Akari Healthcare Ltd

Piper Court

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?	Good
Is the service responsive?	Good
Is the service well-led?	Inadequate

Overall summary

We inspected Piper Court on 5 and 12 November 2014. This was an unannounced inspection which meant that the staff and provider did not know that we would be visiting.

Piper Court is a 60 bedded purpose built care home providing nursing and personal care to people within three separate units. There is a 10 bedded functional mental health unit, 22 bedded nursing unit providing both general nursing and dementia care nursing and a 28 bedded unit providing personal care to people.

At the last inspection in 5 August 2014 the provider had breached one or more regulations associated with the Health and Social Care Act 2008. We found people did not experience care, treatment and support that met their needs, medication was not managed safely and records were not accurate and up to date. We told the provider they needed to take action and we received a report on the 6 August 2014 setting out the action they would take to meet the regulations. At this inspection we found that while some improvements had been made with regard to these breaches there continued to be concerns. We also found additional areas of concern.

Summary of findings

At this inspection were found that no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. It is a condition of the provider's registration to have a registered manager and this is a breach of that condition. 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. A manager had been appointed and had commenced employment within the service by the second inspection day.

People were not always protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. CQC issued a warning notice in respect of this matter following the last inspection and as the breach continues will be addressing this matter outside of this inspection process .

We found that people's care records did not show that people's needs were fully assessed. We found that documents for monitoring people's health such as positional change charts and weights were not always completed appropriately or were inaccurately filled in. Where some specific risks had been identified, corresponding care plans had not been developed. Medication records were also not being accurately completed. CQC issued a warning notice in respect of this matter following the last inspection and as the breach continues will be addressing this matter outside of this inspection process.

We found people were not always cared for, or supported by, enough skilled and experienced staff to meet their needs. Staff had not received regular supervision or annual appraisal to support them in their job roles and some training needed to be updated.

There were not always effective systems in place to manage, monitor and improve the quality of the service provided. The system to regularly assess and monitor the quality of service that people received was not effective. The provider had not ensured the service achieved compliance against the warning notices issued at previous inspections.

Staff were not meeting the requirements of the Mental Capacity Act 2005, which meant people who lacked capacity were not being supported to ensure they received appropriate care.

We found that staff had a good understanding of each person's needs and tailored their approach accordingly. We found that staff could readily explain how they worked with people and had a clear understanding of people's likes and dislikes. We found that staff used this information to assist them to work with people. People had their nutritional needs assessed and there was a system for monitoring this.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we took 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.

Inadequate

Medicines were not always managed safely for people and these records had not been completed correctly. Whilst we saw some improvements since our last visit, there were still some issues which meant that people did not receive their medicines at the times they needed them and in a safe way. Medicines were not obtained, administered and recorded properly.

We found people's care records did not always reflect their care needs and risk assessments were not always in place.

Systems were in place for staff recruitment. However one member of staff commenced employment prior to all checks being returned and this member of staff worked unsupervised, which is not an accepted practice.

Is the service effective?
The service was not effective.

Inadequate

Staff had not received regular supervision or appraisal or regular updated training sufficient for their job roles.

We found the service did not meet the requirements of the Deprivation of Liberty Safeguards (DoLS). Staff had applied for DoLS for people who had capacity to make decisions which is unlawful. Where DoLS authorisations had been not been approved staff continued to work in ways that restricted and deprived people of their liberty. If peoples' freedom was restricted they did not have clearly recorded best interest decisions in their care files.

People were provided with a choice of nutritious food, which they choose at weekly meetings. People were supported to maintain good health and had access to healthcare professionals and services.

Is the service caring?
The service was caring.

Good

Staff were kind and friendly and had developed good supportive relationships with people.

People's independence was promoted and their privacy and dignity respected. People's lifestyle preferences, likes and dislikes were recorded in their care records and we saw that staff followed people's choices.

Is the service responsive?
The service was responsive.

Good

Staff understood the needs of the people they supported and identified the actions they could take, which would specifically meet the needs of each person. People told us staff worked well with them and actively sought their views about the care being provided.

Summary of findings

The people we spoke with were aware of how to make a complaint or raise a concern. They told us they had no concerns but were confident if they did these would be thoroughly looked into and reviewed in a timely way.

Is the service well-led?

Inadequate

The service was not well –led.

