London Residential Healthcare Limited

Solent Grange Nursing Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 17 and 18 March 2015 and was unannounced. The service provides accommodation for up to 76 people who have nursing and/or dementia care needs. There were 39 people living at the service when we visited. The service is split into three areas. Sunflower and Daffodil units provided a mix of nursing and dementia care; Bluebell unit provides accommodation and care for people living with dementia. People lived in each of the units and were able to move freely between them, but spent most of their time in their own areas. Staff were allocated to, and generally worked on a specific unit.

The service did not have a registered manager in place. However, the current manager had applied to become registered with CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The lack of a registered manager has been shown to have a detrimental impact on people using the service.

Summary of findings

At the last inspection on 9 and 13 October 2014, we identified breaches of Regulations 9, 10, 11, 12, 13, 14, 17, 18, 20, 21 and 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We took enforcement action to prevent the provider from admitting new people to the service until 26 April 2015. The provider sent us an action plan on 23 February 2015 stating they were now meeting the requirements of the regulations.

At this inspection we found monitoring systems were not always effective in identifying areas for improvement and audits of care plans had not been started. As a result, people's safety was compromised.

Incidents that caused harm to people were not always reported to the manager and were not investigated appropriately. Dangerous substances were found in an area accessible to people. Procedures were also inadequate to ensure the security of the building.

Emergency procedures were inadequate to ensure people's safety. The risks of people choking were not managed safely and, if people choked or aspirated on fluids, emergency equipment was not immediately available. The fire evacuation register was not up to date. People were not occupying the rooms specified, which could compromise their safety if they had to be evacuated in an emergency.

Bruising or other injuries had occurred which had not been reported to the local safeguarding team. There was inadequate evidence that all of these had been investigated appropriately within the home to prevent future incidents. People did not always receive the health and personal care they required and had developed avoidable skin damage. Action was not always taken when routine observations indicated a need to seek medical advice and the provider's policies for monitoring people who had suffered head injuries were not always followed.

Care plans were not always representative of people's current needs and although some contained a lot of individual detail others did not have all necessary information or had conflicting information. Where care plans had been reviewed, this did not necessarily mean the information in them had been updated.

There were appropriate arrangements in place for the safe handling, storage and disposal of medicines and most people received their medicines as prescribed. Records for the administration of topical creams and ointments were not always completed and did not always contain information about where they should be applied. Pain assessments and 'as and when necessary' (prn) care plans did not contain sufficient detail for people who were unable to state they were in pain.

Staff did not always follow legislation designed to protect people's rights. Although staff showed some understanding of the legislation and people were asked for their consent before care or treatment was given, care records demonstrated that staff did not understand how to make decisions on behalf of people who lacked capacity.

We found the provider had made improvements to staff recruitment procedures, training, staff support and to infection control procedures.

People were encouraged to eat well and were positive about the meals provided but they did not always receive the support or supervision they needed to ensure their safety when eating.

People were cared for with kindness and compassion and could make choices about how and where they spent their time. When staff provided support for people to move from one position or location to another, they explained what they were going to do and checked people were ready to move. People's preferences, likes and dislikes were recorded and known to staff. Support was provided in accordance with people's wishes.

Staffing levels, including those of the nursing staff, were determined using a formal staffing tool however there were not always enough staff on duty. Staff recruitment procedures were safe and ensured staff were suitable for their role. Staff received training and were supported by senior staff.

Appropriate arrangements had been put in place to manage infection control risks and staff demonstrated a good understanding of infection control procedures.

Although information about the complaints procedure was not available to all visitors, people and visitors were able to make a complaint. These were investigated and where necessary action taken to prevent recurrence of the issue.

Summary of findings

People and relatives were able to express their views through meetings with senior managers and the provider's representative, and surveys of people and their relatives. A range of group and individual activities were provided.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to breaches of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken 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

The service was not safe.

Procedures had not ensured that all risks, such as the risk of choking, were managed effectively. Emergency medical equipment was not immediately available and emergency information was out of date.

Incidents of unexplained bruising, skin injuries and falls had not always been reported to the manager and investigated, meaning action was not taken to prevent further incidents.

Medicines were stored securely and most were administered safely and as prescribed. However, topical creams were not applied as directed and there was inadequate guidance for staff to determine when "as required" medicines may be required.

