Four Seasons Health Care (England) Limited

Manor 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 took place on 1 June 2016 and was unannounced. This meant the provider and staff did not know we were coming. A second day of the inspection took place on 2 June 2016 and was announced.

Manor Park Care Home is registered to provide accommodation and personal care for up to 49 people, including people who were living with dementia. At the time of the inspection there were 32 people using the service, 23 of whom needed nursing care. Manor Park consists of three units, Blanchland, Wynyard and Cameron. Each unit support and care for a mix of people who require either nursing or personal care needs. Cameron is a male only unit. .

A registered manager was in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection of the home in January 2016, we asked the provider to take action to make improvements. This was because we found the provider had breached a number of regulations.

We found risks to the health and safety of people who used the service, as well as staff and visitors. Risks had not been appropriately assessed and actions had not been taken to minimise those risks. Staffing levels were not sufficient to safely meet the care needs of the people who used the service. The assessed needs of people were not always accurate therefore the method of determining staffing levels could not be relied on. Staffing levels were not increased following the changing needs of people living at the home.

The registered manager did not ensure care and treatment was provided with the consent of the relevant person. Staff were not familiar with the principles and codes of conduct associated with the Mental Capacity Act 2005, or how to apply them for the people they were caring for. People were not supported in making decisions about their care and well-being.

The provider did not ensure staff received appropriate training and development to enable them to carry out the duties they are employed to perform. Care records did not always reflect people's needs and preferences. The provider did not always ensure people's nutritional and hydration needs were assessed. People's choices were not respected in relation to nutrition. There were inadequate support facilities and amenities provided for the number of people using the service. We also found the provider did not have effective quality assurance processes to ensure that people received appropriate and safe care.

During this inspection we found the provider had continued to breach a number of regulations. Staffing levels were still not sufficient to safely meet the care needs of the people who lived at the home. Risks were not being recognised, therefore risks were not being assessed and mitigated against to minimise the risks to people, staff and visitors. Care records did not reflect people's needs and preferences. We also found the

provider's quality assurance processes remained ineffective, failing to identify issues found during the inspection.

The registered manager conducted thorough investigations into safeguarding concerns and ensured all relevant authorities were informed.

The provider had a monitoring system in place to identify when reviews were required for people's Deprivation of Liberty Safeguards (DoLS). Staff understood and applied the principles of the Mental Capacity Act and consent.

Personal Emergency Evacuation Plans (PEEPS) were in place and included an individual assessment of each person's evacuation needs however these were not reviewed as stated by the provider's own policy.

The provider had a robust recruitment procedure in place which included ensuring appropriate checks were undertaken before staff started work.

Mandatory training was up to date including safeguarding and moving and handling.

The home recently purchased and installed two purpose-built baths which people told us they enjoyed.

Communal areas within the service were clean and tidy. However, we found some equipment within the kitchen was dirty and cleaning records were incorrect.

People were not always offered an alternative meal if they declined to eat their first choice.

During meal times staff engaged with one person who was able to converse and hold a conversation but engagement with the other people who had limited verbal communication was functional and limited.

The provider had systems in place for the receipt, return, administration and disposal of medicines. Audits did not always identify gaps in the administration of medicines.

Where people had no family or personal representative we saw the service assisted people to obtain support from an advocacy service.

People had access to a range of activities including bingo, crafts, armchair exercises and going on outings. Staff supported people to maintain links with the local community.

The provider used an iPad feedback point called 'Quality of Life' to capture views about the quality of the service from people, relatives, external professionals and staff.

People told us they saw the registered manager around the home regularly. One staff member told us, "She's always on the floor and if there's anything that she can do – she'll do it".

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

The service 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.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Risks were not identified, assessed and mitigated against.

Staffing levels were not appropriate to meet the needs of people.

Staff were not readily available to respond to people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Recommendations from dietician's and speech and language therapy were not always implemented into people's care records.

