Par Nursing Homes Limited

Atherton Lodge

Inspection report

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Ratings

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

Overall summary

This Inspection took place on the 10 and 11 of December 2014 and the first day was unannounced. Our previous inspection took place on 6 August 2014 and concentrated on the management of medicines within the service. We found the service was not meeting the standard and following that, the provider sent us an action plan telling us about the improvements they intended to make.

On this visit we looked at whether or not changes had been made. We found people were still not protected from the risks associated with medicine management. We also found additional concerns in relation to the environment, care delivery, records and quality assurance.

Atherton Lodge is a privately owned two-storey detached property that has been converted and extended into a care home. It is registered with Care Quality Commission (CQC) to provide accommodation for 40 people. At the time of the inspection there were 30 people living at the home. There are two units within the home. One unit

Summary of findings

supports people who require nursing and/or personal care. The other has nine bedrooms and supports people who are living with dementia. The home is situated within a mile of Ellesmere Port town centre.

There was a registered manager in place and they have been there since March 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that there were a specific number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People who we spoke to and relatives told us that they felt safe and cared for. They said that the registered manager was approachable and that they had already made some improvements. We saw that there had been no complaints recorded about the care since our last inspection.

Whilst we observed, at times, people received appropriate care, we also saw occasions where people were not treated with kindness or respect.

We found that people at Atherton Lodge were still not were not getting their medications as prescribed and that medicines were also not being stored correctly.

We were concerned that the premises were not safe due to a lack of maintenance and adequate safety checks. The home was cold in places and radiators were turned off. We found that there was a risk that people could leave the building without staff being alerted. The home was not clean and this posed a risk to people as they were not protected from infections.

Care plan documentation described people's needs upon admission and a number of care plans were put in place to guide staff. However, these did not consistently reflect or record changes in someone's physical or mental health. Appropriate care was not delivered consistently and checks on people's diet and fluid intake were not always completed.

People's capacity was not assessed under the Mental Capacity Act 2005. (MCA). We found care records did not consider people's capacity to make decisions which meant there was a risk that their rights were not protected. The manager or staff delegated decision making to family members when there was no evidence legal authority in place.

The manager had not followed the appropriate recruitment checks. This meant that they had not made sure that people were receiving their care from staff that had been thoroughly vetted to ensure they were suitable to do the job

Both the manager and the provider had failed to identified or rectify some of the issues we found during the inspection during their own quality assurance process.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

People were not protected against the risks associated with the administration and management of medicines. People did not always receive their oral or topical medicines at the times they needed them or in a safe way. Medicines were not stored, administered or recorded properly.

People lived in an environment that was not safe because it was cold and unclean.

People received their care from staff that had not been through appropriate recruitment processes to ensure they were suitable to do the job.

People told us that they felt safe and staff were able to tell us about safeguarding those that they looked after.

Inadequate

Is the service effective?
The service was not effective

The capacity of people was not assessed in line with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We found care records did not consider people's capacity to make decisions and there was a risk their rights were not being protected.

Although we found that staff received appropriate training, supervision and appraisals there was a lack of clinical oversight for the nursing staff. Nursing staff were not aware of current best practice.

People were not supported to take adequate food and drink.

People living with dementia were not cared for in an environment best suited to meet their needs or to promote their independence.

Inadequate

Is the service caring?
The service was not always caring

Whilst we observed some positive interactions with staff, we also saw and heard things that demonstrated staff failed to treat people with dignity and respect.

People we spoke to told us they felt cared for and that the staff were nice to them.

Requires Improvement

Is the service responsive?
The service was not responsive.

Inadequate

Summary of findings

People's needs were not always fully assessed. Although a range of care plans were in place, these did not all contain the most up to date, sufficient or accurate detail on people's needs preferences and risks to care.

We found food and fluid intake was not always monitored in line with the requirements of their care plans, which meant there was a risk of dehydration and weight loss.

People's care records did not consistently reflect personal choice.

Is the service well-led?

Inadequate

The service was not well led.

Improvements were required to the provider's audit systems. Although the provider previously noted some of the issues we found during the inspection, these had not been resolved. Additional issues had not been noted, for example failings in the medicine management system and so the audits were not effective.

Significant events were not always reported to the Care Quality Commission.

People and their relatives told us that the manager was approachable and took an interest in them.