There were not always enough skilled and experienced staff to meet people's needs. The recruitment process was safe and ensured staff were suitable for their role.

People were protected against the risk and spread of infection.

Is the service effective?

Inadequate

The service was not effective

Legislation designed to protect people's rights was not correctly applied where people lacked the capacity to make decisions themselves. The Deprivation of Liberties Safeguards (DoLS) had been applied for however, despite training, staff were not aware of people who had had restrictions placed on their liberty to keep them safe.

People did not always receive the correct healthcare and health monitoring they required. Action was not always taken to monitor people's conditions when observations indicated a new health need.

People were offered a choice of nutritious meals and most received

appropriate support to eat and drink.

Staff were suitably trained and received appropriate support from the manager.

Is the service caring?

Requires Improvement

The service was not always caring.

Care practises did not always ensure people's dignity. People's privacy was usually protected and confidential information was kept securely.

People were cared for with kindness and treated with consideration.

Summary of findings

People were supported to express their views and actively involved in making decisions about their care, treatment and support. People's preferences, likes and dislikes were recorded and known to staff.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans had not always been updated following changes in the person's needs and therefore did not always reflect people's current health and personal care needs.

People did not always receive the correct healthcare and health monitoring they required. Action was not always taken following falls or when routine observations had indicated a concern. People had developed skin damage which may have been avoidable.

People and visitors were able to make complaints. These were

investigated and, where necessary, action taken to prevent recurrence of the Issue.

People and relatives were able to express their views through meetings with senior managers and the provider's representative, and surveys of people and their relatives. A range of group and individual activities was provided.

Is the service well-led?

Inadequate

The service was not well led.

The monitoring systems were not always effective. Concerns we had identified in our previous inspection report, in relation to the safety and effectiveness of the service had not been addressed.

Incidents that caused harm to people were not always reported to the manager or investigated appropriately. Dangerous substances were found in areas accessible to people. Procedures to ensure the security of the building were not adequate.

People, relatives and staff praised the manager and said the home was run well. Feedback from people and staff was sought and the information used to improve the home.

Solent Grange Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 17 and 18 March 2015 and was unannounced. The inspection team consisted of three adult social care inspectors and a specialist advisor in the care of older people.

Before the inspection we reviewed information we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. We also gathered information from Isle of Wight Council Adult Commissioning Unit.

We spoke with five people using the service and 8 family members. We also spoke with the provider's Operations Support Manager, the manager, the deputy manager, three nurses, 10 care staff, two activity coordinators, two housekeeping staff and the cook. We looked at care plans and associated records for 16 people, staff duty records, three recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records. We observed care and support being delivered in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

At our last inspection on 9 and 13 October 2014, we found the service was in breach of regulations. The provider did not notify the safeguarding authority of incidents of unexplained bruising. Risks of people falling or choking on their food were not managed safely, nor were environmental risks. There was not always enough staff. Pre-employment checks and processes were not robust. The obtaining, administering and recording of medicines were not always safe. Guidance on the prevention and control of infections was not followed and the risks of cross infection were not managed effectively. We took enforcement action to prevent the provider from admitting new people to the service until 26 April 2015. The provider sent us an action plan on 23 February 2015 stating they were meeting the requirements of the regulations.

At this inspection, we found the provider had made improvements. However, people's safety was still compromised in several areas.

Where people had been assessed by specialists as being at risk of choking on their food or drinks, they did not always receive the care and support they required. The specialist advice for one person stated "use a teaspoon do not use a straw or spouted beaker". We saw care staff giving the person a drink from a plastic beaker with a spout. The person was not sitting upright and started to cough as soon as sips were taken. The care staff told us "everyone does this, none of us knew (that they should not use the spouted beaker)". For another person we saw the specialist advice was not followed and they were coughing in response to attempts to eat. Three people had been assessed by specialists as being at risk of choking on their food or drinks and needed full support from staff to prevent this. However, we saw these people eating independently in their bedrooms without support or supervision. People were at risk of choking and were not receiving the care they required to minimise this risk.

If people choked or aspirated on fluids, emergency equipment was not immediately available. In one bedroom containing emergency suction equipment there were no suction tubes present. These are essential to enable emergency suction to occur. We asked nursing staff where the tubes were. It took fifteen minutes before these could be located. In an emergency this would have been too long.