Meal alternatives were not made readily available if a person declined their earlier choice.

The provider did not ensure appropriate best interest considerations had taken place when required.

Training and development was up to date. Staff told us they attended group supervisions.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff who had completed training with the resident experience appeared to have a better understanding of people's needs.

Relatives we spoke with told us staff were respectful.

The registered manager supported people to gain access to an advocacy services.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans we viewed were confusing and did not give a clear picture of how to support the person.

People had access to activities and had opportunities to socialise with other people.

The provider had a complaints policy and procedures in place.

Is the service well-led?

Inadequate

The service was not well- led

The provider system for monitoring the quality of the service did not identified the areas of concern we discovered during our inspection.

Staff morale had increased since our last inspection.

The provider ensured statutory notifications had been completed and sent to the CQC in accordance with legal requirements.

Manor 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.

This inspection took place on1 June 2016 and was unannounced. A further visit was carried out on 2 June 2016 and was announced.

The inspection team consisted of two adult social care inspectors 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.

Prior to the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events of incidents the provider is legally required to let us know about.

Before the inspection we also contacted the local authority commissioners for the service and the local authority safeguarding team, the clinical commissioning group (CCG) and the local Healthwatch to gain their views of the service provided. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with 10 people living at the service and five relatives. We also spoke with the registered manager, the regional manager, one Care Home Advanced Practitioner (CHAP), one Personal Activity Leader (PAL), the deputy manager, five care staff, one handyman and one kitchen assistant.

We reviewed four people's care records and five staff personal files including recruitment, supervision and training information. We reviewed medicine records, as well as records relating to the management of the service.

We carried out an observation using the Short Observational Framework for Inspection (SOFI). SOFI is a

specific way of observing care to help us understand the experience of people who could not talk with us. We undertook general observations of how staff interacted with people as they went about their work.

We looked around the home, visited people's bedrooms with their permission and spent time with people in the communal areas.

Inadequate

Is the service safe?

Our findings

At the last inspection in January 2016 we found risks to the health and safety of people, staff and visitors had not been appropriately assessed and actions had not been taken to minimise those risks. Staffing levels were not sufficient to safely meet the care needs of the people who used the service. The assessed needs of people were not always accurate therefore the method of determining staffing levels could not be relied on. There were inadequate support facilities and amenities provided for the number of people using the service.

During this inspection we found throughout the home risks were not recognised and mitigated against. Risks to people were not appropriately assessed or updated in response to concerns or advice from healthcare professionals. One person was living with a diagnosis of epilepsy. We did not see any evidence of a risk assessment in relation to this diagnosis. We asked if risks were mitigated against in relation to the person while bathing. The registered manager said, "[Person] has a specially designed chair to be used in the shower, so if they didn't have the chair they wouldn't have a shower." We asked if the chair mitigated any risks in relation to epilepsy. The registered manager said, "No, no, I see what you mean, I will get it worked on tonight." We checked the care records on the second day of inspection and a risk assessment had not been completed.

One person had a risk assessment for the use of bedrails dated 1 July 2012. The reason for considering the use was due to, 'recent fractured neck of femur and non-mobile.' We spoke with the registered manager who said the person still used the bed rails but the reason for use was out of date. This person also had a risk assessment for moving and handling and the use of a profile bed dated 2 April 2013. The document stated, 'This risk assessment shall be reviewed annually or more often as necessary when changes occur.' There was no evidence of a review.