Atherton Lodge

Detailed findings

Background to this inspection

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

This inspection took place on the 10 and 11 December 2014 and the first day was unannounced which meant that the provider and the staff did not know that we would be visiting.

On the 10 December 2014 the inspection team comprised of two adult social care inspectors and a pharmacist inspector who looked in detail at the medicine management system. On the second day the team comprised of the same adult social care inspectors plus an inspection manager.

Prior to the inspection we checked the information we held about the service. We spoke with representatives from the local authority who informed us that they were working with the provider to rectify a number of issues. We also contacted Health Watch who had no information on the service to share.

We used a number of different methods to help us understand the experiences of people who used the service. Many of the people using the service were not able to communicate with us. We used the Short Observational Framework for Inspection (SOFI) in two areas of the home. SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us. We spoke to five people who used the service, three relatives, the visiting GP, nine members of staff, the home manager and nominated individual. We spent time observing care and support being delivered. We looked at care records for five people and other records which related to the management of the service such as staff training records and policies and procedures.

Inadequate

Is the service safe?

Our findings

The people who lived at the home that we spoke to and their families told us that they had "no concerns" and "felt safe". Staff were aware of what constituted abuse and the provider had the appropriate policies and procedures in place. They were also aware of the local authority policy for safeguarding and care concerns. Staff told us, and records confirmed, that they had recently received training is safeguarding.

Risks to some people were minimised as accidents and incidents reported were recorded by staff and the manager undertook a monthly analysis of these. There was evidence that action had been taken to minimise the risks to some people such as the use of falls sensor mats.

We found that the service was not safe.

Most people at the home had medications but could not manage these independently. The pharmacist inspector looked at how medicines were handled in the home because at our last inspection we found they were not being handled safely. Despite some minor improvements with the storage and records about medicines, we found people were still not protected against the risks associated with the unsafe use and management of medicines. One person was given their medicines covertly (hidden) and we found that the home had failed to follow the correct procedures for doing this safely. We found that when people looked after one or more of their medicines no procedures were put in place to check they were managing these safely.

We also noted that a number of people refused their bedtime doses of medicines but there was no evidence that reviews had been carried out to check if people would prefer to be given medication earlier to help optimise the benefits of their medication. There was no information recorded to ensure doses of medicines such as Paracetamol could be given with a safe time interval between doses.

Medicines were still not administered safely. It was difficult to tell if people were given their creams as prescribed because the records were poor. Where we could reconcile the information on the medicines records with the stock held in the home for people, we found that inhalers and some tablets were not always given to people as prescribed. We were previously concerned that, there were not arrangements in place to give people their medication as directed by the manufacturers, especially with regard to food. We found this still to be the case. Medicines were not being given half to an hour before food where it was required. Medicines which should be given with or after meals were not being given as required. Medicines must be given at the correct times and in the correct manner to make sure they work effectively.

We found not all medicines were stored safely. Waste medicines were not stored safely because they were not locked in a secure cupboard. Creams were kept in people's bedrooms and were not locked away and there were no risk assessments completed to ensure it was safe to store creams in this way.

Appropriate arrangements were still not in place to the record medicines. On the day of our visit we saw that a nurse had administered medicines to eight people but she had not signed any of the records, at the time of administration. The Nursing and Midwifery Council code of practice states that an immediate record of medicines must be made. We compared records with the stock and saw that some records had been signed but the medicines had not been given. The records about medicines in the controlled drug register were poorly maintained. The dates on which people were given medicines were incorrect and they were not in chronological order. It is important that there are accurate records are to ensure medicines are given to the right person at the right time. We saw that when medicines had a "limited life once open" that nurses had failed to record the date of opening on the bottle which meant that it could be given when it was unsafe to do so.

If medicines are not given as prescribed people's health maybe at risk of harm. There was still no information available to guide nurses how to give medicines which were prescribed to be given when required. It is important that this information is recorded to ensure people were given their medicines safely and consistently at all times. There was still little information recorded to guide nurses or staff as to where to apply creams. It is important that staff know where creams should be applied to ensure people are given the correct treatment.

We saw that weekly audit about medication had been carried out but was still limited in scope and did not find any of the concerns we found that this inspection.

Inadequate

Is the service safe?

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were not being protected against the risks associated with the unsafe use and management of medicines.