The risks of people falling were not managed effectively. Records showed some people had had repeated falls. Risk assessments and care plans had been reviewed and people had been referred to falls clinics. However, additional measures had not always been followed to prevent further falls. One person had had several falls in the week preceding our inspection. Their care plan specified the need for protective mats to be in place next to their bed, in case they fell out of bed, and for an alarm mat to be in place to alert staff if the person moved about. We saw they were asleep on their bed without this equipment in place. Their care plan stated staff "need to supervise me and ensure I am safe". We saw the person moving about unsupervised and records of a recent fall recorded that staff found the person on the floor.

The above issues are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We identified instances when bruising or other injuries had occurred which had not been fully investigated or action taken to reduce the risk of future injuries. One person suffered three injuries within 48 hours. The person was not mobile and the cause of the injury had not been investigated. Care records detailed unexplained bruising on another person, again there had been no investigation to determine the cause of the injuries. The failure to take action when people had unexplained injuries meant people remained at risk of further injury.

The above issues are a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Personal evacuation plans were not all accurate in respect of the support individual people would need if they had to be evacuated. The fire evacuation register was not up to date as four people were not occupying the rooms specified, which could compromise their safety if they had to be evacuated in an emergency. Emergency information held at the front entrance was also not up to date and listed people who were no longer living at the home. This would mean emergency services would be looking for people who were not present or in the rooms specified.

Inadequate

Is the service safe?

The above issues are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not always managed correctly. The Medication Administration Records (MAR) charts showed that one medicine prescribed to several people, which should be given half an hour before food, was often given with or after food, so may not have been effective. Records for the administration of topical creams and ointments were not always completed and did not always contain information about where they should be applied. A recognised pain assessment tool was used for some people some of the time. Pain assessments and 'as and when necessary' (prn) protocols did not contain sufficient detail to inform staff where people would be unable to state that they were in pain. One stated staff should "observe for non-verbal communication such as facial expression" but did not say what the facial expressions were or what they may mean. People therefore could have been in pain without staff being aware, and may not have received the comfort and pain relief required.

The above issues are a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us staff usually responded promptly. However, one relative said that at lunch time "they could do with more staff as it seems to get busy then. If someone needs the toilet, or food in a room, then food can get cold". On one unit staff seemed to have little time to spend with individuals and as a consequence the interactions tended to be task orientated and event focused. This meant, at times, the staff had to hurry from one person to the next and back again. Staff said to people "I'll be back in a minute" but it was several minutes before they were able to return. One staff member said "to be honest with you, we are short of staff, which means sometimes we have to rush and none of the staff here want to do that". Other staff expressed similar views. Staff told us if staff reported sick at short notice this could not always be covered. This situation occurred on the first day of our inspection in one unit. This meant that some people did not receive their morning personal care until almost lunch time and staff did not have time to provide activities or mental stimulation. Staffing levels, including that of the nursing staff, were determined using a formal staffing tool by the manager who stated the home had adequate numbers of staff employed although on occasions they may have been short of staff.

Records showed the process used to recruit staff was safe and helped to ensure staff were suitable for their role. Interviews included relevant questions to assess the applicant's knowledge and attitudes. Relevant checks were completed to make sure staff were of good character with the relevant skills and experience needed to support people appropriately. Staff confirmed this process was followed before they started working at the home.

Appropriate arrangements had been put in place to manage infection control risks. The provider's policy was appropriate and up to date. It was supported by infection control risk assessments and cleaning schedules which detailed how each area of the home should be cleaned. Check sheets confirmed all cleaning had been completed as planned. An annual statement of infection control had been completed, together with a recent audit which showed procedures were working effectively.

Staff demonstrated a good understanding of infection control procedures. All had received training in infection control and had ready access to personal protective equipment (PPE), such as disposable gloves and aprons. They used this when appropriate and followed best practice guidance when handling soiled linen. Clinical waste was stored safely and disposed of by an approved contractor.

Inadequate

Is the service effective?

Our findings

At our last inspection on 9 and 13 October 2014, we found the service was in breach of regulations. Mental capacity assessments were not completed and decisions made on behalf of people were not made in accordance with legislation. Care staff did not have an understanding of Deprivation of Liberty Safeguards and did not know which people they applied to. People were not supported to eat and drink enough and action was not always taken when people lost weight. Staff had not completed all essential training and there was no system in place to help identify their development needs. We took enforcement action to prevent the provider from admitting new people to the service until 26 April 2015. The provider sent us an action plan on 23 February 2015 stating they were meeting the requirements of the regulations.

