Howard Court Care Home Limited

Howard Court Care Home

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced inspection on the 6 and 7 October 2014. We did this to check whether the provider had met the requirements of the breaches in relation to regulations 9, 10, 11, 15 and 23 identified at our previous inspection on the 24 July 2014. We found evidence of on going concerns and further breaches in the regulations.

We visited the home on 6 October 2014 when a pharmacist inspector focused on the management of medicines and two inspectors visited the home on 7 October 2014. We spoke with four people living at Howard Court Care Home, one relative, four care staff, the registered manager and the provider. We also received information from the local authority and the environment health department. The local authority commissioning Quality Manager had provided support, advice and guidance to the provider and registered manager since our last visit on 24 July 2014.

The manager of Howard Court Care Home has been registered with the Care Quality Commission at this home since September 2011. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'registered persons'. Registered persons have the legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regualtions about how the service is run.

Howard Court Care Home provides care and accommodation for up to 28 older people some of whom may be living with dementia. On the day of the inspection there were 22 people in the home and one person was receiving care and treatment in hospital. The provider is also registered to provide personal care to people in their own homes.

Prior to this inspection we visited the home on 24 July 2014. We found that the provider was not meeting five of the regulations we looked at. Warning Notices were issued requiring the provider and registered manager to be compliant with Regulation 9, care and welfare of people who use the service and Regulation 10, assessing and monitoring the quality of the service provision. Compliance actions were required for Regulation 11, safeguarding, Regulation 15, safety and suitability of premises and Regulation 23, supporting workers. Following the inspection in July 2014 the provider sent us an action plan telling us about the improvements they were going to make.

We revisited the home on 6 and 7 October 2014 to check whether the provider and registered manager had completed the required improvements to the safety and quality of the service identified when we visited in July 2014. We found during this inspection that the provider and registered manager had not taken action to address all of these issues and we identified further concerns that people's safety and well being was being compromised in a number of areas. These were in relation to Regulation 12 cleanliness and infection control and Regulation 13 management of medicines. During our inspection we saw there were considerable improvements in relation to Regulation 15 as we found the environment was cleaner and areas of the home had been redecorated, re-carpeted with new beds and furnishing having been purchased.

At the last inspection in July 2014 care plans did not give effective strategies for managing nutritional needs. During this inspection in October 2014 we looked at how people who used the service were supported with their nutritional needs in the home. We found that people's health care needs were not always assessed accurately and people's care was not planned or delivered consistently. In some cases, this either put people at risk or meant they were not having their individual care needs met. Throughout the day we observed that not all people received the level of support identified in their records. One person was receiving care and support in their own home. At the time of our inspection there were no records available for this person. We could not determine whether there had been an appropriate assessment of needs, care planning or risk assessments completed. This was a an on going breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because the provider did not take proper steps to ensure the delivery of care met people's individual needs. You can see what action we told the provider to take at the back of the full version of this report.

During the last inspection in July 2014 we found that the quality monitoring systems in place were not effective. During this inspection systems were still not adequate to ensure the delivery of high quality care. We identified failings in a number of areas. These included dignity and respect, nutrition, care and welfare, managing risks to people including infection control, medications and staff support. Some of these issues had not been rectified by the provider and registered manager since our last visit, which showed there was a lack of robust quality assurance systems in place. Where accidents and incidents had been recurrent we did not see any analysis to assure us that any action had been taken to learn lessons from these incidents. This was a an on going breach of regulation10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

During this inspection we observed staff completing different tasks without changing their protective gloves and aprons to protect people who used the service against the risk of cross infection. The practices we observed did not comply with the requirements of the local council's environmental health visit made to the home on 12 August 2104 when they had issued the home with three legal requirements and made two recommendations. One of the legal requirements included an urgent review of risk assessments to manage infection risks. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities)

Summary of findings

Regulations 2010 because the provider failed to ensure people who used the service were protected against the risks of acquiring an infection by not operating an effective system to prevent the spread of health care associated infections.

The systems and practices in place for managing medicines in the home were not safe. Inaccurate records kept by the home meant that it was not possible to account for all medicines. Where some medicines were required to be given at specific times or durations this was not always done. There was limited information about individual people's specific needs provided to carers for them to be able to ensure that medicines were given correctly and consistently. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because the provider failed to protect people who used the service against the risks associated with the unsafe use and management of medicines.

At the last inspection in July 2014 we found that staff were not adequately trained to safely manage people who's behaviour challenged the service. We looked at some of the issues resulting from this and we judged that further safeguarding referrals should have been made about

incidents with people who challenged the service. Staff we spoke during the last inspection were not sure if person to person abuse in the home should be included in safeguarding. We also found that staff training in safeguarding adults was not up to date. During the last inspection checks of suitability when staff were being recruited were not robust in order to protect vulnerable adults.

During this inspection staff training for managing behaviours that challenge the service had been identified but had not been delivered. All staff had been signed up to an e-leaning programme and at the time of the inspection we were told by the registered manager that staff were at different stages of the training for safeguarding adults. Records for training were requested and information received showed that six staff out of 19 had completed up to date safeguarding training via e-learning.

At this inspection we looked at the records for recruitment of staff. We found not all of requirements of the regulation relating to the recruitment of staff had been complied with. During the inspection we had concerns relating to the neglect of one person living at the service. The concerns were that they did not receive sufficient fluids and food during the time of inspection. This person had lost weight but we did not see from the most recent nutritional assessment that this persons needs were correctly recorded. Following our inspection we made a referral to the local adult social care team about this persons needs not being met safely. This was a an on going breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider did not make suitable arrangements to ensure that people were safeguarded against the risk of abuse. You can see what action we told the provider to take at the back of the full version of this report.

At the last inspection in July 2014 we judged that the numbers of staff in the evening were inadequate to meet the needs of the service. We also judged that there were problems with housekeeping and catering staff numbers. Staff said they were expected to do some domestic work during their shifts and that the night staff did a lot of domestic work. It was found that given the dependency of people in the home this would be difficult in the evening and at night. Although staff did try to meet people's needs it was noted that they were beginning to create routines that might institutionalise people. Staff told us and records showed that they had not been recieving formal supervision regularly. Elements of staff refresher training had lapsed and some elements of specific training to effectively support the needs of people living with dementia had never been received.

During this inspection staff were seen engaging well with people who used the service, however there were not sufficient staff during meal times to assist all of the people with their dietary needs . The provider did not have a system in place to assess staffing levels required to manage people's individual needs. This meant they could not be sure that there were enough staff to meet people's needs. Whilst the training available for staff had improved since our last inspection in July 2014, we saw during this inspection that the learning was not always put into practice. This was a an on going breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because the provider did not

Summary of findings

have suitable arrangements in place to support staff to enable them to deliver care safely. You can see what action we told the provider to take at the back of the full version of this report

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe. People who used the service were being put at risk because medicines were not managed safely. The infection control practices by staff put people at risk.

Staffing levels were inadequate to meet individual's needs and people did not receive the level assistance recorded in their care plans specifically during meal times.

Recruitment of new staff was not robust to ensure people using the service were kept safe.

Inadequate

Is the service effective?

The service was not effective. People's healthcare needs were not always met, for example around nutrition.

The mealtime experience required improvement. People were not given appropriate support. There was not always evidence that appropriate monitoring and action had been taken to protect those who were identified as being at risk of malnutrition.

Inadequate

Is the service caring?

The service was not caring. Although we saw some good interactions between staff and people, we saw instances of people not being treated with dignity and respect. For example, people left with clothes on that had spilt food on and dressed in an undignified manner.

We found that where there was information that reflected people's preferences or choices this was not always followed. There was very limited information about whether or not people who used the service or their relatives had been involved in making decisions and choices about their care.

Inadequate

Is the service responsive?

The service was not responsive. We found people's care needs were not

always assessed or recorded accurately to enable staff to deliver appropriate care. The service failed to respond to people's changing needs by ensuring accurate amended plans of care were put in place.

We found care was not delivered in line with assessments and care plans.

There were limited activities and people told us there was little to do.

Records for people receiving care in their own home were not available.

Inadequate

Is the service well-led?

The service was not well led. We found a number of concerns during our

inspection which had not been acted upon by the provider or manager.

Where issues had been identified by external agencies, robust action had not been taken to resolve issues.

Inadequate

Summary of findings

Accidents and incidents were not properly analysed and there was a lack of action taken to prevent re-occurrences.

The monitoring systems of service provision and quality were not effective.

Howard Court 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 and to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

This inspection was to check whether the provider and manager had completed the required improvements to the safety and quality of the service identified when we visited in July 2014. After the inspection in July 2014 the provider undertook a voluntary suspension of new admissions to the home in order to provide a safer environment.

This was an unannounced inspection that took place over two days. We visited the home on 6 October 2014 when a pharmacist inspector focused on the management of medicines and two adult social care inspectors visited the home on 7 October 2014. We spoke with four people living at Howard Court Care Home, one relative, four care staff, the registered manager and the provider. We also received information from the local authority and the environmental health department. The local authority commissioning Quality Manager had provided support, advice and guidance to the provider and registered manager since our last visit on 24 July 2014.

We observed care and support in the communal areas of the home and looked at four people's bedrooms. We reviewed a range of records about people's care and how the home was managed that included the care records for nine people, the staff training and induction records for staff employed at the home, recruitment records for four care staff and one cleaner, and the quality assurance audits that the registered manager completed. We also looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock and other records relating to medications for eight people living in the home.

Inadequate

Is the service safe?

Our findings

On arrival to the home we were given access by a senior carer wearing a red tabard used to alert people to not to disturb them as they are focusing on dispensing medications. The senior carer was also supporting people in the dining area with the ordering and handing out of their breakfasts whilst completing the distribution of medications. The staff in the home used hand held walkie talkies to communicate with other staff in other areas around the home these were very audible and the inspectors heard several requests, one was for staff to remove items that may be blocking hallways and corridors and another staff member requesting support with moving and handling. During the morning routines we observed that four people had been left with their breakfasts and drinks and were not supported to eat or drink as identified in their care plans.

Throughout the day we observed that not all people received the level of support identified in their records. There were three care staff and two senior care staff on duty in the morning; one of those seniors was covering in the absence of the manager while she was attending external training.

The manager arrived at the home later in the day.There were 22 people receiving care and support on the day of our visit. We looked at the records of care for nine people living at Howard Court Care Home. We did not see that people's individual dependency needs had been assessed in relation to ensuring sufficient staff being available at the time people required assistance. During the morning routines and at lunch time there were not sufficient staff to meet people's individual needs.

We found safeguarding training had been commenced but not all staff had completed it. We could not tell from the records kept for training the exact number of staff who had attended this training. We requested that training records be provided after the inspection and these were forwarded.

The manager confirmed during the inspection that not all staff had yet completed their training. We were also informed by the manager that training for managing behaviours that challenge had been sourced but had not been booked. This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because the provider did not have suitable arrangements in place to support staff to enable them to deliver care safely.

We saw that the home was now fully compliant with the Fire Service regulations and requirements. The owner of the home told us the work on the kitchen was still in the planning stage and a date for commencing the works was to be confirmed. However there was no formal plan to see how the works would be managed to reduce any impact on people living at Howard Court Care Home.

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There were new floor coverings in main hallways and upstairs lounge. Carpet cleansing had been undertaken, new beds and mattresses had been purchased and headboards were in the process of being replaced. The home was much cleaner and we saw that cleaning schedules were in place. Housekeeping staff told us there had been an increase in the domestic staff hours and one new member of housekeeping had been employed. We also noted that some areas of the home had been redecorated.

We saw work was in progress to become compliant with the requirements of the local council's environmental health visit made to the home on 12 August 2104 when they had issued the home with three legal requirements and made two recommendations. The legal requirements included an urgent review of risk assessments to manage infection risks, control of legionella, hot water and surfaces, aggression to staff and falls from windows. The second requirement was to read and follow the guidance for the Reporting of Injuries, Disease and Dangerous Occurrences (RIDDOR). Thirdly there was a requirement to ensure safe manual handling by following current guidance.

We were told during our visit by the manager that about 50% of staff had completed the required training identitified by the environment agency. However records requested showed that two out of 19 staff had completed training in infection control and no training in managing aggression had been completed by any staff. On the day of our visit the manager was attending training to update her knowledge in training the staff on moving and handling. During this inspection we observed staff complete moving and handling tasks using the same gloves to then hand out meals and assist with feeding of service users. This meant

Inadequate

Is the service safe?

that staff were not protecting people who used the service against the risk of cross infection. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because the provider failed to ensure people who used the service were protected against the risks of acquiring an infection by not operating an effective system to prevent the spread of health care associated infections.

At this inspection we found that people using the service were not always protected against the risks associated with the use and management of medicines. People were at risk of not being given their medicines at the times they needed them. Most medicines were kept in locked cabinets and a locked trolley and the keys to these were kept securely; however we found a small quantity of medicines where they could be accessed by unauthorised staff.

It was not possible to account for all medicines, as care workers had not always accurately recorded the quantity received into the home, or how much had been brought forward from the previous month. When care workers had a choice of how much medication to administer, e.g. where a dose of 'one or two' tablets had been prescribed, the exact quantity had not always been recorded. When medicines cannot be accounted for, it was impossible to tell whether or not they have been given correctly.

Some entries on the Medications Administrations Records (MARs) had been handwritten by care staff; but the details recorded did not accurately match the instructions printed on the medicines labels. We found one box of medicines that were unlabelled, meaning it was impossible to see who they had been prescribed for. We also found medicines present that were not listed on the current MARs. Having inaccurate records increases the risk of medicines being missed and therefore not administered as prescribed.

We saw that doses of antibiotics were not always spaced evenly. This meant people would be at risk of suffering unnecessary side effects whilst reducing the likelihood of the courses of treatment being successful. We were told care staff applied creams where necessary, however the use of creams and other external preparations had not always been recorded. This meant it was impossible to see whether or not these products had been used as prescribed. It was of concern that the administration time of medicines containing paracetamol had not been recorded; meaning care staff did not know when they could safely offer or administer the next dose.

Many people living in the home were prescribed medicines to be taken only 'when required' e.g. painkillers, laxatives and medicines for anxiety. Due to dementia or other medical conditions, some people were unable to recognise when they needed their medicines or tell care workers when they needed them. There was little or no information for care workers to follow in order to ensure that these medicines were given correctly, consistently and with regard to the individual needs and preferences of each person. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because the provider failed to protect people who used the service against the risks associated with the unsafe use and management of medicines.

Inadequate

Is the service effective?

Our findings

During our visit we observed one person where their breakfast had been on the table for 30 minutes and no assistance had been offered and the food and drink were removed. This happened for all food and drink given to this person during our time at the home, apart from one drink in the afternoon where a member of staff sat with the person and assisted them to drink it. The records for this person showed that support with eating and drinking was required and specialist equipment was required to help the person to eat independently. We did not see that this equipment was used.

The records for this person showed that an increased fluid intake was required due to risk of urinary tract infections we did not see any records to show how much fluids had been given. This person had lost weight but we did not see from the most recent nutritional assessment that this persons needs were correctly recorded. Following our inspection we made a referral to the local adult social care team about this persons needs not being met safely.

We saw that three people were at risk of not drinking sufficient fluids there was nothing in the records to show if these people had drunk enough fluids to keep them hydrated, or what action had been taken when only a small amount of fluid had been drunk. This meant that people's individual and recorded needs were not being met. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because the provider did not take proper steps to ensure the delivery of care met people's individual needs.

During this inspection of the nine records we looked at four did not accurately reflect people's needs that had been identified in their assessments. For example the review of a nutritional assessment stated that weekly weight monitoring was required but this had not been completed. One person's care plan that had been reviewed did not make reference to their nutritional needs when their weight monitoring records identified there were problems and that they required a fortified diet. There was no reference to people's communication needs when their first language was not English. It was recorded that one person required dentures and wore glasses we did not see that either of them were in place. This meant that people's individual and recorded needs were not being met. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because the provider did not take proper steps to ensure the delivery of care met people's individual needs.

We checked to see if the improvements in staff training and supervision that had previously been identified had been made and found that they partially had. Staff had been enrolled on a number of on line courses in areas to include safeguarding, health and safety, fire safety, dementia awareness and infection control. However up to date records of who had completed the training were not available at the time of the inspection.

There were inconsistencies in what the manager told us in relation to staff training and what the records showed. For example we were told by the registered manager that staff had completed fire safety training. However records provided after the inspection showed that six staff still needed to complete the training. Staff training records also showed that only five of the 26 staff had been trained in how to respect people's privacy and dignity. The manager had developed a structured supervision plan for staff however we could only see supervisions that had taken place since our last visit and could not say that these were yet held on a regular basis. . This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 The provider did not have suitable arrangements in place to ensure staff had received appropriate training.

People were not protected during decision making about end of life care and whether to have a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) in place. We asked staff about their understanding of the Mental Capacity Act (MCA2005) and Deprivation of Liberty Safeguards (DoLS). The MCA 2005 sets out actions to be taken to support people to make their own decisions wherever possible. Assessments completed did not meet the full requirements of the Mental Capacity Act 2005. For example, significant questions that formed part of the decisions made about end of life care had not been completed or recorded in people best interests. This meant that people did not have their rights protected as their views were not taken into account appropriately when making decisions about their care.

Inadequate

Is the service caring?

Our findings

During this inspection we observed that the dining experience of people had not improved since the previous inspection when people were not supported to eat and drink. Staff did not always ensure that people were eating and drinking enough to keep them healthy. We saw that one person had been assessed as being nutritionally at risk, this person's food intake was monitored for a three day period but the records did not make it clear how much they had eaten and we did not see if they had been offered any snacks. This person was supposed to be on a soft diet with prompting or full assistance to eat and drink. We saw at lunch time they did not eat much of their main course and when this was removed no alternative was offered. The pudding was placed in front of them and left and they ended up eating this with their fingers as no support was given. We also observed at breakfast another person ate their breakfast with their hands as no assistance was given. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because the provider did not take proper steps to ensure the welfare and safety of people.

Whilst some improvements had been made since the last inspection in July 2014, some people were not being adequately cared for. We saw some staff and people who lived in the home interacting well but people who were quiet were given very little attention. For example, we saw that two people were sat in a smaller lounge on the upper floor of the home. From their records we saw that one person was assessed as lacking capacity and having complex and behaviours that challenge. We visited this lounge several times through the day and on each occasion there were no staff present. We saw that at breakfast this person was left to eat their breakfast with no assistance. This person then sat for the rest of the day with dried food matter on their clothing. This indicated a lack of dignity and respect towards people.

We observed some instances of staff speaking to people with patience, warmth and affection for example when we observed part of a medicines round. We saw care workers talked to people kindly and supported people to take their medicines patiently without rushing them. We received some positive comments about the staff and about the care that people received, such as: "Staff are very nice and I have no concerns'' and ''They [staff] are very helpful'', One person told us that their relative "seems very happy and any concerns I have raised with the manager are dealt with''.

However, staff did not always treat people with dignity and respect. Some interactions appeared entirely task-focused and staff did not engage in chat with people and occasionally undertook tasks without speaking to the person. For example, in one lounge, two members of staff were using a hoist to transfer a person from their chair to a wheelchair. They did not speak to the person as they put them into the sling. They did not offer any reassurance or commentary whilst they were hanging in the hoist waiting to be lowered into the wheelchair. We also observed one person who sat in the communal lounge was dressed in an undignified way and an hour after our arrival to the home a staff member covered them with a blanket over their knees. Another person who lacked capacity had been assisted to dress but we saw their blouse had been buttoned up wrong and this was not altered during the day to make them look more dignified. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because the provider did not take proper steps to ensure the delivery of care met people's individual needs.

We looked in detail at the care records for nine people who used the service. We found that where information that reflected people's preferences or choices was not always followed. One persons recorded preference was to get up at 07.30 AM we observed this person, after being assisted to dress, brought into the dinning room for breakfast at 10.10 AM. We also noted for another person it was recorded that '' has not got the capacity to make decisions about their health and well being'' we did not see who else if anyone had been involved in the care planning on behalf of this person. There was very limited information about whether or not people who used the service or their relative had been involved in making decisions and choices about their care.

Inadequate

Is the service responsive?

Our findings

When we arrived at the home we saw one person sat hunched over in an arm chair with a small table in front of them with their breakfast and a drink on. Due to medical reasons this person required specialist seating and whilst a recent referral for an occupational assessment for specialist equipment had recently been made by the staff. This had not been requested in a timely way to ensure this persons comfort and posture.

We were also concerned that some very frail people living at the home may have felt isolated as there were not enough meaningful activities for people either as a group or to meet their individual needs. People were mainly left sitting in the lounges with little interaction between them. People had little stimulus other than the television and they looked bored. One person told us, "There's not much to do". We asked staff about the planned activities for the day and were told that the arranged activity had not been commenced due to the person organising it not arriving at the home. The staff in the main lounge area then put on an activity however not all people were asked to be involved or if they wanted to participate.

We asked staff if they were aware of what was written in the care plans. We were told by one staff member that they had not read all of the care plans but were aware that senior staff had started to update information in them. This meant that staff delivering care and support were not always fully informed.

We observed that care was not always delivered in line with people's care plans. We found people's personal care needs were not being met. For example, one person's care plan stated they should receive support to drink plenty. During the time we observed people in the home from 9.30 am to 4.30pm this person received support with one drink. This left the person at risk of dehydration and prone to urinary infection. The staffing levels were not adequate to meet everyone's needs in a timely manner specifically during morning routines and lunch time. Overall we did not find that improvements required following the last inspection had been fully met. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because the provider did not take proper steps to ensure the delivery of care met people's individual needs.

The provider was also registered to provide personal care to people in their own homes. We were told that one person was receiving care and support in their own home. This service was being supported by the staff team at Howard Court Care Home. At the time of our inspection there were no records available for this person. We could not determine whether there had been an appropriate assessment of needs, care planning or risk assessments completed.

Where accidents and incidents had been recurrent we did not see any analysis to assure us that any action had been taken to learn lessons from these incidents. We also found one record of serious injury in which a notification should have been submitted to the Care Quality Commission (CQC).

We looked at the care files for nine people who used the service; these were kept securely in the home. We saw each person had an individual care file in place however they lacked accuracy and consistency in their chronology. This meant it would be difficult for staff to locate relevant information easily; putting people who used the service at risk of unsafe or ineffective care.

The care files we looked at had hospital passports which detailed what people's individual needs were should they be admitted to hospital. One hospital passport did not provide accurate details about the person. The passport did not inform that bed rails were used or that they were prone to pressure sores. People who used the service were not protected from the risks associated with the lack of consistent and relevant documentation.

We saw evidence of some reviews of care planning taking place and care plans being amended accordingly. However in one file we looked at there had not been any review recorded of their moving and handling risk assessment or pressure area care since November 2010. It was recorded in the original risk assessment that they required turning regularly through the night but there was no record of their requirements during the day. This meant staff did not have access to completed up to date documentation that related to people's needs.

Inadequate

Is the service well-led?

Our findings

On the day of our visit the registered manager was attending training and the home was being managed by a newly appointed, experienced, senior carer who was being supported by the provider. The registered manager arrived at the home late in the afternoon.

The registered manager and provider confirmed they had been working on an improvement plan that was put in place after the last inspection and were being supported with this by the local authority commissioning Quality Manager. As part of a robust quality assurance system the registered manager should actively identify improvements on a regular basis and put plans in place to achieve these. During this inspection systems were still not adequate to ensure the delivery of high quality care.

We saw care plan audits (checks) had been undertaken since our last visit. The audits identified areas of concern however we did not see that any progress or completions of actions required had been achieved. We found some care plans lacked detail and others did not contain appropriate advice for staff to follow. We found various instances of care not being delivered in line with people's care plans. These issues could have been identified through a formal system to assess and monitor the quality of care.

We looked at a number of policies and procedures for the home and found that some were not up to date with current legislation and practise guidance. We saw from the policies and procedures that the recruitment of new staff employed since our last visit did not follow the company's own policies and procedures. Where the home's policy said references would be obtained from previous employers we saw that some references had been provided by work colleagues and not the actual employers. This meant that the recruitment procedures were not robust. This was a breach of regulation10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider did not where necessary make changes to the policies and procedures to reflect information in current guidance and legislation.

We saw regular audits of medicines were completed, however they were not effective meaning that concerns and discrepancies had not always been identified and addressed. It is essential to have a robust system of audit in place in order to identify concerns and make the improvements necessary to ensure medicines are handled safely within the home. This was a breach of regulation10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider did not protect people from the risks of unsafe care and treatment by regularly monitoring the management of medicines effectively.

Health and safety and infection control, concerns had been identified by the local authority environmental health, who conducted an audit at the home in August 2014. They had identified a number of issues and we found that some of these were still present during our inspection. This demonstrated the provider and registered manager had not taken satisfactory action following the audit.

People we spoke with living at the service told us if they had a problem they could raise it directly with the manger and it would be sorted. A relative told us that they had raised a concern and that the manager had addressed the issue straight away. There had been no formal complaints recorded since our last visit in July 2014.

There was no formal system in place to assess and monitor staffing levels. We did not see how the dependency of each person was identified within their care plan to determine the level of support they required. There was no evidence this was used to calculate staffing levels within the home. We found staffing levels were inadequate which could have been identified and addressed through observations and/ or the use of a formal staffing level tool.

Staff meetings took place periodically and there was evidence that issues found during the last inspection were discussed with staff. The minutes from the meeting indicated that the registered manager was unhappy with the findings during the last inspection and told staff that certain practises need to change because CQC had said so. For example ''CQC were not happy when they found staff wearing lots of rings, necklaces and so on'', however the homes own policy on uniform was clear on the dress code and the wearing of jewellery. The minutes also stated the registered manager said that ''according to the CQC she would not be able to keep staff employed if they did not complete mandatory training''. The manager referred to the CQC as being the care home police and that the staffing levels had to increase even though the staff had reported it was not necessary. This demonstrated that the manager had not acted with integrity and professionalism.

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person did not have effective systems in place to monitor the quality of the service delivery.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The registered person did not have effective systems in place to protect people from the risks of acquiring a health care associated infection as appropriate standards of cleanliness and hygiene were not maintained.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe administration and recording of medicines.**

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The registered person did not have suitable arrangements in place for ensuring service users were protected against the risks of inadequate nutrition and hydration.**

Regulated activity	Regulation
	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The registered person did not have suitable arrangements in place to that persons employed for the purposes of carrying on the regulated activity received adequate training. Regulation 23(1)(a).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person had not made suitable arrangements to ensure service users were safeguarded against the risk of abuse. Regulation 11(1)(a)(b).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The registered person did not operate an effective recruitment procedure to ensure that no person was employed for the purpose of carrying on a regulated activity unless the person was of good character or was physically and mentally fit. Regulation 21(a) (i) (iii) and (b)**