Panaceon Healthcare Ltd

Chapel View Care Home

Inspection report

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Date of inspection visit:
09 October 2017
12 October 2017
17 October 2017

Date of publication:
22 December 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Chapel View Care Home (known to people using the service, their relatives and staff as Chapel View) on 9, 12 and 17 October 2017. The first and second days of inspection were unannounced. This meant the home did not know we were coming.

Chapel View is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Chapel View is registered to provide nursing and residential care for up to 39 people. On the first day of inspection 32 people were using the service. None of the people were receiving nursing care and the registered provider was in the process of deregistering the home as a provider of nursing care. The building has two floors. There are communal lounges and a dining area on the ground floor, and shared bathrooms and toilets on both floors. The home has 37 ensuite bedrooms, two of which can be used as double bedrooms.

Chapel View was last inspected in August 2016. At that time we rated the home as 'Requires Improvement' overall, as it was deemed to be 'Requires Improvement' in the key questions of Safe, Effective and Well-led, and 'Good' in the key questions of Caring and Responsive.

The home had a registered manager. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Most checks on the building, its equipment and utilities had been completed appropriately. However, we identified aspects of the building and facilities which posed a risk to people.

People's care plans did not always contain sufficient detail to inform staff how to support them safely. Care staff we spoke with could describe the support people required which evidenced this was an issue with record-keeping.

We identified some accidents and incidents which the registered manager was not aware of, because they had not been recorded on accident and incident forms. Records showed the registered manager had oversight of those accidents and incidents which were recorded properly.

Some parts of the home were not clean. In places the home's décor and fittings were tired, which made them more difficult to keep hygienically clean, although a programme of improvement was underway. We recommended the registered manager update infection control procedures in accordance with nationally recognised good practice.

Sufficient staff were deployed to meet people's needs.

Most aspects of medicines management were undertaken safely, although the application of people's topical creams was not always recorded.

Records showed the registered provider and registered manager had not ensured the principles of the Mental Capacity Act 2005 were consistently followed for those people who may lack mental capacity. This was a finding at the last inspection in August 2016.

Most feedback about the food and drinks served at Chapel View was positive. We observed staff focused on tasks at mealtimes and chatted amongst themselves, rather than interacting with people. Food and fluid documentation did not always reflect people's needs; this was an issue at the last inspection.

Staff received the induction, supervision and training they needed to meet people's needs.

Records showed people had seen a wide range of healthcare professionals, such as GPs, community nurses and dieticians, in order meet their wider health needs.

Good practice on dementia-friendly environments had been used when updating and improving the building.

People and their relatives told us staff were kind and caring. We observed some positive and caring interactions during this inspection; however, we also had serious concerns about the lack of respect some staff showed for people's privacy and dignity. From our observations we concluded this was due to a lack of awareness rather than any intention to cause upset to people.

People were supported to remain independent. They also had access to advocacy services if they needed help to make decisions.

People and their relatives (if applicable) were not always involved in writing and reviewing people's care plans. The registered manager planned to review all people's care plans with them, including those for end of life care, and document people's involvement going forward.

The quality of people's care plans varied; some were person-centred, whereas others lacked detail. Daily records evidenced people received the support they needed, however, some record-keeping required improvement.

People told us they had enough to do at Chapel View; we observed people had access to a wide range of activities both inside and outside the home.

People and their relatives felt confident to complain if they needed to. Records showed complaints had been investigated and responded to appropriately.

The efficacy of audits at the home was mixed. Records showed some audits had led to improvements and others had missed the issues we identified at this inspection. There had been gaps in audits for some months in 2017 when the registered manager was also acting manager of another home.

The registered provider and registered manager had failed to notify CQC of incidents of abuse between people at Chapel View.

People and their relatives had opportunities to provide feedback about the service. Staff meetings had been sporadic in 2017; minutes showed these meetings focused on issues and problems.

The registered provider was keen to use information technology to drive improvement at the service.

We found breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014 and Care Quality Commission (Registration) Regulations 2009. You can see what action we have told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to people posed by the building and facilities were not always assessed and managed. People's care plans did not always contain sufficient detail about risk management.

The registered manager was not aware of all the accidents and incidents which had occurred at the home.

Most aspects of medicines management were done safely. Sufficient staff were on duty to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered provider was not compliant with the Mental Capacity Act 2005. This was a finding at the last inspection.

Most feedback about the food and drinks on offer at the home was positive. We found issues with nutrition and hydration records.

Staff received supervision and training to support them in their roles, but not always in line with the registered provider's policy.

Is the service caring?

Requires Improvement

The service was not always caring.

We had serious concerns around the lack of respect some staff showed towards people's privacy and dignity. We felt this was due to a lack of staff training and awareness.

People were supported to retain their independence by staff; this was reflected in their care plans.

People's care plans did not evidence how they had helped develop them. The registered manager planned to include people and their relatives in future care planning reviews.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people's care plans lacked detail, whereas others were informative and person-centred.

People were happy with the provision of activities at the home. We saw, and records showed, people took part in activities in the home and in the community.

The registered manager had investigated and responded to complaints according to the registered provider's policy.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A system of audit was in place but it was not always effective in driving improvement.

There had been a failure to notify the Care Quality Commission about incidences of abuse between people at the home.

People and their relatives had opportunities to provide feedback about their experience of the service.