On the 11 December the home was cold in a number of communal areas and in some bedrooms. We found that some of the radiators had been turned off but the manager was not able to tell us who had turned these off and for what reason. Three bedrooms were observed to be cold as the windows were left wide open in the afternoon. We were told, subsequent to the inspection, by the nominated individual that bedroom windows were initially opened to "air" the rooms and then closed. We were concerned that windows remained open in the afternoon and it would take a long time for these rooms to warm up to a satisfactory temperature. People could not immediately return to them should they wish to do so.

We observed one person sat at breakfast with a footplate missing off the wheelchair and staff were not aware of this when we brought this to their attention. This meant that the person was at risk of injury when being moved.

People did not always have access to equipment that helped keep them safe. We saw that there were call bells missing from five bedrooms. This meant that people could not call for help if they needed it. The manager and the provider told us that everyone should have a call bell in place and that this was checked by the maintenance man. There had been a room check completed on the 9 December 2014 which did not identify the issues found on the day of the visit.

There was a sign on the door of an upstairs bathroom stating that it should be kept locked. It had been out of use since the early 2014. It was open on both days of the Inspection despite the fact that we told the registered manager about this on the first day. This meant that a person could try to use the facility when it is not safe to do so.

We saw that an upstairs fire door was not alarmed and led straight onto a fire escape. The manager told us this was not a risk as no one in that area was mobile but there was no risk assessment in place that considered people moving around within the home.

We saw that the home had carried out some safety checks. The manager was unable to provide evidence that concerns raised by the Gas Safety inspection in June 2014 had been rectified. The manager told us that the portable electrical appliance tests (PAT) were out of date but was unable to find the last certificate. We were informed by the manager that they would be done on the 17 and 18 January.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were not being protected against the risks associated with unsafe or unsuitable premises.

We saw that a person using the service had bedrails but there were no comprehensive risk assessment in place to explain why they were used or which less restrictive alternatives had been considered. There was no evidence that informed consent had been sought, there was no best interest decision or evidence of consideration of DoLS where someone lacked capacity. We saw that these risk assessments were not all signed or dated.

This was a breach of Regulation 18 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because there were not suitable arrangements in place for obtaining and acting in accordance with, the consent of people using the service and also failure to keep an accurate record.

People who used the service, staff and other people were at risk of acquiring or transferring infections because we observed the home was visibly unclean in a number of areas. Some of chairs in the lounge and “quiet” room were dirty as were the window ledges. People had individual tables next to their chairs and these were all sticky, dirty and a number of them had worn and cracked edges that could harbour bacteria. On the day of our second visit there was a strong smell of urine in three of the bedrooms and in the main lounge where we sat to carry out an observation. Waste in bins was not stored securely and we observed one to contain soiled pads and another was overflowed with waste. This meant that there could be a risk of cross contamination. Bathrooms and en-suites had grouting and sealant that needed repair. Commodes, bath seats and wheelchairs were not visibly clean. There was evidence of nail brushes being used and not named to an individual. People used chipped plates that posed a risk as a person could cut themselves. Ceramic plates being used were chipped at the edges and the plastic ware was scored. This could harbour infections.

Inadequate

Is the service safe?

The home had a bird cage in the lounge but on the day of the visit, the area around this was dirty. Cups and juice jugs were stored next to it. This lack of cleanliness meant that people were being put at risk because the risks of transferring any avian related infections were not being minimised.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were not being protected against identifiable risks of acquiring an infection.

People were not protected from the risk of their care being provided by someone unfit to work by nature of character or health. Recruitment processes were not safe. We looked at the records of six staff and found that they were all incomplete or contained inaccurate information. For example, we found that one staff member had a Disclosure Barring Service (DBS) from January 2014 that had been taken by a previous employer but there was no evidence that the provider had ensured that they had validated this information prior to them commencing employment at the home. There were no references in file for this person. The registered manager told us that they were taken but lost.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because the provider was not operating effective recruitment procedures.

Inadequate

Is the service effective?

Our findings

The staff, manager and nominated individual did not have an understanding of the Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (DoLS). DoLS requires the provider to submit an application to a supervisory body where is believes it is depriving someone, who lacks capacity, of their liberty. The provider had submitted a number of DoLS applications to the local authority but prior to this the provider or staff had not carried out a mental capacity assessment or best interest decision in order to validate or justify these applications.

A person had been given medication covertly which meant without their knowledge or consent. Staff had failed to follow the MCA 2005 or other guidelines such those issued by the Nursing and Midwifery Council. They had not assessed and documented that the person lacked mental capacity to make the decision themselves or to demonstrate that therefore it had been administered their "best interests". They had consulted the GP and thought this was sufficient. The nurse practitioner who visited the home had recommended the provider consult the pharmacist as to the risks associated with placing these medications in food and how this could affect absorption but they failed to do this. We were concerned that the medications being "hidden" should not be administered with food.

There was evidence that family members were asked to consent or refuse care on behalf of their relatives. This was for significant decisions such as the flu jab, bedrails and covert medication. The manager could not show us that relatives had the appropriate legal authority to do this, such as lasting power of attorney for care and welfare. For example: in one care file we saw a letter from a relative who gave permission for their mother to have their medication "hidden". In another care file we saw a signed consent for bedrails in place for a person and it stated on the form 'I having Power of Attorney give my signed consent in their best interests'. There was no mental capacity assessment in the file, and no best interest's decision. We asked the nominated individual and the registered manager where these would be and they stated they should be in the file but they were not.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because there were not suitable arrangements in place for obtaining and acting in accordance with the consent of people using the service.

The unit that accommodated people living with dementia was not "dementia friendly" and it did not meet the needs of people who lived there. There were nine bedrooms in the unit but we saw on both days there were 12 people who used the communal lounge area and it was over crowded. People sat in their chairs on either side of the narrow lounge with very little room to walk through it. The manager told us that some people in the main part of the home were also living with dementia and required the extra support of the staff from the unit. They spent the day in the unit and returned at night to their own bedrooms.

We saw that people stayed in the lounge for the majority of the day. There was only a small dining table at the top of the lounge which sat three people. This meant that not all people had the choice to sit at a dining table to eat their meals and ate on a small table in front of them. We did not see that these choices and decisions were recorded in the care plans we looked at.

It did not meet the standards as described in guidance such as that issued by National Institute for Clinical Excellence (Dementia Gateway CG42) .Pathways and corridors were difficult to navigate easily. There were no clear notices or calendars to aid orientation. There were no clear signs on bedroom doors to help people identify their rooms. The signs on the bathrooms and toilets were in very small printed writing and difficult to read – therefore not easily identifiable. There were very few items about for people to touch, pick up and encourage interest or discussion for people living with dementia.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because the design and layout of the building did not meet the needs of those who lived there.

We observed, in the unit for people living with dementia, that people were offered choice and encouraged to eat by the staff looking after them. This was not consistent across the home. We saw in the rest of the home that not all people were supported to ensure that they had adequate nutrition. We saw that one person had their dessert taken

Is the service effective?

away as they had not eaten it but staff did not to try to ascertain why or offer an alternative. We heard a staff member shout across the room that "[a] only had two mouthfuls of that again and then pushed it away".

Accurate records were not kept to assist staff to monitor whether someone had adequate food or nutrition even when there was a risk. We saw records for a person assessed at risk of malnutrition and dehydration there were no accurate details about the amount of fluids given. In several entries "juice given" or "dinner given" was documented. Some entries were "half dinner" eaten but there was no suggestion as to how big the dinner was or how much this would be. We also saw that there were no entries made after evening meal or overnight until breakfast.

We found that people's nutritional status was not always monitored. For example one person had a nutritional risk assessment in place that identified that they were very high risk. Their body mass index (BMI) and weight were last recorded in August 2014 and at that point staff took the decision that they were too frail to weigh in the future. The care plans and risk assessments had not been updated following that decision and no alternative way of monitoring considered. Monthly evaluations of the care plans failed to reference weight, did not analyse food and fluid intake nor highlight the need for increased assistance. We asked the nurse in charge about this person's care and they said the person "eats and drinks fine at the moment". The records we looked at contradicted this. Intake charts for this person failed to detail the amount of food and fluid they required or record accurate consumption.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were not protected from the risks of inadequate nutrition and dehydration.

Daily records being kept by care workers were not meaningful and did not give an indication of what care was being delivered or how someone had been on that day. Staff wrote general comments such as "all care given" or "settled".

Care plans were in place and written at the point of admission. We looked at four care plans and found that where there had been significant changes with people's health, the care plans had not all been rewritten, revised or evaluated in the light of this. For example, one care plan dated 3 May 2012 identified that the individual required little assistance with maintaining continence. However, entries in daily notes in October and November 2014 indicated the use of incontinence pads day and night and close supervision due to some behaviour to ensure dignity.

We saw that a number of people were on pressure relieving mattresses but there were no assessments to indicate what pressure setting was required and no evidence that they were checked throughout the day to ensure they were working properly. This meant that people could be at further risk of developing skin problems if the settings were incorrect.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were not protected against the risks of unsafe or inappropriate care due to a lack of proper information about them.

The registered manager told us that they were carrying out regular supervision of all the staff but there were not up to date supervision records in the staff files that we reviewed. Staff told us that they received regular supervision.

There was no evidence that clinical supervision and support was being provided to the nurses to ensure that they were aware of and following guidance issued by the National Institute for Clinical Excellence (NICE) and best practice. The nursing staff could not tell us when they last had clinical supervision but that it was over six months ago. They were not aware of some of the best practice guidelines. The manager was not aware how nurse qualified staff were keeping up to date with their continuous professional development.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because staff had not received appropriate training and professional development supervision.

There was evidence that staff had received mandatory training and some staff had also completed National Vocational Qualifications (NVQ). Staff told us they had not received any training in equality or diversity or addressing the needs of people with protected characteristics.

Requires Improvement

Is the service caring?

Our findings

Relatives told us that the staff and the manager were caring and that they listened to their concerns. One person told is that they always "ring to reassure you when there is a problem and they listen". They told us that staff were "kind and always smile" and another commented" I don't know how they do it as some people are very hard to look after". Some of the people we spoke to were able to tell us that the staff were kind to them and that they usually came quickly to help when they needed someone.

We saw some examples of staff promoting people's dignity. We saw in the unit that accommodated people with dementia, a towel was placed on a person's knee to protect them during the time they were assisted to eat. We also saw during this time that when one person became agitated staff quickly went to them and sat with them, talked quietly and calmed them down.

The provider had information available on the advocacy services for those persons who needed support and we saw that one person had the assistance of an advocate.

We observed situations where people were not treated with dignity or respect. We observed a member of staff walk through the lounge talking loudly to another about a person and their failure to eat their meal. We also saw the same member of staff talk harshly to a person when they removed their teeth saying "no mate, don't do that, that is disgusting and people are trying to eat their dinner". This was brought to the attention of the registered manager during our feedback.

We carried out an observation in the main lounge and saw that staff placed food in front of people with no explanation as to what was being served. Three people struggled to eat as their plates slipped around on the tables or they were not placed at an appropriate height.

People across the home were provided with some plastic tableware which did not promote their dignity. Staff could not tell us why plastic was used apart from the fact they thought people with dementia should not have crockery and it was coloured to assist people living with dementia.

Some people required puree food and on the first day of the inspection we were told that foods were blended and served separately so that food looked more appetising. On the 11 December we observed whole meals blended together and served in a plastic bowl. Staff told us "there are only a few feeds that need it so it's easier to do it this way". This use of language to describe those needing assisting with food showed a lack of consideration and respect for the persons.

A person had their dignity and privacy compromised as staff had placed big sign outside their bedroom door "this person needs hoisting at all times". This should not have been required as staff should have been aware of that person's needs.

Staff described the behaviour of a person living with dementia as "irrational" which showed a lack of understanding of the illness and its impact on the individual.

It was also evident from minutes of a staff meeting that the manager had overheard a staff member talking inappropriately about the assistance required by people who lived in the home but there was no evidence that this was recorded and dealt with in a formal manner with the staff.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were not treated with consideration, dignity, and respect.

People had very basic care plans about their end of life wishes. We saw that one person had a "Do not attempt cardiopulmonary resuscitation' (DNACPR) form in place but this had not been reviewed since 20 November 2012. We observed that a person, deemed to have capacity, had a DNACPR in place but no evidence of this being discussed with them. We saw that documentation had conflicting dates. One DNACPR form was dated 11 April 2012 but had been signed 11 April 2014. This means that people's end of life requests may not be honoured as the documentation to protect them was not accurate.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because people were not protected against the risks of receiving care or treatment that they would have deemed inappropriate.

Inadequate

Is the service responsive?

