(a)(b)(2)(v)(3) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision.** The registered person did not have effective systems in place to monitor the quality of the service delivery.

The enforcement action we took:
Warning Notice was issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Management of medicines.** The registered person did not protect service users and others against the risks associated with unsafe use and management of medicines.

The enforcement action we took:
Warning Notice was issued