Chapel View Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 9, 12 and 17 October 2017. The first and second days of inspection were unannounced. The inspection team consisted of three adult social care inspectors and one 'expert by experience' on the first day of inspection, and one adult social care inspector on the second and final days. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider completed a Provider Information Return (PIR) in June 2015 but we had not asked for it to be updated since then. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of the inspection we reviewed the information we held about the service and requested feedback from other stakeholders. These included Healthwatch Barnsley, the local authority safeguarding team, the local authority infection prevention and control team, and the Clinical Commissioning Group. After the inspection we received feedback from four healthcare professionals who visited the home to support people there.

During the inspection we spoke with eight people who used the service, six people's relatives, four members of care staff, the registered manager, the deputy manager, a director for the registered provider, an activities coordinator, a kitchen assistant and a cook.

We spent time observing care in the communal lounges and dining rooms and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us.

As part of the inspection we looked at five people's care files in detail and selected care plans from four

other people's care files. We also inspected seven staff members' recruitment and supervision documents, staff training records, five people's oral medicines administration records and one person's topical medicines administration record, accident and incident records, and various policies and procedures related to the running of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at Chapel View. One person said, "I feel safe here", and a second person told us, "Yes, I suppose I feel safe." Relatives told us they felt their family members were safe at the home. Comments included, "From what I can tell the care is safe", and, "[My relative] is safe here. If [they] fall [they] have someone to pick [them] up."

At the last inspection in August 2016 we identified concerns around staffing levels and received mixed feedback from people and their relatives about staffing; we recommended the registered provider monitor and review staffing levels on a regular basis.

At this inspection people told us there were enough staff to provide them with support. Comments included, "There are enough in my opinion", "There are normally enough, except in exceptional circumstances", and, "Oh yes, there's enough staff here", although one person commented, "Sometimes they could do with more, maybe in the evenings." Feedback from relatives around staffing levels was positive. One relative said, "They are reasonably staffed", a second told us, "There are enough to cope from what I've seen", and a third commented, "I've not noticed any particular times (when the home is short-staffed)."

We also asked staff at the home if they felt staffing levels were appropriate to meet people's needs. Most felt they were. Comments included, "I don't think we're short staffed at all", "Through the day, fully staffed, they do OK", "Yes (enough staff) – to meet people's needs. We don't always have time to chat", and, "More staff would make things better and safer."

Rotas showed one senior care worker was deployed each day shift, with four care workers. At night there was one senior care worker with two care workers. A director for the registered manager explained their electronic rota system, which care staff could access from their mobile phones. When there was a gap in the rota due to staff sickness or annual leave, other staff members would get an alert and could pick up the shift in addition to their normal hours. This had reduced the use of agency care workers at the home.

We arrived before 7am on each day of this inspection. On the first day, nine people were up, dressed and in the downstairs communal area at 7.05am. On the second day, there were seven people up, dressed and downstairs at 7am; and on the third day five people were up at 7.07am. The registered manager told us night staff were never asked to get people up, unless the person wanted to, in order to take pressure off the day staff. People told us they could get up when they wanted, although most people we saw up early were unable to tell us if they had requested to get up, because they were living with dementia.

We made observations of staffing levels throughout this inspection and noted that whilst there were busy periods, such as in the morning when people were getting up and mealtimes, people received support in a timely way when they needed it. This finding supported feedback from people, their relatives and staff, that sufficient numbers of staff were deployed to meet people's needs.

At the last inspection in August 2016 we noted some parts of Chapel View were not clean or not well

maintained, and we recommended the registered provider take action to ensure the home was cleaned and maintained appropriately. At this inspection we found some concerns persisted. An infection control audit by the local infection control team in September 2017 had resulted in a low compliance score and action plan. During our inspection of the building we found that whilst most parts of the home were clean and odour-free, some were not. This included mouldy grout in a bathroom, a stained hoist and sling, dirt on radiators inside covers, a malodorous sluice room, and a heavily stained stair and upstairs corridor carpet. In some areas tired décor and fittings made cleaning difficult, such as chipped paint on handrails and skirting boards.

The registered manager was able to demonstrate progress with the home's infection control action plan and the issues with cleanliness we identified, with the exception of the tile grout, were addressed immediately. Cleaning records had been revised since the last inspection so they were now kept in rooms, for example on bathroom doors, and were signed with the date and time to show when they had been done. The home's cleaning products supplier had also been changed since the last inspection as the registered manager was not satisfied with their quality. The registered provider was in the process of working through a programme of upgrades to décor and flooring, which included decorating and replacing handrails at the home. This meant at the time of this inspection some action had been taken in terms of infection control since the last inspection, but there was still more to do.

After this inspection, in November 2017, the home was subject to a full infection control audit by the local infection control team and received a much higher compliance score. This evidenced improvements had been made

We recommend the registered manager accesses nationally available best practice and uses it to review and update the infection prevention and control procedures and practice at Chapel View to ensure the recent improvements are sustained in the long term.

Chapel View shares kitchen and laundry facilities with another home run by the same registered provider on the same site. Shortly before this inspection the other home had experienced an outbreak of a diarrhoea and vomiting bug. The registered manager explained the measures put in place to prevent the infection spreading to Chapel View, and these had been successful. However this had meant some people's beds lacked duvet covers and pillow cases on the first day of our inspection due to a backlog in the laundry.

Most aspects of the building's facilities, equipment and utilities had been serviced and maintained appropriately to ensure people were safe, for example, the home's moving and handling equipment and gas and electricity supply. