Indigo Care Services Limited

Green Park Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was carried out on 22 and 23 May 2017 and was unannounced on the first day.

Green Park Care Home compromises of five purpose built units and is located in the suburb of Great Sankey in the Warrington area. The service can accommodate up to 105 people who require twenty four hour care. The service provides residential, nursing and dementia care. At the time of our inspection there were 81 people living at the service.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service had a manager in place who had commenced the application process to become the registered manager with Care Quality Commission.

The service changed registered provider in September 2016 and has not been previously inspected under Care Quality Commissions new methodology. During our inspection we found a number of breaches of the Health and Social care Act 2008. CQC are now considering the appropriate regulatory response to the concerns we found. We will publish the actions we have taken at a later date.

Medication was not administered to people safely. There was a lack of instructions and guidance available to staff on the use of 'as required' (PRN) medication. For example, what the medication was for, when it should be given and interval between doses. Staff failed to follow the instructions provided by a GP when administering PRN medication to one person putting the person's health and safety at risk.

The quality assurance systems in place were not effective, they failed to identify that checks which were required across the service had not been carried out. They also failed to identify that action plans had not been completed to address improvements which were needed. There was a lack of management oversight to ensure checks were carried out as required across the different areas of the service. Records were not properly maintained to make sure they were accurate and fully complete. Care plans and supplementary care records lacked important information about people's needs and they failed to record the care people had received. There were many examples were records including care plans and audits had not been fully completed, signed and dated.

Accidents and incidents were recorded by staff, however there was a lack of evidence within audits to demonstrate that a robust analysis of falls, patterns or trends were identified. There were no recorded actions completed for two people who had multiple falls within a period of one month, to state what had done to prevent and minimise the risk of further harm/occurrences.

The Mental Capacity act (MCA) was not always followed to ensure people rights and best interests. Records in relation to MCA (2005) were completed in full and there was evidence of decision specific assessments

and associated best interest meetings in place for people who were assessed as lacking capacity to make decision about their care, treatment and support. However, the records contained standard and set phrases for each question. These phrases and responses were the same for all people living at the service. Information regarding people's ability to consent was not always accurate or in line with information recorded in care plans. Staff were observed seeking peoples consent in practice.

People were not always protected from the risk of malnutrition and dehydration. There was a lack of action taken when it was identified that people had lost significant amount of weight over a short period of time. Weight losses recorded for eight people across the service showed they had lost between 3kg – 7kg in weight, despite this no action was taken in response. There was no evidence that people were referred onto a dietician for their input. Staff failed to refer one person to a dietician and consult with a person's GP following written advice provided by another external healthcare professional.

Charts which were in place to record and monitor people's food and fluid intake were not always completed effectively or in a timely manner. Information relating to what people had eaten was not always completed in detail to accurately reflect what they had consumed. Food and fluid charts were not consistently totalled to accurately assess whether people had received adequate food and fluids to protect them from the risk of dehydration and inadequate nutrition.

People's needs were not always assessed and planned for to ensure they were met. One person had a behaviour chart in place which had been completed by staff. However no assessment or care planning documentation had been completed for this area of need. There were no care plans in place for another person who had recently moved into the service, despite initial assessments showing that they had a variety of complex needs.

People's privacy, dignity and confidentiality were not always respected. Staff engaged with each other loudly about people's care on corridors near to bedrooms where people were sleeping. Staff placed people in view of others who were watching TV in a lounge. Language used by staff in people's care records showed a lack of understanding about people living with dementia and a lack of positive intervention to help people overcome periods of anxiety and stress.

We have made a recommendation about staffing. Staffing levels required to meet people's needs and keep them safe were maintained across the service. However there was a high use of agency staff to achieve this. The deployment of agency staff was not always proportionate across the units For example; shifts on some units were covered by 50 % of agency staff whilst other units at the same time were fully staffed with permanent staff.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept

under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

There was a lack of instructions for the use of 'As required' (PRN) medication and it was not administered to people safely.

The deployment of staff was not always proportionate to people's needs and safety.

A whistleblowing policy and procedure was made available to staff, however not all staff fully understood the procedure and some lacked confidence in it.

Is the service effective?

Requires Improvement

The service was not effective

People's rights and best interests were not fully protected in line with the Mental Capacity Act.

Although parts of the environment were adapted to meet the needs of people living with dementia, staff did not always fully understand how to use it to engage people.

People were given a choice of food and drink which they enjoyed.

Is the service caring?

Requires Improvement

The service was not caring

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

People did not always receive the support they needed to help them overcome period of anxiety and stress.

There was a lack of consideration by staff for people who were in bed sleeping and those watching the television.

Is the service responsive?

Inadequate

The service was not responsive

Supplementary care records did not provide important information about people's needs and they failed to show that people's needs were met.

Appropriate action was not taken for people at risk of malnutrition and dehydration.

Some people's needs had not been assessed and planned for.

Is the service well-led?

Inadequate

The service was not well led

The system in place for assessing, monitoring and improving the safety and quality of the service was ineffective.

There was a lack of management oversight to ensure audits were consistently completed and reviewed.

Action plans were not developed to address required improvements. Records were not maintained to ensure they were accurate and complete.

Green Park Care Home

Detailed findings

Background to this inspection

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

We visited the service on 22 and 23 May 2017. Our inspection was unannounced on the first day and the inspection team consisted of four adult social care inspectors, a specialist advisor and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with twenty one people who used the service and six of their family members. We also spoke with fifteen members of staff, the home manager and two interim area managers. We looked at the care records relating to 13 people who used the service, which included, care plans, daily records and medication administration records. We observed interaction between people who received support and staff.

Prior to the inspection we reviewed the information we held about the service including the Provider Information Return (PIR). 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. We also reviewed other information we held about the service including notifications of incidents that the registered provider sent us since the last inspection, including complaints and safeguarding information.

We contacted local commissioners of the service to obtain their views. At the time of our visit we had not received feedback about the service.

Inadequate

Is the service safe?

Our findings

The majority of the people living at the service told us that they felt safe. They told us, "There is always someone here to help you, no matter the time of day" and "I feel safe and content here. It's not like being at home, but I have everything I need and help anytime I need it". However, some people raised concerns regarding the response times to call alarms and told us, "It's okay here, but sometimes you can wait ten minutes up to an hour if you press the call bell for someone to respond. They are very busy". Family members raised concerns with regards to the use of agency staff across the service.

Medication was not always administered to people safely. Some people were prescribed PRN medication. This is medication which should be given to people when they need it, for example if they are experiencing periods of anxiety or pain. PRN medication should be administered at the request of the person or when care staff observe the need. However we saw examples where there was no protocol in place with guidance for staff about when and how PRN medication should be administered.

Two people were prescribed Lorazepam to be taken when required. Lorazepam is used to treat anxiety disorders. There was no PRN protocol in place to direct staff on the effective and safe use of Lorazepam. One person's medication administration records (MARs) had been signed by nurses to show it had been administered to them on a regular basis. For example each morning on four consecutive day's week commencing 15th May 2017. The nurse in charge on the first day of the inspection confirmed to us that there was no protocol in place for the administration of Lorazepam for this person. This meant there was no information about what the medicine was for, the reason for giving it, interval between doses and the expected outcome for the person.

The nurse explained to us that the person experienced periods of anxiety during which time they would shout out and make repetitive noises. The nurse went on to tell us that they administered Lorazepam to the person routinely as a preventative measure, to stop the anxiety from happening. This practice was unsafe and was not in line with the GPs prescribing instructions which were to administer Lorazepam to the person only when required. There was no care plan in place for the person to guide staff on how to help the person overcome periods of anxiety before the use of medication. This was despite two members of staff telling us that they considered that medication intervention was not always necessary. They told us that when the person became anxious they used interventions with positive outcomes for the person such as assuring and comforting them. Despite the regular use of PRN Lorazepam there were no records to show that the person's GP or any other healthcare professional had been consulted to review this.

We saw examples throughout the service where people did not have a PRN protocol in place for pain relief including paracetamol. Although the medication was listed on the persons MARs the instructions stated 'up to four times a day when required'. There were no other instructions such as what the medicine was for, the reason for giving it, interval between doses and the expected outcome for the person. Some people were unable to verbally communicate when they needed pain relief however there was no information to guide staff about how the person expressed pain. The lack of information about the use of PRN medication was unsafe and put people at risk of experiencing unnecessary pain and discomfort.

The allergy section of people's MARs had been completed to indicate any known or unknown allergies. However one person's MAR and medication care plan recorded that they had an allergy to Codeine. Despite this their medication profile which was in front of their MAR stated; 'Ok with Codeine'. When asked if they were aware of any allergies the nurse on duty told us the person did not have any. This put people at risk of being administered medication which was unsafe for them to take.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014 because the registered provider failed to have a proper and safe system in place for the management of medicines.

Medication rooms we viewed were kept locked when not in use and medication was administered only by the nurse or senior carer on duty. The temperature of the rooms and medication fridges were monitored and recorded each day. This helped to ensure that medicines were stored at the correct temperature so they remained effective. Opened Items of medication stored in the fridge had the date recorded on the label, to show when they were opened. This helped to ensure that they were not used past their expiry date after being opened. Information including the registered providers policy and procedure for the safe management of medication was displayed in the medication room. This included guidance about the use of PRN medication.

Discussions with people and their family members confirmed that staff did their best to meet the needs of everyone supported. Family members told us that at times the staffing levels were very varied. They told us, "Sometimes there are lots of regular staff on shift and other times there isn't a face you recognise. It can be very up and down" and "It's getting better, but there are times when there seems to be a lot of agency staff on duty". Records showed that staffing levels were based on a dependency assessment and these were reviewed and updated regularly. This information was then used to determine appropriate staffing levels for each of the five units. The area manager confirmed that staffing levels would be reviewed following any new admissions at the service. This provided flexibility to review and amend staffing levels in response to changes in people's needs.

Although we found that staffing levels were in line with the registered provider's assessed allocation, rotas showed that the use of and deployment of agency staff across the service was not proportionate. This was evidenced during both days of our visit. For example the week commencing 22 May 2017, we noted that on Windsor unit there were four day shifts where four out of the six staff required where from the agency. On Devonshire unit rotas evidenced that two out of the three staff required were from the agency. The area manager told us that the service worked hard to ensure consistent agency staff where used to minimise any impact of care delivery. We raised our concerns regarding the safe deployment of agency staff across the service. The registered provider advised us they would review the rotas following our visit.

We recommend that the management team undertake a full review of the deployment and use of agency staff to check there is a sufficient mix of agency and regular staff to provide people with person centred care appropriate to their needs.

The registered provider had a whistleblowing policy. Whistleblowing is when staff report concerns in confidence and their disclosure is protected in law. Staff we spoke with knew there was a whistle blowing policy, however three staff were unsure about whom they could speak with outside of the organisation if they needed to raise any concerns in confidence. Staff informed us that previous information shared with a member of the management team about concerns had not treated with confidence. They said that as a consequence they did not feel confident about raising concerns internally. We raised this with the registered provider during our visit who advised they would look into this as a matter of urgency.

The registered provider had a policy and procedure in place to review and monitor accidents and incidents. Accident and incident records had been completed as required when events had occurred at the service. Records evidenced incidents such as slips, trips and falls and any injuries sustained by people. Body maps were used to document any injuries, wounds or marks found on people's bodies. However, we saw an example were one body map had been used to document all of the injuries the person had sustained over a period of time rather than using a separate body map for each injury. The person's body map identified 12 different marks. The record did not include any information to show that the progress of the person's skin had been monitored to ensure healing. This meant that people were at risk of not receiving appropriate support following injuries sustained. We have further reported on the analysis of accident and incidents in the well led section of this report.

Each person who used the service had a personal emergency evacuation plan (PEEP). PEEP's were however unavailable on all the units. Staff on duty informed us that they were held in the reception area near to the main entrance of the service. This meant that they were not easily accessible to staff on the unit should they need them to safely evacuate people. PEEP's had not been reviewed since February 2017 despite monthly reviews being required. This put people's safety at risk as there was no guarantee that PEEPs accurately reflected their needs.

The registered provider had recruitment and selection procedures in place. Information contained in staff files demonstrated that appropriate checks had been carried out prior to them starting their employment. For example, for four staff recruited since our last visit we saw that an application form had been completed, evidence of formal identification had been sought and written references had been obtained. In addition a check with the Disclosure and Barring Service (DBS) had been carried out. These checks were carried out to ensure that only staff of suitable character were employed by the registered provider.

Staff told us and records showed that they had undertaken training in topics such as health and safety and fire awareness. They knew of their responsibilities to keep people safe. Staff knew where to locate emergency equipment such as firefighting equipment and first aid boxes.

Infection control processes were in place to keep people safe. Infection control information was displayed around the service, including the registered providers infection policy and procedure. There were hand sanitizers and handwashing instructions displayed near to hand basins. There were plentiful supplies of personal protective equipment. Staff wore PPE for tasks such as handling soiled laundry and when assisting people with personal care. A colour-coding system for cleaning equipment such as bins, cloths, mops and buckets was in place at the service along with guidance for staff on its use. The laundry room was in the process of being refurbished and was clean and well organised. Laundry was handled and laundered in line with infection control procedures.

Staff knew where to access safeguarding information, including the registered providers safeguarding policy and procedure. They knew what was meant by abuse and they gave examples of the different types and signs and symptoms of abuse. They understood their responsibilities to report any concerns about abuse and told us they were confident to do so.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and DoLS. Not all of the people who used the service were able to make complex decisions for themselves, such as where to live, the impact of refusing treatment or how to keep themselves safe. Care plans across all units contained evidence of 'decision specific' mental capacity assessments (where required). These were with regards to support tasks such as medication, personal care, diet and nutrition. Best interest meeting records outlined further discussions that had taken place with relevant others, where people had been assessed as lacking capacity to make a specific decision. However, we noted the use of exactly the same consistent sentences across four people's individual assessments and best interest meetings. Best interest meetings recorded that families had been involved in discussions; however there were no signatures in place to confirm this had occurred. Comments such as, 'discussed with son' were documented, but we found no information to outline discussions that had taken place to support the decision making process. One person's assessment was in the process of being completed. The record stated that the person had impairment to their capacity due to having a stroke. The assessment had been partially completed to identify that the person lacked capacity to make specific decisions. However, observations and discussions with the person identified that they were able to make decisions about their own care and welfare. Records relating to two other people also contained inaccurate information regarding their level of capacity. This meant that records did not accurately reflect the individual's capacity to make their own decisions.

DoLS applications had been submitted by the registered provider to the local authority for a number of people who used the service. These were for people they believed could not make a decision, due to mental capacity, as to where they should reside or the use of other restrictions in place such as the use of keypad locks on doors. However, as previously stated capacity assessments completed did not always contain accurate information. Even though we did not evidence any harm to people supported, this meant people were at risk of having their ability to make decisions regarding their care and support unnecessarily restricted. We spoke with the registered provider who confirmed they would review records following our visit.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as the provider had not ensured that care and treatment was provided with the consent of the relevant person.

People told us, "Most of the staff here make sure they ask me about what help I need. You get the odd one

you have to remind that you have a voice" and "They always talk to [my relative] about what they are going to help them with. Even though sometimes [my relative] doesn't respond". Throughout the inspection we heard staff asking people for their consent before providing care and support. Records showed that the majority of staff had attended training in MCA and DoLS and they showed an awareness of the basic principles of the acts.

Staff told us that access to training to support them in their role was overall good. As part of their induction and following initial training new staff were required to shadow experienced staff. This helped to ensure they were familiar with people's care and support needs. Newer staff members confirmed that they had their competency and skills assessed as part of their induction process. Once staff were assessed as competent and confident, they were able to work on their own. The registered provider provided CQC with a copy of the staff training matrix for our review. The matrix showed that training that had been undertaken with staff included safeguarding adults, moving and positioning, equality, diversity and inclusion and dementia awareness. Training was completed in a range of methods including e-learning, classroom based and practical competency assessments. Records confirmed that staff supervisions and team meetings had been completed as required.

The environment within the units that supported people living with dementia had been adapted to promote a dementia friendly space. There was clear signage in place using both pictures and words to help and aid orientation. Items of interaction and stimulus were located in hallways which could be used to support reminiscence and wayfinding such as personal photo boxes outside of bedroom doors, pictures of the local areas and favourite pastimes of people supported. The décor consisted of muted colours and consideration had been given to limiting different patterns and colours both within the flooring, walls and accessories such as curtains. However, staff we spoke with did not always understand how the environment could be used to actively engage with people. We spoke with the registered provider who advised they would discuss this further with staff to aid their understanding.

People and their family members confirmed that routine healthcare appointments had been attended to keep them healthy. They told us, "If I'm not feeling too good they will get the GP for me" and "The staff do their best here. They always let us know if [our relative] is not feeling well or there are any changes in their health needs". Staff explained their role and responsibilities and how they would report any concerns they had about a person's health or wellbeing. For the majority of people appropriate referrals were made to other health and social care services. Staff identified people who required specialist input from external health care services, such as GP's and District nurses. However we found that two people who had significant weight loss had not been referred to the relevant professionals in a timely manner. We raised this with the registered provider who took immediate action during our visit. There is further detail about how staff monitored people's diet and fluids in the responsive section.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014 because risks to the health and safety people were not assessed and mitigated.

Visiting health professionals told us that they felt things 'were improving' and 'most times visits were ok' and that the service was beginning to get some structure in place.

People told us, "The food is not bad at all", "It's actually quite nice. We all have different expectations but its usually good quality" and "If I don't like something I can get an alternative. I never go without". People and their family members told us that the chef regularly visited the units to request feedback about the meals presented or to see if people had any special requests. The atmosphere at the lunchtime meal in the dining area on both Cavendish and Devonshire units was relaxed and calm. The meal service was unrushed and

people received the support they needed to drink and eat their meal. Dining tables were well presented and condiments were available for people to use. People were offered a choice of where and whom they would like to sit with and some people chose to eat in their own personal rooms. Clear explanations and visual choices were offered to people (where required). Care plans described the support people needed to eat and drink including any specialist equipment people needed to promote their independence at meal times.

Requires Improvement

Is the service caring?

Our findings

People told us they were well cared for and that their privacy and dignity was always respected. Their comments included; "All the staff are lovely they care for me very well", "The staff are very respectful. They help me to be as independent as I can", "The staff are very respectful. They knock on my door and shout can I come in" and "The people [staff] here are nice, they know how to look after you. They look after me very well. I am happy here". Family members told us that they thought the staff were caring and that their relative was treated with dignity and respect. Their comments included, "The general staff are very caring, friendly and cheerful. Management are not available they change all the time". "Mum likes her door open all the time, but they [staff] always close it when they are doing personal tasks for her.

People's privacy and dignity was not always respected. Two people were observed from corridors lying on their bed. One person was unclothed from the waist down and the other person had no underwear on, the bedroom doors to both people's rooms were wide open which meant both people could be seen by anyone passing their rooms. One person who was sat in a lounge had nasal mucus dripping from their nose towards their knees. Staff were sat with the person at the time; however they made no attempt to assist the person to clean their nose. The same was observed an hour later when a different member of staff was sat with the person. They too did not provide any support to the person. Staff failed to acknowledge that this may have been uncomfortable and distressing for the person who was unable to attend to their own personal care needs.

One person received a visit from a district nurse who was attending to take a blood sample. The nurse on duty led the district nurse into the lounge where the person was sitting and expected the district nurse to carry out the procedure there and then amongst other people who occupied the lounge. The district nurse requested that the person be assisted to their bedroom so that the procedure could be carried out in private.

People's confidentiality was not always respected. There were occasions when staff shouted to each other down corridors near to bedrooms where people were sleeping. During these times they asked questions about people and shared information about them. For example, "I'm just going to get [x] up" and "Can you come and help me put [X] on the toilet".

There was a lack of consideration given to people viewing the television. Staff escorted people into the lounge and placed them in view of others who were sat behind watching the television. A member of staff conducted a telephone discussion in the lounge which people occupied. During the discussion the member of staff paced up and down. This disrupted and obstructed peoples viewing of the television.

Some staff understood that people living with dementia could express communication through behaviours, noises and gestures. They explained how they would offer reassurance and comfort to people during periods of increased distressed behaviours. However entries made in care notes showed that there was a lack of understanding by some staff as to whether people were showing signs of distress or communicating through the use of noise. Records also demonstrated a lack of positive intervention to help people

overcome periods of anxiety and stress. Entries recorded by staff included; "Reassured to no avail" "Shouting and asking for the toilet again and again. Assisted to the toilet but didn't do anything. Asked why are you shouting, [x] didn't know" and "Sat with [x] still wanting attention".

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as the provider had not ensured that people were treated with dignity and respect.

Observations of other care interventions and interactions showed that staff spoke with affection and respect to people and it was clear staff knew them well and their likes and dislikes. A happy and relaxed atmosphere was observed across the service and many people were seen smiling and enjoying laughing and joking and singing with the staff.

People were encouraged to personalise their bedrooms as they wished. Bedrooms displayed items such as keepsakes, pictures, photographs, plants and ornaments. Some people had easy chairs and other items of furniture which they had brought with them from their previous home. People also personalised their rooms as they wished with televisions and radios. Bed linen and towels were provided as part of the service and nicely laundered. The staff working in the laundry demonstrated respect for people's clothing. They followed a system which ensured clothing was properly cleaned and pressed and returned to people promptly. They made every effort to make sure unmarked items were returned to people. Laundry staff explained that visited each unit with any unmarked items to try and establish who they belonged to.

Inadequate

Is the service responsive?

Our findings

People had mixed views with regards to the level of activities taking place in the service. They told us, "I think it's great. We play bingo, quizzes, we have a good old sing song and we spend time together", "I go to the local community centre for silver service lunch. It's so nice, I feel really special going there". Other people commented, "There doesn't seem to be much going on here. We could do with some more things to do" and "I would like to be involved in more activities. I can get a bit bored sometimes and it's nice to be doing something".

The majority of people had access to regular drinks and food. The registered provider had supplementary records which were used to record food and fluid intake for people who may be at risk of dehydration and malnutrition. Food and fluid intake charts for seven people living at the service were reviewed. Records for all seven people were not completed accurately and in detail and fluid intake had not always been recorded in a timely manner. Records evidenced gaps of up to 7 hours where fluid intake had not been recorded. The British Dietetic Association (BDA) guidelines state that over a 24 hour period the average intake for adults including the elderly should range between 1600-2000mls. One person's chart recorded a total intake of 30mls of fluid over a 24 hour period. Charts for another person who was at high risk of dehydration and malnutrition had recorded no food or fluid intake/refusal over a 7 hour period. Observations showed that people did not always consume the amount of fluid recorded on the charts. Inspectors observed staff leaving a cup of tea with one person and recording 300mls of fluid intake on their chart. The person did not consume the drink and it was later removed by staff untouched. Charts did not always clearly identify the amount of food people consumed. Inspectors found that charts were not consistently totalled to accurately assess whether people had received adequate food and fluids to prevent the risks of dehydration and malnutrition.

People did not always receive safe and effective care to meet their needs. People who were at high risk of weight loss where monitored on a weekly or monthly basis. However, care plans failed to evidence robust actions taken in response to significant weight loss or gain. One person's risk assessment identified them as being at risk of weight loss and dehydration. Records evidenced a 5kg weight loss in a four week period. Another person had lost 5.3kg in a six day period. There were no recorded actions taken in response to these identified weight losses. One person on Windsor unit had lost 4.3kg between January and May 2017. Their care plan notes dated 6 April 2017 stated 'refer to dietician'. We found no evidence in their care plan to support dietician involvement. A letter received from the senior nurse practitioner stated 'discuss supplements with GP'. Again we found no evidence that this discussion had occurred with a GP or that supplements had been sought for the person. The registered providers audits dated April 2017 identified that five other people had also experienced significant weight loss at the service. We found limited evidence with regards to appropriate actions being taken in a timely manner to safely protect people from the risk of malnutrition.

People's needs were not always assessed and planned for. A behavioural chart was being used by staff to record specific information about one person's behaviour. Entries made onto the behaviour chart recorded instances when the person had shouted and made repetitive noises, during periods of anxiety and stress.

Despite this there was no assessment documentation to demonstrate that this had been identified as an area of need. There was also no care plan to direct staff on how best to support the person with their behaviour and during periods of anxiety and stress. Another person who had moved into the service six days prior to our visit had no care plans or risk assessments in place. This was despite a range of complex needs highlighted in the initial assessment carried out in respect of the person prior to them moving into the service. We brought this to the immediate attention of the registered provider who addressed this during our visit.

This was a breach of regulation 12 and 17 as the registered provider failed to ensure that robust records were kept in relation to assessing and planning people's care and monitoring people's food and fluid intake. People were not adequately protected from the risk of receiving unsafe care and treatment.

The majority of people's needs were assessed and care plans were clearly titled which showed the area of need. Care plans contained varied levels of detail about how to meet people's needs. Consideration had been given about how to promote some people's independence and how to comfort and reassure people. Examples included in care plans reviewed stated, "[Name] can be reluctant to have a shave. But if you explain to [name] about their appearance and offer help and support, they will shave themselves".

Regular reviews of care plans were completed, although we found that where there had been changes to people's care and support needs, for example, new risks, they had not always been consistently recorded across all units. Comments such as 'no changes required to care plan' were noted in a number of care plan reviews over periods of up to three months. Daily notes completed during each shift contained generalised information. Statements such as, "diet and fluid intake good" and "settled day" were consistently recorded by staff. Records provided a basic overview of the care and support people had received.

There was a limited evidence to show that people and/or their representatives had taken part in the assessment, development and reviewing of people's care. An example of this was how a staff member had attended the service until 11pm to write care plans for the afore mentioned person. The person had capacity to contribute to the planning of their own care and support. There was limited evidence that people or relevant others had been involved in signing their care plans to agree with the written content (where appropriate). People and family members we spoke with could not recall being involved in the development or review of care plans.

Records such as daily mattress and bed rail checks were not always completed in full detail. Information relating to the specific unit, month and year was not always recorded. Records were not always consistently signed and dated. This meant that there was a potential that records would not be able to be reviewed accurately in line with the registered providers monthly audits. We raised this with the management team who stated they would raise staff awareness regarding the importance of accurate and completed records following our visit.

This was a breach of Regulation 17 of the Health and Social Care Act as the registered provider did not ensure that accurate and contemporaneous records were held in respect of people supported.

Inadequate

Is the service well-led?

Our findings

At the time of our visit the service was not currently managed by a person registered with the Care Quality Commission (CQC). There was a new manager at the service who had commenced their employment in April 2017. They had started their application with CQC to become the registered manager. The home manager was supported by two interim area managers recruited by the registered provider.

People and their family members told us that they weren't sure who was responsible for managing the service. They commented, "There has been lots of a change. I don't get affected by it though, if I need anything I will speak to the staff and they will sort stuff out for me" and "I know there has been a recent change to the manager. We met him at the carers meeting. Seems a nice enough man".

The registered provider had in place a comprehensive framework with clear guidance, for assessing and monitoring the quality of the service and for making improvements. The new home manager and the interim area manager were responsible for the completion of audits and checks at the service. These checks included reviewing medication procedures, care plans, falls, the use of bed and grab rails and monitoring weights. However, systems in place to assess and monitor the quality of the service were not always effective. Records showed that issues with regards to the management of medicines, weight loss, and care planning that we identified as part of our visit had not been identified by the registered provider. There was a lack of evidence to demonstrate where improvements were required in response to shortfalls in these areas.

Accident and incidents audits were not always effective. Records relating to two people, who were identified as a high risk of falls, evidenced that they had encountered a combined total of ten incidents between March and April 2017. The registered provider's monthly incident analysis record for April 2017 had not been completed to establish any trends or patterns in incidents that had occurred. There were no recorded action plans in place to evidence what steps had been taken to prevent the risk of repeated harm.

The registered provider's monthly weight audit failed to evidence robust monitoring and actions taken in response to significant weight loss or gain. Audits we reviewed dated April 2017 identified that eight people had lost between 3kg and 7kg in weight in a four week period. For one person who had lost 4.25kg, comments noted on the audit included, 'On pureed diet, assisted all meals, diet and fluid chart'. Another person who had lost 5.6kg had no comments or actions to be taken recorded. This meant that people were not safely protected from the risk of malnutrition.

A range of audits records in March, April and May 2017 were incomplete. Sections requiring information relating to date, month and which specific unit the audits related too where left blank. Where audits required a 'yes' or 'no' response, the registered provider had 'ticked' the box. An example of this was the pillow audit completed on Balmoral unit. The registered providers audit states, 'Poor condition pillows may be a source of healthcare associated infections'. The information collated by the auditor did not provide a clear overview of the condition of the pillow one person used. The audit was not completed in full detail signed or dated.

Audits did not always identify specific timescales for actions to be completed and there were limited action plans in place to demonstrate improvements implemented by the registered provider. These systems did not ensure that people were protected against the risks of inappropriate or unsafe care and support. The lack of robust oversight by the registered provider failed to ensure the quality of care and facilities provided to people who used the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider's quality assurance audit systems were not effective.

A resident and relative meeting had been undertaken in April 2017. Minutes showed that a range of items had been discussed, including the introduction of the new home manager, maintenance updates and review and rewriting of care plans that had taken place. Family members had raised concerns during the meeting with regards to the use of agency staff and the impact on their relatives and staffing levels at mealtimes. Feedback had been provided during the meeting as to how the registered provider would look into these matters. However, there was no action plan in place to evidence how issues had been addressed or resolved. We raised this with the management team who advised us they would complete this action in future meetings.

Through discussions with the home manager it was clear that his aim was to re-establish a culture that promoted openness, honesty and transparency. Staff confirmed that team meetings had been held where they were introduced to the home manager. Meeting were also used to discuss the service and to ensure that important information regarding any changes to the service or practice were shared. Some of the areas that had been discussed included punctuality and record keeping. Staff members spoke positively about the recent management changes and commented that they hoped the changes would help them to feel supported in their work.

The registered provider had a comprehensive set of policies and procedures for the service. The registered manager informed us that policies were reviewed and updated as required. Records confirmed this. Policies and procedures in place gave guidance to staff about how to carry out their role safely. Staff knew where to access the information they needed.

The service had notified the Care Quality Commission (CQC) of significant events which had occurred in line with their legal obligations.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider did not ensure that people were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider did not ensure that care and treatment was provided to people with the consent of the relevant person.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The registered provider did not ensure that people who used the service received safe care. They failed to assess and mitigate risks to health and safety of people.

The enforcement action we took:

A warning notice for regulation 12 was issued to the registered provider with a compliance date of the 16 October 2017.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered provider did not operate an effective system for assessing, monitoring and improving the quality and safety of the service. The registered provider did not ensure that accurate and contemporaneous records were held in respect of people who used the service.

The enforcement action we took:

A warning notice for regulation 17 was issued to the registered provider with a compliance date of the 16 October 2017.