Another person had a choking risk assessment which stated they were able to feed themselves independently and safely, there was no difficulty swallowing and they ate food of a normal consistency. A letter from the speech and language therapy team (SALT) recommended, 'normal thin fluid from an open cup with single sips. Offer a fork mashable diet, texture E diet – soft finger foods, e.g. sandwiches with moist fillings (crusts removed). Staff to supervise and assist with food and drink, e.g. load the spoon if need and prompt to return attention to the meal. Offer oral intake only when fully alert and sitting upright/remain upright for 20 – 30 minutes after oral intake. Referred to dietitian but in the meantime offer high calorie fortified foods.' This means the risk assessment had not been updated to reflect the recommendations of the SALT team.
The lift was out of order on both days of our inspection. We found staff using the main stairs to transport hot food up to the first floor dining rooms. The main stairs were accessible for visitors, staff and people living at the home. At one point we saw a kitchen assistant carrying food up the stairs holding a metal container containing food with an artic roll in a plastic container under their armpit. We brought this to the attention of the registered manager. We asked what risk assessments had been conducted to ensure staff and people were protected. The registered manager said, "No, I'll be honest with you there isn't, I'll do it tonight."

We noted the kitchen door had been left unlocked which meant people had free access to cooking

equipment and utensils placing them at potential risk of harm. Sandwiches had been left on a serving trolley covered in cling film, the kitchen assistant said, "The care staff have left them there for people who didn't want their tea." There was out of date milk in one fridge and microwaves had a hard build-up of food inside them, there was a pan full of oil sitting on kitchen roll which was oil soaked. We found pans and trays which still had food on them along with a build-up of oil and old food. We checked the cleaning schedules which recorded the microwave had been cleaned and the weekly deep clean had been completed. The registered manager said, "I clearly need to monitor it more." The microwave and other equipment was placed in the bin by the regional manager. We informed the Local Environmental Health Authority of our findings.

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

One person told us, "Could do with more staff - they work long hours. Sometimes too busy to chat". Another person said, "Sometimes could be a few more. Don't wait too long. Don't have time to chat as they are too busy." A relative said, "There seems to be enough staff most of the time. Response times are good".

The provider's dependency tool was used to assess the number of staff required to meet people's needs. The regional manager explained they were currently providing more staff than the dependency tool indicated were enough. The registered manager said, "There's one carer on each unit upstairs and one staff member floating, three or four carers and a nurse downstairs." One staff member said, "There's not enough staff if I'm honest with you." We asked the registered manager about staffing levels, they said, "I'm very confident there's enough staff, as a nurse I use gut instinct and CHESS [dependency tool], there's no falls, no pressure ulcers and no complaints so I'm comfortable there's enough staff."

On two occasions we had to seek staff to support people. We heard one person shouting for help and another person shouting for the commode, we waited for seven minutes for care staff to attend when no one did we sought out the nurse who attended to the people. One person repeatedly asked would we stay and chat as staff didn't have the time.

During the visit we heard a loud bang from the room adjacent to the one we were based in, we went to see what had caused the noise and found the person's side table and meal on the floor. No staff were in the vicinity and we had to go to the other end of the premises to ask staff to assist the person.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The fire service had completed a visit and the home was assessed as broadly compliant with no schedule of works to be completed. The registered manager said, "We have eight evac slides and two evac chairs. All staff are trained in the slides but not all on the chairs." Personal emergency evacuation plans were in place however they all stated they should be reviewed on a monthly basis. There was no evidence that the reviews had been completed which meant the registered manager had failed to follow their own procedure.

An electrical installation certificate dated 17 April 2014 had rated the condition of the installation as unsatisfactory. We also saw an emergency lighting certificate which showed faults. We spoke with the registered manager and area manager who said, "The work has been done, we can get it off the system for you." Following the inspection the registered manager provided us with records showing that the remedial work had been completed.

An emergency contingency plan was in place which included action for staff to take in the event of a loss of

premises, a flood or lack of staff, however it did not include lift failure nor had it been updated to reflect the details of the registered manager.

Some weekly checks for premises and fire safety had not been completed. The fire door check was last completed 17 May 2016, the emergency lighting had not been checked since 13 April 2016. We found the acoustic door closers were last checked 25 April 2015. We also saw that checks were not completed if the handyman was on holiday. The registered manager had failed to delegate health and safety checks to ensure the premises were safe in the event of a fire.

One staff member spoke with us about safeguarding. They said, "It relates to everyone, for example a controlling visitor. We got an advocate involved who was able to speak up for the person and say what they wanted. A safeguarding was raised and now we act in the persons best interest."

The registered manager had investigated and made safeguarding referrals to the local authority where required. For each safeguarding record we saw appropriate information was recorded, including the people involved and whether any further action was required. The registered manager told us they submitted a weekly return to the regional manager which included safeguarding concerns.

During the last inspection we found people did not have access to a bath. We saw two new purpose built baths had been installed. One person told us, "I enjoy a bubble bath".

We reviewed the accident and incident records. The registered manager advised accidents and incidents were logged and stored electronically within the provider's own system called Datix. We saw information was collected, including types of incidents and times they occurred. We asked the registered manager if an analysis was carried out to identify any trends or contributory factors which may require investigation. They advised us that when an accident or incident is recorded in to the system they are made aware and deal with the matter if required. Whilst analysis was not automatically actioned the system offered the function if required.

The provider had an effective recruitment process. We reviewed five staff recruitment files. Four records held an application form, records of the interviews held, two completed reference checks and a Disclosure and Barring Service (DBS) check. DBS checks help employers make safer decisions and help to prevent unsuitable people from working with vulnerable adults. One recruitment file held a police check from a European country prior to a DBS being carried out in line with the provider's recruitment process.

During the last inspection we found systems to be in place for the safe management of medicines. One person who was being supported to take their medicines said, "I have trouble swallowing so they look after me and my medicine." We found gaps on medicine administration records (MAR) for evening medicines on one day in May 2016 and also found one person's medicine recorded as 'not in stock.' We spoke with the staff member managing medicines and they investigated both concerns immediately updating us on progress. The person had received their medicines but the MAR had not been signed, the registered manager said, "[Staff member] will be spoken to." We asked why this hadn't been picked up on an audit, the area manager said, "Weekly meds audits are completed on 25% of residents, so it would be picked up on the cycle." The person whose medicine was recorded as out of stock had had this medicine discontinued by their doctor. All other records we viewed were correct.

Requires Improvement

Is the service effective?

Our findings

At the last inspection of the home in January 2016 we found the registered manager did not ensure care and treatment was provided with the consent of the relevant person. People were not supported in making decisions about their care and well-being. Staff did not receive training that was relevant to the needs of the people who used the service and people's choices were not always respected in relation to nutrition.

Improvements had been made in training with all staff completing the provider's designated mandatory training.

The registered manager said, "Mandatory training is at 100%." One senior care staff member said, "I've done training in diabetes, medicines, it's all about continuous training." Another staff member said, "I've done practical moving and handling, resident experience training, diabetes, dysphasia, weight and nutrition."

The training matrix showed that all staff had attended training in first aid, moving and handling, equality and diversity, fire safety, health and safety, safeguarding and mental capacity and DoLS. All staff who were administering medicines had attended training. 35% of staff had attended training in person centred care, and 36% resident experience training.

Staff told us they received regular supervision and had an annual appraisal completed by the registered manager. We looked at supervision records and noted 16 out of 49 staff had not taken part in a supervision either 1:1 or as a group supervision. The regional manager said, "We only had one nurse so group supervisions happened." The regional manager and registered manager stated the priority was to complete appraisals, the regional manager said, "Now the nurses are in post they need to be allocated care staff to supervise to have one to one meetings."

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 so that they can 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 whether any conditions on authorisations to deprive a person of their liberty were being met.

Assessments of mental capacity were recorded, and best interest decisions were documented however there was no record of the options considered within the best interest decision and whether or not the option was the least restrictive in relation to mitigating risk. Best interest decisions had not been reviewed.

We asked the registered manager about this and they said, "It would only be recorded if there was a change." The Mental Capacity Act 2005 Code of Practice states. 'What is in a person's best interests may well change over time. This means that even where similar actions need to be taken repeatedly in connection with the person's care or treatment, the person's best interests should be regularly reviewed.' We noted this was area previously identified during our inspection in January 2016.

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

One staff member said, "We would go through the criteria to determine if the person can make major decisions or day to day decisions. If people don't have capacity we use multi-disciplinary team, family and the person to make bigger decisions. All decisions need to be in the person's best interest."

A log of authorised DoLS was in place which included expiry dates and dates for the resubmission of applications to deprive the person of their liberty.

We observed the lunchtime experience in each of the three dining rooms. The tables were laid with tablecloths, placemats, condiments, cutlery and a jug of juice. A pictorial menu was on display with a written menu on each table. The pictorial menu didn't always reflect what was on offer, for example the word burger was written near the image of the chips, indicating burger and chips. On one day we noticed there was no vegetarian option available with meat pie or burger and chips available.

One visitor told us they thought that the food was variable and was sometimes good and sometimes not. They gave an example of a meal of sausage roll and chips for one person which was very dry. When the person asked for something else a dessert was offered but no alternative main meal.

On the Wynyard unit we witnessed the same lack of available choices once the mealtime was underway. We observed one person only ate a couple of mouthfuls of food and said that they were finished. A member of staff took the meal away and then provided the dessert which the person ate. The staff member did not ask why they didn't wish to finish their meal or offer an alternative before giving them a dessert. The dining experience was a sociable one where staff were talking to people all the time and music was played in the background. One person described meal times by saying "We all gather round and chat with friends".

On the Blanchland unit, we saw six people were sitting in the dining area for lunch which meant nine people were having lunch in their rooms. We observed the staff presence in the dining room to be intermittent due to carrying plated meals to people's rooms. Three people needed physical support to eat their meal which staff provided on a one to one basis. Communication and engagement was limited. We saw one person supported to eat their meal by the staff member using a large dessert spoon, the staff member did not explain what the person was about to eat, nor did they ask if they were ready for another spoon of food. There was no conversation other than an occasional, "Have you had enough," and "Have some more milk."

Staff engaged with one person who was able to converse and hold a conversation but engagement with the other people who had limited verbal communication was functional and limited. We spoke to the registered manager about this who said, "There's enough staff, we monitor weights and very few people are losing, that's my measure of if people are getting enough support. Staff have more than enough time to sit and speak to people."

We observed meals were placed in front of people with a, "Here you go." Staff did not explain to people what their meal was, nor did they ask if that was still their choice or if they wanted something different. We asked

the registered manager how people chose a meal, they said, "Menus' go out after breakfast, it's on the board and the printed menu. There's always sufficient if someone changes their mind on their meal. People should be reminded when meals are given that that was ordered and an alternate offered if wanted." We advised that we had not observed this happening.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence in care records of cooperation between care staff and healthcare professionals including dietetics, occupational therapists, physiotherapy, and GPs to ensure people received effective care. We saw involvement from dieticians and speech and language therapy, however care records had not always been updated to reflect the recommendations made. This meant that staff did not have up to date information to be able to support people safely or appropriately.

Requires Improvement

Is the service caring?

Our findings

At the last inspection of the home in January 2016 we found the service was not always caring. During this inspection our observations were mixed as we witnessed both positive and negative interactions between staff and people living at Manor Park Care Home.

The registered manager told us two staff members had taken part in training with the resident experience team. One of the staff members who took part described the training where the staff played the role of people who live in the home to understand some of the challenges that they face. They advised that the training was to be rolled out across the home.

During our two day visit we observed mixed levels of interactions between staff and people. We noted the most positive interactions we viewed involved the staff who had received the resident experience training. We heard one care staff member use the person's nickname which the person responded to with a broad smile and engaged in a chat which clearly involved the person. They were able to detail how to support the person when they were reluctant to engage with staff.

One staff member was able to tell us about people's needs and how to support them, for example they could describe the signs and symptoms people presented with if they were feeling unwell due to living with epilepsy or diabetes.

The registered manager was able to share information about people's life history, such as their experiences of growing up and areas they had lived in. The registered manager told us the home had purchased a mobile phone for a resident's husband who had been hospitalised recently to ensure they maintain contact.

One person who spent their time in their room knocked their table over, including a meal. We heard the noise and ensured the person was alright. After fifteen minutes there was no response from staff we found a staff member who went to the person's room with us. We observed they entered the room and cleared the floor although some food debris remained. The staff member did not speak to the person. The person told inspectors they were sick, this was passed to the care staff who said they would tell the nurse. We waited a further 15 minutes and the nurse did not attend. We went to the registered manager and regional manager and expressed concern about the length of time that had lapsed with the person not receiving any support.

We asked how people who were unable to use their nurse call sought staff support other than by shouting. The registered manager said, "I think it's about deployment." The regional manager said, "I know its choice but do we need to look and consult to move people so they are in a smaller area so staff are more visible." They went on to discuss looking at the allocation of staff to zones.

One person asked if we could sit and chat with them as no one did. They told us their buzzer didn't work and they had told staff. We tested the buzzer and found it sounded initially then stopped. We advised the registered manager and the buzzer was fixed immediately.

We witnessed one staff member approach a person from behind place their hand on the person's shoulder which shocked the person and they shouted out, "Oh you nearly frightened me to death." We observed staff assisting people with the use of hoists to and from wheelchairs. Two staff were always present; although the task was performed in a safe manner staff didn't explained what was happening to the person and engaged in limited conversation.

People's confidential information was held securely in the nurse's offices. We found in one person's care plan confidential information relating to another person. The word 'error' had been noted underneath but the entry was clear to read. This meant a person's confidential information was accessible by those who did not have a right to view it.

We saw there were no curtains at the windows in the downstairs shower room, the windows were frosted but a person would still be visible from the outside. We asked the registered manager about the dignity of people using the shower. They advised, "I thought with it being frosted it was okay."

People and relatives told us staff were respectful. One person said "They are all very nice I like them. They help you keep your independence." Another said "The staff are really nice". However one person told us, "The nurses are lovely but some carers are funny." One visitor said that staff put their relative at ease by explaining what they are doing when giving care. They added "They always give (person) their full attention. I've not met any that make her feel uneasy. They are all lovely girls."

Information was displayed on noticeboards throughout the home promoting the local advocacy service outlining the support available. The registered manager told us if anyone required an advocate they would be fully supported to obtain help.

Inadequate

Is the service responsive?

Our findings

At the last inspection of the home in January 2016 we found care records did not reflect people's needs and preferences.

We reviewed four care plans and found a continuation of the issues we identified in our last inspection.

One person was living with epilepsy, however there were no care plans in place, nor was epilepsy mentioned in any of the care plans that had been developed, such as personal care and bathing. We spoke with the registered manager who said they would be put in place that night. We checked on the second day and a senior care staff member had developed two care plans in relation to supporting the person. There was no detail on the specifics in relation to timing the seizure and at which point emergency services should be contacted, the care plan stated, 'If the seizure is long contact the GP or paramedics.' This left the person vulnerable and at risk of potential harm.

One person had a medicine care plan and a human behaviour care plan which recorded the medicine they were prescribed. The medicine care plan evaluation notes recorded a change in the medicine, but this was not completed on the human behaviour care plan. The change in medicine had not prompted an update of the care plans; therefore staff had conflicting information to follow.

One person's mobility section of their care records stated they were, 'assessed as not independently mobile, not able to weight bear.' The records went on to document how the person was able to transfer with two staff and could, 'stand for minutes with a carer each side.' This meant the risk had not been appropriately assessed, staff had conflicting information to follow and the person and staff were left vulnerable to harm dependant on which strategy staff followed. The registered manager confirmed the person as being able to weight bear. The person also had a room manual handling assessment which stated the person was deaf. This was incorrect as the registered manager confirmed the person was not deaf.

Within one person's care records we saw daily records were basic and repetitive. They reported, 'Good fluids, medication offered, incontinence needs met,' there was no further description included regarding the persons care or support and each day recorded the same entry. Within the nutrition section we saw a letter form the dietician, it stated, 'Trialling Maxijul to be added to foods such as yogurts, porridge, rice puddings and drinks.' This information had not been added to the person's care plan which meant staff did not have up to date information. Maxijul is a carbohydrate nutritional drink supplement designed for adults and children.

We reviewed one person's care plan, throughout the records it made reference that the person was to be nursed in bed. On examining the whole care plan we were unable to establish why the person was nursed in bed. We discussed the matter with the registered manager who, on the second day of the inspection supplied archived documents which contained the first instruction to be nursed in bed on 29 September 2015.We noted from the professional notes the person's relevant person's representative (RPR) attended on 24 March 2016 and discussed, 'Possible referral to consider whether (person) can be assessed for a

wheelchair to eliminate time spent in bed without stimulation'. Although previously physiotherapists had been involved, action was not taken until 21 April 2016 following the discussion with the RPR."

We found one person's choking risk assessment contained contradictory information. One section stated the person did not drink independently and safely whilst a later section stated they were able to drink independently. The conflicting information meant staff did not have clear guidance on how to support the person safely.

Within people's care records we did not see evidence that people and those important to them were involved in the review of their care and support. However, one visitor told us "We feel involved in care. We've recently had an annual review". We saw one person had remained in bed for four months before the person's RPR encouraged a review of his care and treatment; the home had not been proactive prior to that point and it took a further month before staff made contact with the community physio.

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

Activities were advertised daily on the notice board in the entrance of the building. During our visit we saw people take part in an armchair exercise class which people seemed to enjoy. The registered manager advised they had just gained use of a minibus which they shared with a local sister home.

The Personal Activity Leader (PAL) said, "We have armchair exercises twice a week and a bible reading class once a week." The registered manager said, "There's a monthly special event, such as a puppet show, the miniature pony." The PAL advised an activity committee had been set up which was made up of a number of staff members and the registered manager and explored how they can continually improve the resident experience in the home through activity.

One person advised they spent time with the PAL looking at pictures on a tablet and said, "[PAL] he's a lovely lad, he's absolutely lovely, he does anything you want."

We observed a session in the sensory room where people were relaxing in a darkened room with peaceful music and a bubble effect light show. People appeared to enjoy the experience. Some were laying on the bean bags, others were sitting on chairs. The PAL said, "90 percent of people have used it." The registered manager explained they were keeping a record to evidence the impact on people. We asked about training for the use of sensory rooms for people living with the dementia, the registered manager said, "A nurse who left set it up and has told [PAL] all about it."

During the last inspection we raised the issue of the lack of activities for those living with dementia with the registered manager. The home had introduced the sensory room since the last inspection however we did not observe any other stimulating activities designed specifically for those living with dementia. The registered manager advised they have asked people and relatives to bring in reminiscence images and objects which will decorate the corridors. They also advised following consultation with people, a beauty salon and 50's style ice cream parlour is to be created. We reviewed the consultation conducted, 32 people were consulted with three people mentioning ice cream/milkshakes and four mentioned a music room. Twelve people agreed to the creation of a beauty salon.

The registered manager told us the home had been selected to be a pilot home for the provider's new dementia awareness framework which explores all areas of dementia including environmental design and specialist training for staff.

A mobile tuck shop was provided and one person supported the PAL to walk around the home with the trolley on a daily basis. One staff member said, "We could do with an arts and crafts room and some outside activities like crazy golf." The registered manager said, "Funnily enough we ordered a crazy golf set but didn't get any puts with it. We have said just to buy some." Another staff member said, "There's plenty for the women but what about the men?"

Complaints were recorded and investigated. Lessons learnt were recorded on each individual complaint and included areas such as ensuring people are appropriately clothed. Conclusions noted a need to reinforce person centred care as opposed to task orientated activity. We did not see confirmation from complainants that they were happy with the outcome of their complaint. One visitor said "If I have any concerns I can approach staff and they'll deal with it.

Inadequate

Is the service well-led?

Our findings

At the last inspection of the home in January 2016 we found the provider did not have effective quality assurance processes to monitor the quality and safety of the service provided and to ensure that people received appropriate care and support.

The provider had an electronic system called TRaCA for monitoring the quality of the service which included care plans, incidents and accidents, safeguarding incidents, medication and daily running of the home T. We questioned the effectiveness of the provider's system as throughout our inspection we identified areas of concern which should have been highlighted via the process. We found issues which we discussed with the provider during the last visit were still evident. For example care plans held contradictory information and content that did not reflect the person's current needs and risks had not been recognised and mitigated against.

We viewed the medicine audit completed via the TRaCA system and noted there was no information on whether the audit looked at gaps on MARs. We did not see any action plans in relation to audits, audits did record, 'action from previous weekly audit completed – 100%.' We could not see evidence of the action needed or taken and from our own findings the audit process had not been effective at identifying concerns.

Regional manager TRaCA 's were completed monthly from February to May 2016. These audits showed that at least one resident TRaCA was completed each week and daily and weekly medicines TRaCA's were completed. It had recorded that a quality dining audit had been completed. There was no information on the TRaCA of the outcome of audits or any actions either taken or planned to improve the quality of the service for people .

We found the providers audit system, ie TRaCA 's had not been effective in identifying the concerns noted by the inspectors. We raised this with the registered manager and the regional manager who did not comment .

This was a breach of Regulation17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager advised us of the home's achievements in the last five months which included all staff completing mandatory training and introduction of new training which the home is piloting. Staff had taken part in training with the resident experience team which has had a positive impact in the home and the creation of the sensory room. They had also introduced formulation and distress reactions meetings where staff and external professionals discuss any distress reactions displayed by people; agree strategies, review people and share lessons learnt.

One senior care staff member said, "I audit medicines and if there are gaps on the record I ring the staff member concerned and ask their view of why there's a gap. I'll investigate it myself as well."

The registered manager told us the provider had an electronic system called 'Quality of Life", which captured people, staff and visitors feedback. An IPad feedback point was located in the entrance of the building. They advised all visitors were asked to give feedback. People told us that family members attended resident/relatives meetings on their behalf but one person attended themselves and felt able to give their views. Visitors described being involved in meetings and felt they were listened to when making individual requests. For example a request for a new chair.

People told us they saw the registered manager around the home regularly. One person said of the changes "I think it's a good thing". One visitor said things were "Much improved - no smells, the place feels and looks different". Of the Manager they said "she's very nice, she's introduced herself and I've seen her around a lot. Another said "she's usually about – very approachable and [deputy manager) is lovely too".

Staff also described the positive effect of the recent changes implemented by the registered manager and in particular the daily staff meetings. One staff member said "I've seen improvements every day. When you come in for the morning you know what you're doing. I'm going on holiday and I know when I get back there will be even more improvements that have happened." Another said, "She's always on the floor and if there's anything that she can do – she'll do it".

We saw from the results of the staff survey that morale had improved since our last inspection. We examined the results from staff surveys conducted over the period of March to June 2016. To 'I feel part of a team', it reported 33.8% strongly agreed and 50% agreed. For 'I have the knowledge and tools I need to do a good job', 47.18% strongly agreed and 47.18% agreed.

The registered manager told us, "Managers from the local Hartlepool homes regularly met and discuss best practise". The registered manager encouraged an open and honest culture in the home. The home had a notice board which detailed 'Know how we are going' which displayed outcomes relating to the home, these were also discussed in relatives and residents meetings.

The registered manager has notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities and were proactive in consulting with the inspector of the home.