At this inspection we found people's nutritional needs were being met and staff had received all necessary training. However, staff were not following the principles of the Mental Capacity Act, 2005 (MCA).

The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant.

Care records demonstrated that staff did not understand how to make decisions on behalf of people who lacked capacity, such as those living with advanced dementia. The relatives of five people had signed their consent for the person to receive the care and treatment that staff had planned. However, the relatives did not have the legal right to make such decisions. For five other people, staff had made best interest decisions for people without having first assessed the person's mental capacity. One of these people was being given medicines hidden in their food without their knowledge. People's rights, therefore, may have been compromised.

The Deprivation of Liberty Safeguards (DoLS) protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. No one was subject to a DoLS however these had been applied for in respect of three people and were waiting assessment. One staff member said they thought "everyone was on a DoLS, it's a dementia floor". People were at risk of not having their legal rights upheld as staff were unaware of if and who restrictions could legally be applied to.

People received healthcare from the trained nurses. This included wound dressings, blood sugar monitoring and insulin injections. However, records did not always show that action had been taken when routine observations identified a concern. One person, who had a history of stroke, had a recorded monthly blood pressure reading which was significantly higher than previous recordings. Another person's care plan stated that blood pressure should be checked before and after administration of a medicine which could significantly affect blood pressure. This had not occurred and no action had been taken to discuss this with the GP. This placed the person at risk of further health problems. In other situations, where people had seen specialists, such as speech and language therapists, records showed guidance was not always followed. One person's care plan stated they should have hand splints for a medical condition. These were not being used and there was no indication why they were not being used or what action was being taken to ensure the person's hands were being protected from further deformity. This meant people may not have their medical needs met.

Staff monitored the food and fluid intakes of people at risk of malnutrition or dehydration. However, there were no target fluid intakes for individual people recorded on care plans or fluid charts. This meant staff may not have known how much individual people should have to drink. Daily intake was not always totalled up, meaning staff may not have recognised when people were having insufficient fluids. Guidance for staff within care plans was vague stating, for example, "give fortified drinks and pureed diet".

The above issues are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People praised the quality of the food, which they said had improved. One person said, "The food is better and looks better." Another person told us, "The food is good and you

Is the service effective?

always get a choice." People were offered varied and nutritious meals including a choice of fresh food and drink. Kitchen staff were aware of people who needed their meals prepared in a certain way or fortified.

People were encouraged to eat well and staff. When people did not eat their meals, staff tempted them with alternatives, such as sandwiches or fresh fruit and gave people time to eat at their own pace. The manager had recently started monitoring people's meal time experiences. They had identified how this could be enhanced and had made changes, including ensuring more staff were available to support people.

A programme of induction training was completed by all new staff. In addition, new staff 'shadowed' experienced staff by working alongside them until they were confident in their role. Training records showed staff had completed all essential training required by the provider. Staff training was provided in a variety of formats, including face to face and by viewing DVDs. The DVDs included a knowledge check at the end of the training which checked staff had gained the necessary knowledge. New staff were positive about their induction and other staff said ongoing and refresher training had been of value.

Staff received appropriate support through the use of one-to-one sessions of supervision and appraisals. These provided opportunities for them to discuss their performance, development and training needs.

Requires Improvement

Is the service caring?

Our findings

At our last inspection on 9 and 13 October 2014, we found the service was in breach of regulations. Staff did not always treat people with dignity and respect. People were not always involved in planning their care. We took enforcement action to prevent the provider from admitting new people to the service until 26 April 2015. The provider sent us an action plan on 23 February 2015 stating they were meeting the requirements of the regulations.

At this inspection, we observed several occasions when staff shouted to each other down corridors. This was to do with their work programmes such as "have you done (person's name) yet" and "did (person's name) eat much". This was in an area open to visitors and others accessing another service run from the same building and meant people's dignity and confidentiality was compromised.

One person's dignity was not protected when they were brought into a lounge wearing clothing which did not conceal the leg drainage bag from their urinary catheter. On other occasions we saw a portable dignity screen was used when people were transferred by a hoist between wheelchairs and lounge chairs. This ensured their dignity would be maintained if, for example, their clothing became dislodged in the process. People's privacy was protected by staff knocking on people's doors before entering and ensuring doors were closed when they delivered personal care. Confidential information, such as care plans were kept securely and only accessed by staff entitled to view it.

We found people were cared for with kindness and compassion and could make choices about how and where they spent their time. One person told us "Things are improved. They treat me better now, on the whole." Another person described staff as "marvellous." A family member of a person said, "I've never seen [the person] so happy. Staff are very kind and caring." Comments made in response to a recent survey conducted by the provider were positive and showed staff were caring. One said: "The staff are always cheerful and nothing is too much trouble. Great care is taken when seeing to residents who are unable to see to themselves."

When staff provided support for people to move from one position or location to another, they explained what they were going to do and checked people were ready to move. Where people were not able to respond verbally to questions, staff observed their reactions to assess whether the person understood and was ready to receive the support offered. For example, one person was gently woken and invited to visit the hairdresser. They were tired and showed no interest in moving, so staff left them to sleep. Later, when the person was more alert, staff again offered them opportunity to go to the hairdresser. A family member said of the staff, "They always take time to ensure [the person] makes choices by constantly talking to [them]."

Comments in care plans showed people and relatives were involved in planning the care people would receive and that family members were kept up to date with any changes in their relatives needs. Two people in the Bluebell Unit, who were living with dementia, had no one close to them to speak on their behalf. Lay advocates had not been appointed to support them, although the manager told us they were planning to arrange this.

People's preferences, likes and dislikes were recorded and known to staff. Records showed support was provided in accordance with people's wishes. People chose when to get up and go to bed and records confirmed their wishes were respected. One person said, "I chose to have a lie in today, so did." We found people (or their families where appropriate) had been involved in decisions relating to end of life care and resuscitation. We heard people being asked for their consent before care or treatment was given.

Staff communicated effectively with the people they were supporting and treated people with warmth and interest. They knew the people they were caring for well and were able to deliver care in the way the person preferred. For example, when a GP had prescribed tablets for a person, staff requested the prescription was changed to a liquid form of the medicine, which the person preferred. We observed positive interactions between staff and people. For example, when a staff member helped one person put their socks on and gave another person a cup of tea, they spent time chatting and engaging with them. When people became upset or anxious, staff offered comfort and support by speaking kindly and using touch appropriately. In one of the lounges we heard staff asking people where they wanted to sit, whether they wanted the radio on and gave them a choice of drinks. A member of staff told us, "We laugh and joke and it makes for a happy atmosphere."

Inadequate

Is the service responsive?

Our findings

At our last inspection on 9 and 13 October 2014, we found the service was in breach of regulations. There was a lack of activity provision, care plans did not contain enough information or were not up to date and neurological observations were not always conducted when people sustained head injuries. The provider did not always take account of complaints to make improvements to the service. Records did not show people had received the care they needed. We took enforcement action to prevent the provider from admitting new people to the service until 26 April 2015. The provider sent us an action plan on 23 February 2015 stating they were meeting the requirements of the regulations.

At this inspection we found more activities were provided, care plans had been developed, record keeping had improved and complaints were used effectively. However, care plans were not always reviewed in line with the provider's procedures and did not always reflect people's current needs.

People were not always adequately monitored in situations where their health may change such as following a fall. Full neurological observations were not conducted when two people had a fall and suffered a head injury. This meant potentially serious injuries may not have been identified and prompt action taken to prevent further complications.

Records of skin care and skin damage did not show people received all necessary care. We found a person had developed two open red areas. Records of repositioning and care showed that in the preceding two days there had been several periods of up to 14 hours, when repositioning was not shown to have occurred. Records showed a non-prescribed topical cream had been applied which was not suitable for the person's skin condition and may have contributed to the deterioration of the person's skin. The person's care plan identified they were at risk of pressure injuries and should receive care "every three to four hours" which records showed had not occurred. Records viewed showed two other people had developed avoidable moisture lesions, which are caused by extended contact with urine or faeces, and skin pressure injuries.

Care plans had not been updated to reflect the changes in people's skin condition. For a person who sustained an injury there was no information detailing wound care required or how staff should provide care when moving the person or providing personal care. The records of another person stated that they had sustained a skin abrasion under their left elbow. A wound care plan was subsequently found however, there was no information or investigation as to how the injury had occurred. Care plans did not always reflect the care people were receiving. One person's care plan stated they should have a plate guard and food cut up. We saw that a plate guard was not provided during any of their meals during the inspection. Staff were therefore not following the guidance in the care plan.

Staff did not always have correct information about people's current care and support needs. Some care plans contained inadequate or conflicting information. For example, records of people's weights in their care plans did not agree with records in the weight recording book. There were also inconsistencies with how often some people should be weighed and between information in care plans and the way people were cared for. Information about one person's ability to communicate was contradictory with information in their daily records which showed they were able to make communicate their wishes.

Care plans were not always reviewed as directed by the providers procedures. Where care plans had been reviewed this did not necessarily mean the information in them had been updated. We discussed our findings with the manager who agreed "Care plans were not reflective of needs but had been reviewed and not updated". This placed people at risk of not having their needs met in a responsive and consistent manner.

People who displayed behaviours that challenged were not always supported appropriately. The care plans for two people did not provide clear guidance to staff about the support needed. One stated the person should be supported to "accept appropriate techniques", but didn't say what these were. Similarly, the records of incidents where this person had displayed such behaviour were not comprehensive. They did not always identify what triggered the behaviour, how long the behaviour lasted or what interventions were used. Similar concerns were found in another care plan which contained no information for staff as to how they should support a person with a particular behaviour. Consequently, this person may not have

Inadequate

Is the service responsive?

received consistent, responsive support. The manager showed us a comprehensive new tool they were planning to introduce to monitor people's behaviours and pain more effectively.

Staff told us they used a recognised scale to assess and monitor the pain levels of people who could not verbalise their pain. However, although staff were clear about the signs and behaviours people displayed when they needed pain relief, these were not always recorded. We saw no evidence of a recognised assessment tool being used consistently, which meant people may not have received appropriate pain relief when needed.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were satisfied with the quality of care and told us their needs were met. One person said, "I get all the help I need and get baths every week." One staff member said "We have a handover which is really helpful and tells us what we need to know but to be honest with you we don't have time to look at the care plans".

Activities were provided by three activity coordinators. In addition, staff were encouraged to spend time with people on a one to one basis. Records showed staff did this regularly and talked about topics of interest to each person. These included reminiscing about their lives, looking at photographs or listening to music. One person enjoyed watching a particular type of film and these had been provided for them. A bird feeder had been set up outside the room of a person who enjoyed wildlife, so they could watch the birds. We observed people taking part in craft activities and a visiting singer provided live music which people enjoyed. People and their families were aware of a fete which was due to take place shortly after our inspection and they had been involved in planning it. For example, one person showed us paintings they were planning to display at it.

The service had a complaints policy and a system to record and investigate complaints. This was provided to people when they moved to the home. The procedures were not displayed anywhere in the home, although people told us they knew how to make a complaint. We viewed the most recent complaints and saw they had been dealt with promptly and in accordance with the provider's policy. Following a complaint relating to missing property, the manager described the extensive actions they had taken to find the item and the changes they were making to ensure a similar incident did not occur again.

The provider conducted regular surveys of people and their relatives. We viewed the latest survey and saw most comments were positive. The manager had responded to any negative comments by contacting respondents directly and addressing their concerns effectively. Residents meetings were held monthly and were used to update people on changes to the home and to seek their views. These had resulted in changes to the laundry and the introduction of new activities. A senior representative of the provider had also visited to run a 'meet the MD' meeting. Although this had not been well attended it had given people and staff an opportunity to provide feedback to the provider at a senior level.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 9 and 13 October 2014, we found the service was in breach of regulations. Action had not been taken to address previous failings, the system used to monitor the quality of care provided was not effective, audits were not robust, lessons were not learned from previous incidents and there was a lack in the continuity of management. We took enforcement action to prevent the provider from admitting new people to the service until 26 April 2015. The provider sent us an action plan on 23 February 2015 stating they were meeting the requirements of the regulations.

At this inspection we found the monitoring systems were not always effective and concerns we had identified in our previous inspection report, in relation to the safety and effectiveness of the service, had not been addressed. Consequently, people continued to be at risk of choking on their food, action not being taken due to unexplained injuries and skin damage and having their rights compromised.

Quality assurance systems were not always effective in ensuring the service met all necessary standards. Care plans were reviewed by senior staff but were not audited by management. As a result, gaps and contradictions within them had not been identified. The registered manager showed us a tool they were intending to introduce to conduct these audits after our inspection. Two medicines audits had been completed; one by the external pharmacist and one by staff. The audit by staff had identified and addressed some concerns, although neither had picked up that a medicine was not being given at the correct time or that topical creams were not managed safely. The head of housekeeping conducted audits of the environment and infection control. However, these had not identified that dangerous substances had been left in an area accessible to people or that records of cleaning for the juice machines were not up to date.

Incidents that caused harm to people were not always reported to the manager and were not investigated appropriately. Staff did not always follow guidance to ensure safe care. Five of the care records we looked at in depth demonstrated that people were not always provided with safe care. This should have been identified during audits. Dangerous substances including concentrated weed killer and slug pellets were found in the garden where people could have been walking unsupervised. Nail varnish remover was found in an unlocked drawer in an area accessible to people living with dementia. Procedures to ensure the security of the building were not adequate. Environmental audits had not identified these items and ensured they were stored correctly. A garden gate was left open by contractors meaning people could have left the garden and had access to nearby roads.

There was a process in place for recording accidents and incidents. These included falls and incidents of urinary infections. However, the manager had been unaware of some instances of unexplained injuries. This meant they had not been investigated in line with the provider's procedures.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives praised the management of the service. One relative told us "There's a good manager in charge now." Another said, "[The manager] is always about and she has a no-nonsense approach." This was confirmed by responses to a survey conducted recently by the provider. Comments included: "Care and environment is much improved"; "We've noticed a huge improvement over the last few weeks"; and "The home and care is improving greatly".

There were appropriate management arrangements in place. Although the service had not had a registered manager for five months, the current manager, who had been in post since the previous registered manager left, was going through the process of registering with CQC. Support for the manager was provided by an Operations Support Manager, who visited several times each week, and a new deputy manager. Daily meetings were held with the heads of all departments, in addition to shift briefings which all staff attended.

Regular staff meetings were also held and minutes showed these had been used to reinforce the values and vision of the service. Staff spoke highly of the management, received appropriate support and felt valued. One staff member said of the management, "They're making real progress with improving things." Another told us, "Things have really smartened up and are better now." A third staff member

Inadequate

Is the service well-led?

said, “The manager always asks how we are, she cares about us.” Another commented “things are better organised and you feel appreciated, but you know who is in charge”.

There was a whistle blowing policy in place and staff were encouraged to raise concerns. Where the performance of staff was raised as a concern, action was taken in a transparent way in accordance with the provider’s policies and recorded in staff records. During the inspection, we found the management team was open to receiving our feedback about the service and showed a desire to improve. The manager encouraged visitors and family members to provide feedback. They had a clear vision for the service and an appropriate plan for achieving it. Staff understood this and shared the management’s desire to provide a high quality service.

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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Regulation 9(1)(a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 - Care and welfare. This corresponds to Regulation 9(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Person-centred care. The registered person had not taken proper steps to ensure service users were protected against the risks of receiving care and treatment that is inappropriate or unsafe by means of the planning and delivery of care to meet service users' individual needs.

The enforcement action we took:
We have added a condition to the provider's registration to prevent the service from admitting new service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision Regulation 10(1), Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 – Assessing and monitoring the quality of service provision. This corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance. The registered person had not protected service users, and others, against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to regularly asses and monitor the quality of services provided and identifying, assessing and monitoring risks relating to the health, welfare and safety of service users and others.

The enforcement action we took:
We have added a condition to the provider's registration to prevent the service from admitting new service users.

This section is primarily information for the provider

Enforcement actions

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 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 – Safeguarding service users from abuse. This corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding service users from abuse or improper treatment. The registered person had not protected service users against the risk of abuse or improper treatment.

The enforcement action we took:
We have added a condition to the provider's registration to prevent the service from admitting new service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 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. This corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment. The registered person had not protected service users against the risks associated with the unsafe use and management of medicines.

The enforcement action we took:
We have added a condition to the provider's registration to prevent the service from admitting new service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

This section is primarily information for the provider

Enforcement actions

Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 – Consent to care and treatment. This corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent.

The registered person had not made suitable arrangements for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided.

The enforcement action we took:

We have added a condition to the provider's registration to prevent the service from admitting new service users.