There was no registered manager in post. There had been a lack of stability both with the day-to-day management of the service and the oversight from more senior managers. The home manager had come into post on the second day of our visit.

There were systems in place for monitoring the quality of the service and for completing audits within the service, however these were not effective. The provider had not closely overseen the service and ensured action was taken to implement change and resolve compliance issues identified in previous inspections.

Piper Court

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 checked whether the provider was 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 over two inspection days, 5 November 2014 and 12 November 2014. The first day was unannounced and the inspection team consisted of two inspectors and a pharmacy inspector as well as 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 service, that being older people and people with a dementia type illness. The second day we gave short term notice and the inspection team consisted of two inspectors.

Before the inspection we reviewed all of the information we held about the service including statutory notifications we had received from the service. As part of the inspection process we also reviewed information received from the local authority who commissioned the service and the local clinical commissioning group (CCG). We spoke with one of the local authority commissioning team about the service as well as a member of staff from the CCG.

Throughout both of the inspection visits we spent time observing the interaction between people who lived at the service and staff. We also spent time looking around areas of the service including people's bedrooms (with their permission) and communal areas. We also carried out Short Observation 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.

At the time of the visit, there were 47 people living at the service. During the visit, we spoke with 10 people who lived at the service, eight relatives of people and two family friends. We also spoke with the regional manager, manager, deputy manager, two registered general nurses, three senior care assistants and four care assistants.

We looked at a range of records, which included the care support plans of 12 people who lived at the service. We also looked at six sets of staff records; records relating to the management of the service, the medication systems and 11 people's medication records in detail.

Inadequate

Is the service safe?

Our findings

Following the last inspection we had asked the provider to take action to address a breach of regulation. The breach was as follows:

The provider failed to protect the people who used the service against the risks associated with the unsafe use and management of medicines. Staff failed to make appropriate arrangements for the obtaining, recording and safe administration of medicines used within Piper Court.

The provider failed to ensure people were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information. We found that care records such as fluid balance and positional charts were not consistently completed and other care records did not detail people's needs, which meant staff had inadequate information to assure themselves and others that people were receiving the care they needed.

The provider sent us regular information to show how they were addressing this issue.

During this inspection we found medication practices remained unsafe. Medicines were not always managed safely for people and records had not been completed correctly. Whilst we saw some improvements since our last visit, there were still some issues which meant that people did not receive their medicines at the times they needed them and in a safe way. Medicines were not obtained, administered and recorded properly.

We saw a nurse giving people their medicines. They followed safe practices and treated people respectfully. However we intervened when an incorrect dose of medicine was measured out to be given to one person.

Nine medicines for six people were not available. This meant that appropriate arrangements for ordering and obtaining people's prescribed medicines was failing, which increased the risk of harm.

Medicines were not handled safely because records relating to medication were not completed correctly, placing people at risk of medication errors. We saw for some medicines that no record had been made of medication received mid-month or carried forward from the previous month on the Medicine Administration Record (MAR). This was necessary so accurate records of medication were available and staff could monitor when further medication would need to be ordered. Handwritten entries for two people did not have a second signature as the medicines policy stated to confirm that the entry was correct. Incomplete record keeping means we were not able to confirm that these medicines were being used as prescribed.

This was a breach of Regulation 13 (Management of medicine); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This breach was identified at a previous inspection and CQC issued a warning notice in respect of this matter and CQC is taking steps outside of the inspection process to address this continued breach of regulation.

The care records remained inaccurate. We looked at the assessments and care plans for 12 people who used the service. We saw there was a range of generic risk assessments in place, including risks associated with nutrition, skin integrity and moving and handling. We saw that these assessments had been reviewed and updated on a monthly basis. Where there were more individual risks, such as risks associated with people's behaviour that could challenge the service or choking risks, we found that specific risk assessments and care plans had not been developed. This meant that people could be at risk of harm.

In two people's care records we found that the assessment tool included information about people's cognition and mental health needs but not, although appropriate, included in other people's assessments. We found that the assessments had not been revisited since Spring 2013 but people's needs had changed. One person who was originally admitted with a mental health condition had subsequently been also diagnosed with dementia and this was only apparent when we read the professional visit records. Another person had been admitted with Parkinson's disease and had been mobile. They subsequently had experienced a large number of falls and needed to use a wheelchair and their behaviour had changed markedly. None of these changes were detailed in their assessment and the care plans provided very little information about how these new needs were to be met. We were however satisfied from observing staff working with people and talking to them that they had the knowledge and understanding to support people and meet their needs.

Inadequate

Is the service safe?

Staff had identified in the records that they used mechanical restraints such as lap straps on wheelchairs and some people actively tried to remove these or stand whilst in the chair. No risk assessments were in place to deal with how to reduce the risk of people tipping out of the wheelchairs or care plans to explain how to assist people reduce their level of anxiety and agitation when in the wheelchair. We found that the staff were aware of the risk and had taken action to ensure this person' s anxiety was reduced.

This was a breach of Regulation 20 (1) (Records); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff we spoke with were able to provide a wide range of detail about people's needs and the actions they were taking to meet each person's needs. They could readily explain how they had obtained advice and support around assessing and resolving presenting needs. We found the staff were able to confidently outline each of the 12 people we reviewed needs.

People we spoke with told us they were very happy and settled living at Piper Court.

We looked at the recruitment records for five staff, including a recently appointed staff member. In the main we saw there were good systems in place for the recruitment of staff with the required checks having been completed. The manager told us they were recruiting for registered nurses, however were not having much success. As such, the day duties were being covered by agency nurses. We saw on the duty rota that there was some continuity of staff, with four agency nurses being supplied on a regular basis. However on the first inspection day, the agency nurse on duty was the first time they had worked in the service. On the second inspection day, the manager informed us that they were in the process of appointing a full time registered general nurse who should be commencing employment within the service very shortly and they were also interviewing two further registered general nurses. This would then provide continuity of care to people who used the service.

There were mixed views from people who used the service and relatives about the sufficiency of staff available. No concerns were raised in respect of the residential unit or the functional mental health unit. However, concerns were expressed about the staffing levels within the nursing unit primarily from relatives. Their concerns related to the availability of staff and comments included that staff were not always available within the lounge when people were in there and availability of staff to support people with their meals.

Within the nursing unit we saw there were insufficient staff to support people over the lunchtime period. We observed the lunchtime meal on the nursing unit. Staff told us that four people who were in the dining room required support from 1:1 staff to help them eat as did five other people who received their meals in their rooms and needed 1:1 help to eat. The two care staff on duty asked the agency nurse to help people with eating which they agreed to do but care staff told us that some agency staff don't help people to eat and so it takes longer to get round everyone.

The meal trolley arrived at 12.20pm and the nurse took one meal to a person in their room, and four other peoples were plated and covered with a bowl and placed on a dining room table. Names had been put on these with a scrap of paper by care staff and were for people who were in their rooms. We saw the two care staff support people in the dining room with their meals in a caring and compassionate manner. At 12.29pm one of the care staff took one of the meals left on the dining table for a person who needed support in their room. The remaining care staff told us; "Some nurses do help but not all of them. There are four people who choke in this dining room so someone needs to be here. Every day there is an agency staff, its hard as they don't know the residents. We've had relatives complaining to us about it." The agency nurse returned at 12.50pm and took the last meal from the dining table to someone in their room. This meant that meal had been left unheated for 30 minutes. We also saw for a short time (approximately six minutes) that the care staff in the dining room was called away to help another person get ready for a hospital appointment. This left four people alone in the dining room with food and drink who were at risk of choking. We found that insufficient consideration had been given to the needs of people and this led to staff not being deployed in ways that met the demands of the service.

This was a breach of Regulations 22 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw one person sitting in the lounge in their wheelchair. Staff told us this person was susceptible to falls. The

Inadequate

Is the service safe?

person's care plan stated the person was at risk of falls and that the lap strap on the wheelchair was to be fastened. We noted that when this person was in the lounge that their lap strap wasn't fastened. The lack of attention meant this person was placed at risk.

Staff spoken with on the residential unit said that as long as there were the five staff on duty this was sufficient to meet people's needs, however on occasion due to sickness this had reduced to four staff, which staff said impacted on people's care delivery. Examples given were that people did not get up when they wanted to, they had to stay in bed longer. On the first inspection day we saw evidence of this as a member of staff had telephoned in sick at short notice. We saw that arrangements were made for agency staff to come in an support but they did not arrive until later in the morning. We saw people did not get their mid morning drink until 11.40am. We also saw there were times when people were in the lounge for periods of time without any staff being present, although they were visible and kept checking the lounge. We were informed that recruitment for additional staff was underway and saw by the second inspection day that staffing levels had been increased.

We saw the service was clean and very well maintained. There was a good level of communal space and access to the garden from one of the lounges. We looked at a sample of maintenance and servicing records. These included in-house records detailing health and safety checks which showed that regular checks had been carried out in respect of weekly fire alarm systems, hot water temperatures and window restrictors. We saw up to date certificates in respect of the fire alarm system, fire fighting equipment, portable appliance testing and the gas landlord certificate. It was also evident that effective arrangements were in place for the maintenance and servicing of equipment with the service.

Inadequate

Is the service effective?

Our findings

We found that over the last year regular appraisals and clinical or general supervisions had not been carried out at the frequency determined by the service. The provider's supervision matrix indicated that staff had been receiving these sessions. When we spoke with staff about supervision and appraisal they said they had not received supervision sessions over the last six months nor had they received appraisal. Within the five staff files we looked at we could see no evidence that an appraisal had been completed in 2014. Neither the new regional manager or acting manager could provide information to confirm the accuracy of the supervision matrix.

The regional manager and acting manager had identified that staff had not undertaken updated training, such as infection control, food hygiene and basic first aid. They had also found that not all of the relevant staff had not completed refresher training for instance in safeguarding of vulnerable adults, infection control, moving and handling and fire safety. The training information provided showed action needed to be taken to ensure all of the staff received the required training. The acting manager was in the process of making arrangements to ensure all of the staff received this training and a training plan was made available that detailed this along with corresponding dates.

This was a breach of Regulations 23 (Supporting workers) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005 (MCA) legislation which is in place for people who are unable to make decisions for themselves. The legislation is designed to ensure that any decisions are made in people's best interests and the least restrictive option is taken. We found that care plans noted that people were able to make decisions yet we found that the forms to make DoLS applications had been filled in. Also we saw that the majority of care records contained no capacity assessments or information about people's ability to make decisions, yet again DoLS had been completed. When we reviewed the 22 DoLS applications that had been completed we found one had been authorised by the supervisory body; staff told us another had been approved and one had not been approved. The regional manager could only provide the appropriate documentation from the supervisory body to confirm approval for one person and confirmed that none had been received for any one else. We reviewed the content of the remaining DoLS and we found staff were incorrectly completing them and putting in applications for people who had no disorder of the mind that would indicate they may lack capacity. Staff we spoke with told us the previous manager had told them to make DoLS applications for everyone in the home irrespective of whether people lacked capacity or not. The regional manager told us they were in the process of putting a DoLS applications in place for one person whose family had stated they were to remain in bed. On exploration we found that this person had capacity to make decisions and had independently decided they did not want to use the hoist as they had previously been injured whilst using this equipment. The regional manager acknowledged the person's concerns were legitimate but felt the DoLS safeguarded the home in relation to the relatives views. Neither regional manager or staff we spoke with were aware that this action was inappropriate and would not safeguard them as the person retained capacity to make decisions. Neither were they aware of the need for relatives to obtain lasting powers for care and welfare if they were to determine how care was delivered. Or that when people retained capacity it was their choice about how their care was delivered not their relatives. The Mental Capacity Act 2005 and accompanying Code of Practice highlights that all steps should be taken to assist people make decisions and the decisions people can make recorded.

In five of the care records we looked at there was no information to show that staff had made sure 'best interest' arrangements were in place. These people's lifestyles were restricted in that they were only allowed to leave the building if accompanied by either staff or a family member; their healthcare was monitored and they were accompanied when attending to personal care tasks. There was no evidence that a multidisciplinary team or family had considered the decision under the 'best interest' processes. The staff we spoke with told us that they were unaware that of the types of decisions that could be taken for people or they could make in people's 'best interests'.

We saw in other people's care records, family members had been asked to sign care plans but there was no information to show they had the authority to do this or that the person, where able, had agreed to this occurring. We saw evidence of DNACPR (a form stating the person does not want to be resuscitated if they have a cardiac arrest) in care

records we looked at and there was evidence of family and GP involvement in this decision. Staff we spoke with told us the completed forms were in the front of individual people's care records. We found that staff had taken no action to determine if the person wanted their family member to act on their behalf. For those people who lacked capacity they had not taken action to determine if the family member had the legal authority to make decisions on behalf of their relative. So no information was contained on file to indicate if this relative had been appointed as a deputy via the Court of Protection or was named in a last power attorney for finance and/or care and welfare.

This was a breach of Regulation 18 of The Health and Social Act 2008 (Regulated Activities) Regulations 2010.

We looked at food and fluid charts that related to people on both the residential and nursing unit. There were no target quantities on peoples fluid charts so staff would not be quickly able to assess whether people were having their hydration needs met. Food charts were not always completed fully so half days may be missed or the quantity of food was not recorded. This could mean people were at risk of not having their nutritional needs met. We also looked at individual bath and shower records. Staff we spoke with told us that people would usually have a bath or shower once to twice a week and were happy with this frequency. People did look clean and well presented and we identified no concern in relation to hygiene practice.

We reviewed the care file of people who were nursed in bed and therefore required positional changes to ensure their skin integrity was maintained. We saw that one person's Waterlow assessment stated they were at "very high" risk of skin tissue damage. Two risk assessments regarding pressure area damage were in place and the actions on these differed. One stated the person should have positional changes "every 2 to 3 hours" and the other stated " every 2 to 4 hours." Staff could not tell us which risk assessment provided the correct information. We looked at positional charts for this person and on 1st November 2014 they showed one person had only had their position changed at 05.20am and then at 20.40pm when they were moved from their chair back into bed. We spoke with two care staff told us they filled out the positional change sheet when any repositioning or care had been performed. Other charts we reviewed for this person showed they were repositioned twice on 2nd November at 04.30am and then at 22.40pm and repositioned twice on 3rd November at 5.05am and 22.30pm. This meant the person was at risk of not being turned regularly as the care plan was not clear.

This was a breach of Regulations 20 (1) (Records) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We noted that the home provided services for people who may display behaviour that could challenge the service but none of the staff had received any training around how to deal with this type of behaviour or basic breakaway techniques. We found that at times staff had to deal with aggressive outbursts which had involved them needing to remove people from main areas of the home or deal with items being thrown at them. In the care records we saw no care plans had been developed around managing this type of behaviour and no appropriate records were maintained to detail how staff should physically intervene in a safe manner.

This was a breach of Regulations 11 (2) (Safeguarding service users from abuse) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We did see that specific sessions had been completed with relevant individuals in respect of the following concerns identified at the previous inspection. We saw that staff had received training around respect of records keeping, charts and care plans. We also saw that staff who were involved with the administration of medication had received refresher training and had completed a range of competency assessments.

We saw where permanent staff were appointed to the service there was a comprehensive induction programme, which we saw had been completed for staff whose recruitment files we looked at. We did however note that there was no formal induction programme for agency staff. The regional manager informed us that any agency staff did receive an induction, which covered layout of the home and health and safety practice such as the fire system and fire exits. We saw evidence of this being carried out during the inspection.

We spoke with people who lived at the service about their meals. Most people told us that the food was sufficient and good. One lady said that it was, "A very nice dining room" and that they were, "Never hungry." Other people said, "lovely meals" and "meals are nice, always enough." A

Inadequate

Is the service effective?

relative told us that her mother complains that there is too much food. We looked at the menu which was a four week menu. We saw that people were provided with choice on most days, except for Sunday lunch and Wednesday lunch when a roast dinner was served. We did however see that people could have alternatives if they did not want the roast dinner. On other days, there were clear choices available to people. A pictorial menu was also on display outside one of the dining rooms.

Good

Is the service caring?

Our findings

Following the last inspection we had set a compliance action in relation to ensuring people's care and welfare needs were met. Following the inspection the provider supplied information to show us what action they were taking to address this breach of regulation. The breach was as follows:

People were not protected against the risks of receiving improper care because assessments were not reviewed and the planning of care did not take account of changes in people's needs.

At this inspection we found that the provider had taken steps to ensure that people's assessments of care were reviewed and updated.

People we spoke with told us they were happy living at Piper Court. Comments included, "Staff are pleasant. You can't fault them" and "The staff are lovely. They'll help you as much as they possibly can. If time the girls will talk to you."

All the interactions we observed between staff and people living at the home were positive. Staff helped people to move and supported them to eat in a patient and sensitive way. Many people commented that the staff were very friendly. One relative said, "I could live here." Another said, "The staff have been really good to her. They are caring and do their utmost."

Staff we spoke with had a good knowledge of people living at the home. We discussed individual people with them and they were able to outline the care and support needs as detailed within people's care plans. We observed how they transferred the information from people's care plans into practice, for example staff could discuss the advice visiting healthcare professionals had provided in respect to changes in individual's needs and the impact this had upon how they supported the person.

We looked at the care records of 12 people who used the service and saw there was information recorded about people's like, dislikes and preferences as well as life history information. This gave staff important information, which assisted them in supporting people in a more holistic way.

During the inspection we observed kind and respectful interaction between staff and people who used the service. Every member of staff that we observed showed a very caring and compassionate approach to the people who used the service. This caring manner underpinned every interaction with people and every aspect of care given. Staff spoke with great passion about their desire to deliver high quality support for people. We found the staff were warm, friendly and dedicated to delivering good, supportive care.

It was evident from discussion that all staff knew people very well, including their personal history preferences, likes and dislikes and had used this knowledge to form very strong therapeutic relationships. We found that staff worked in a variety of ways to ensure people received care and support that suited their needs. The staff we spoke with explained how they maintained the privacy and dignity of the people.

Good

Is the service responsive?

Our findings

People told us the staff knew them and their likes and preferences. One person said, “They know I like tea – I always get a second cup.” Visitors came and went freely and there were plenty of areas where they could talk in private with their loved ones. Some residents told us they could get up when they wanted to and we observed some late risers having breakfast.

People also told us staff were responsive to their changing needs. One person we spoke with told us the staff responded very quickly if they were unwell and needed a doctor. We also saw when other changes occurred such as higher risk of falls the staff were responsive and arranged for the involvement of the NHS falls team for advice. Within the care plans we looked at we saw people had access to health care service as needed. This included involvement of speech and language therapist, dietician, GPs, district nurses and community psychiatric nurses. Their involvement was recorded within the multi-disciplinary records contained within people’s care records.

A full time activities co-ordinator was employed by the service and people spoke very highly about this person. A relative said, “He’s brilliant with them - very caring, very patient.” We saw people had opportunities to be involved in a range of activities if they wanted to. An activities notice board containing information about forthcoming activities was on display in the main reception area of the home. We observed the activities co-ordinator scanning the paper and discussing an article with a gentleman. People told us about occasional outings they went on. We saw people enjoyed a chair exercise class, which was lively and full of fun. There was a warm, engaging atmosphere during this activity and people looked to be enjoying it. We heard background music playing in the home, which was appropriate music for people who used the service and people were singing along to it.

We saw that since our last inspection improvements had been made to the care records and care plans had been reviewed. The care records we looked at showed that staff working in the service were responsive to people’s changing needs. We saw that pre-admission assessments had been completed, This assessment process identified people’s needs and a decision was then made as to whether it was suitable to admit people to the home. This information was then used as a basis of developing a more detailed care plan. We saw that some of the care plans we reviewed had been re-written and provided up to date information about people’s needs. However we saw that some still required work to ensure they were an accurate record of the person’s needs and that charts, such as those for fluid intake and positional changes were accurately completed.

We saw good examples of other healthcare professionals being involved as needed. This included the staff contacting the local community psychiatric team when a person’s behaviour that challenged the service had deteriorated. It was clear that the staff followed the advice of the visiting professional and the person was cared for and supported appropriately. Another example included a person who had some seating difficulties, the staff had contacted the relevant professional and a different wheelchair was in the process of being provided.

We were told during the inspection that mealtimes had been problematic within the residential unit, due to the different needs of people who used the service and some people’s mealtime experience being disturbed. People had raised their concerns about this and the regional manager and staff had implemented a system for two sittings. This was still in the early stages of testing and would be reviewed over time.

We saw information was available to inform people about what they should do if they had concerns or complaints. We also looked at the complaint folder and saw information to show that complaints had been acknowledged and responded to within the appropriate timescales. During the inspection one relative we spoke with expressed some concerns about the care provided to their relative. They had spoken with staff about their concerns but did not think anything had changed as a consequence. The person confirmed that they had not raised their concerns with more senior staff or the regional manager. During the inspection it was agreed that the regional manager would meet with the person concerned and to take whatever action was needed.

Inadequate

Is the service well-led?

Our findings

On the first inspection day there was no registered manager in post and no actual manager employed by the service. However the provider had recently appointed a person into this role, who was due to commence employment imminently. The manager had commenced employment by the second inspection day. The service had been without a registered manager since June 2012. A manager was appointed earlier in the year but resigned without applying to become a registered manager. It is a condition of the provider's registration to have a registered manager and this is a breach of that condition. We are taking action away from this process to address this matter.

We also noted that the CQC registration certificate on display was out of date and did not therefore reflect the current conditions imposed on the service.

Staff we spoke with said there had been meetings. One member of staff said, "Lately there have been loads of meetings the last one was about medication and the staff roles."

We looked at the systems in place for monitoring the quality of the service. The regional manager told us that this was an area that the provider was in the process of developing but, at the time of the inspection, they recognised that the current system did not assist staff to critically review the service. We asked the regional manager for the audits or reviews that were carried out by the home on a regular basis to assess areas like care planning, quality of the care records, medication and risk assessments. We reviewed the audits and system, and found there were gaps in the frequency of completion. Also we found that the system was not always effective. For instance we found a number of errors were being made in the administration of medicines, such as mislabelling medication, not signing for medicines given or not ensuring medicines were returned but the relevant audit had identified these issues. However the scoring process was flawed and although there could be in excess of 11 actions needed, some of which were significant such as not having correct amounts of medicine on site, the audit still scored the provision as being good to excellent. Even with four actions of significance such as managing stock control being identified the audit scored the home as 98% compliant in medication. We saw that when issues were identified there was no evidence to show staff had taken action to deal with these and we saw that the same issues were repeated in subsequent audits.

We found that the provider had not devolved their responsibility for completing monthly visits to check the service to regional managers. We found that the regional managers had not always either completed the visit or completed the report. It was unclear as to how the outcome of the visits were then brought to the attention of the provider. Providers are required in regulation to maintain oversight of the services they provide. We noted that insufficient action had been taken at a provider level to deal with the concerns raised in the two warning notices we issued in August 2014. Only following the first day of our inspection was any proactive action taken by the provider. Prior to the second day of the inspection the provider ensured a deep impact analysis of the home was completed and the chief executive officer visited the home. This had not previously occurred and appeared to be initiated because we continued to find breaches in regulation.

We found that regular resident and relative meetings had not been taking place and from the evidence we reviewed it appeared none had taken place during 2014. We found no evidence to suggest that surveys had been completed with people and then the data analysed to identify where improvements could be made. The regional manager and new manager recognised this deficit and were in the process of organising meetings with people who used the service.

This was a breach of Regulation 10 (Assessing and monitoring the quality of service provision); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

From a review of the care records we found that care plans and risk assessments did not identify the needs people had or detailed how to deliver the appropriate care. We saw that assessments were inaccurate or out of date and risk assessments had not been completed. We saw that changes in care needs were not reflected in care plans. Routine action was not taken to establish whether any lasting power of attorney either for financial or care and welfare agreement were in place. We saw information contained throughout one set of care records

Inadequate

Is the service well-led?

indicating that care and welfare lasting power of attorney was in place only to find from discussions with the acting manager that in fact it was not. This had not been identified as an issue within the care plan audit.

This was a breach of Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This breach was identified at a previous inspection and CQC issued a warning notice in respect of this matter and CQC is taking steps outside of the inspection process to address this continued breach of regulation.

A new manager commenced work at the home in between our visits and we met them on the second day of the inspection. At that time the manager had been in post for a couple of days. Staff told us that for many months they had felt unsupported and there was a lack of direction but it was good to have a new manager in post. They had found that in the couple of days the manager had been in post they had made a positive impact. Staff told us that they had confidence in the new manager's approach and leadership style and thought this would lead to the home improving.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **People who use services and others were not protected against the risks of inappropriate or unsafe care because an effective system for monitoring the service was not in place.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The provider had failed to ensure that staff were equipped with the skills needed to intervene when people displayed behaviours that challenged.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The provider failed to ensure staff adhered to the requirements of the Mental Capacity Act 2005.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The provider failed to ensure appropriate numbers of staff were deployed within the home to meet the needs of the people who used the service.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff

The provider failed to ensure that suitable arrangements were made to train and supervise the staff working at the home.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not always protected against the risks associated with medicines because the provider failed to have appropriate arrangements in place to manage medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The provider failed to ensure accurate records were maintained in respect of each person using the service and the management of the home.