Our findings

The provider had a complaints policy that was displayed in hallway. It contained timescales, who to contact internally and how to contact CQC. We were told by the manager that there had been no recent complaints at the service. CQC were not aware of any complaints about the service at the time of the inspection. People we spoke to told us that they had not made a complaint. Relatives and people spoke to told us they would speak to the manager if they had any concerns.

During our SOFI, we observed that people in the main lounge, were not given a choice as to where they wished to eat at lunch. People were not able to tell us if this was their choice but the manager and staff told us that it was. We saw that people were sat throughout the morning in the same place as they were served food. They were not given the opportunity to move and a staff member was observed to speak to another pointing at people and calling "[name a], [name b] and [name c] stay here and we will do [name d] last". In the dining room, on both days, we observed that people sat for breakfast and lunch in wheelchairs. The four care plans we looked at did not make reference to people's choices. The care plans did not record what someone liked, what times they wished to get up or go to bed, where they wanted to eat etc. In the dementia unit we observed that choice of meal and food size was given and people were assisted to make that choice.

We looked at the care plans for a person who was living with dementia who became agitated at night. Their care plan described them as getting and "more aggressive". This was particularly when staff were checking two hourly for signs of incontinence. Staff had not been responsive in their evaluation as they had continued this regime despite the distress caused. There was no evidence that they had considered if it was necessary or if a review of their continence products was required. They recorded a need for "constant" supervision which was not provided.

We saw correspondence following a hospital appointment in December 2014 stating that a person was at risk of hypoxia (a condition where a person may be deprived of adequate oxygen) and therefore may need oxygen. The care plan indicated no issues with breathing and there was no further information about actions taken. This meant that this person might not be getting the treatment they required.

We saw that when people developed a temporary condition, that required additional care, there were no short term care plans put in place. Records were not completed consistently and there was a lack of evidence to demonstrate how staff monitored the care required. We saw that one person's bowel charts had not been completed daily and therefore staff could not tell if some had failed to go to the toilet for a significant number of days. We saw that a person had a urinary tract infection and daily notes on the 28 November 2014 suggested that staff were to "encourage fluids". There was no care plan in place that recommended the amount fluid required, how this was to be achieved or monitored. They had not considered how this had impacted on the person's behaviour.

Key factors were documented in the wrong care plans and therefore a risk that key aspects of care were missed. We saw that a care plan for eating and drinking contained entries about key changes in skin condition and the monitoring required. This had not been transferred to a skin care plan. We noted that the same person had seen a consultant in August 2014 but there was no outcome recorded.

This was a breach of Regulation 9 and Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2010 because people did not have care that was planned and delivered in a way to meet their individual needs and which ensured their welfare and safety. They were not protected against the risks of unsafe or inappropriate care and treatment arising from a lack of accurate records.

The provider had a person employed to carry out a range of activities with people and these were clearly visible on a time table. We did not directly observe activities taking place throughout the time of our inspection on either of the Units.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in place and he has been there since March 2014. The staff, people and relatives we spoke to were positive about the manager and they felt that they were making some positive improvements. The staff said that they felt supported by him and he was enthusiastic. Relatives told us that the manager took an interest in them as well as their loved ones and kept them up to date with information about their relatives. There was evidence of residents meetings taken place on in October 2014 and December 2014 and the feedback was positive. Staff had been praised for birthday celebrations for two people who used the service in particular. The provider had not carried out any recent surveys, customer or professional satisfaction questionnaires as to the quality and effectiveness of the service.

There was a quality assurance system in place for the registered manager and the provider. The provider had not ensured that concerns raised in these audits had been addressed. The provider had given CQC an action plan following the last inspection but we found that they had not completed the actions they had identified. The provider was also failing to fulfil the actions they had stated in an improvement plan to the local authority from September 2014.

We found that the quality assurance system was not effective. The manager had carried out a number of medication audits but these had not highlighted the concerns found by the pharmacy inspector. The provider had undertaken an audit on the 18 November 2014 that highlighted deficits in recruitment practice but they had not ensured remedial action. The lack of fluid recording and lack of mental capacity assessments had not been identified through the programme of care plan audits. We identified issues with the premises such as missing calls bells, safety hazards, and infection control that had not been highlighted by provides own audit systems.

We saw that the registered manager had failed to take action where there were repeated concerns. We read in the staff minutes dated 9 September, 6 October, and 21 November 2014 that there were issues with cream. ("Cream book must be filled in to comply with CQC regulations". Filling this in incorrectly will have repercussions"). There were significant issues with recording and administering of creams on our inspection so improvement had not been made and staff had not been held to account. We saw that there was a lack of robust audit of care records. Our inspection highlighted concerns in documentation and the poor monitoring of people's care. The staff meeting minutes stated that registered manager would be auditing care plans twice a week. This had not been effective as there were still significant issues.

The manager told us that they carried out a regular audit and assessment of resident dependency to ensure that there were the "right" numbers or skill mix of staff. We saw that one person had been assessed as low dependency over many months yet their mental and physical health had deteriorated and they required specialist dementia nursing care. We looked at the care plans for a person who was very ill but they were deemed as only requiring medium level of care. This was not an effective system to identify, assess and monitor the dependency of people and staffing levels.

Staff meetings took place on a monthly basis but the minutes given did not indicate which staff were in attendance. These meetings aimed to address concerns around poor practice as well as personnel issues relating to staff. There were a number of issues that reoccurred and were recorded in the minutes of September, October and November. This evidenced that the manager passed on instruction to staff who had not taken this on board. These issues included staff repeatedly wearing mobile ear phones on shift, smoking in the home and inappropriate attitude.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because there was a failure to regularly assess and monitor the quality of the service or carry out investigations into the conduct of staff in order to protect people against inappropriate or unsafe care and treatment. The views of people using the service or persons acting on their behalf were not sought on a regular basis.

The Care Quality Commission had not been notified consistently about safeguarding matters relating to people who lived at the home. We were aware of a number of issues that the local authority was investigating but the provider had not told us about these. This meant that the provider and the manager were not keeping us up to date with events of significance within the Home.

Inadequate

Is the service well-led?

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 because the registered person had failed to notify the commission without delay of incidents that had occurred within the home.

The provider had a service user's guide and a statement of purpose. It had general information about the home including staff, fee structure, type of care provided, visitors, special features and services; and contact details and a location map. This had been reviewed March 2014 and was due to be reviewed again March 2015. The document talks about Outcome 15 of CQC quality standards and so needs updating in line with current legislation. The Service User Guide also needs updating as it refers to the Commission for Social Care Inspection and local offices that no longer are in existence. There was also a brochure of the Home that showed pictures of the home with décor looking tired and dated.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because there was a failure to keep accurate and proper information.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control How the regulation was not being met: The service was failing to ensure people were protected from the identifiable risks of acquiring a health care associated infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment How the regulation was not being met: The provider was not complying with the Mental Capacity Act 2005 or the Deprivation or Liberty Safeguards. The service was failing to ensure suitable arrangements were in place for gaining people's consent with regard to their care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs How the regulation was not being met: People were not protected from the risks of inadequate nutrition and dehydration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records How the regulation was not being met:

This section is primarily information for the provider

Action we have told the provider to take

People were not protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services How the regulation was not being met: The service was failing to ensure that people's dignity and/or choices were being respected

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: The service was failing to ensure suitable arrangements were in place to support employees to enable them to deliver care and treatment safely and appropriately.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents How the regulation was not being met: The registered manager was not reporting to CQC notifiable incidents which occurred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met:

This section is primarily information for the provider

Action we have told the provider to take

The service was failing to ensure people were protected against the risks of receiving inappropriate or unsafe care or treatment.

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 Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not protected against the risk associated with medicines because the registered person did not have appropriate arrangements in place for the safe storage and administration of medicines. Regulation 13

The enforcement action we took:
We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises People who used the service and others were not protected from the risks associated with unsafe or unsuitable premises. Regulation 15 (1)(a)(b)(c)(i) and 15(2)

The enforcement action we took:
We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People who used the service and others were not protected against the risks associated with unsafe or inappropriate care because the registered person did not have effective systems in place to monitor the quality of service delivery. Regulation 10 (1)(a)(b)(2)(b)(iii)(iv)(v)(c)(i)

The enforcement action we took:
We issued a warning notice.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers People who used the service were not protected as the provider did not follow safe recruitment processes. Regulation 21(a)(i)(b) and Schedule 3.

The enforcement action we took:
We issued a warning notice.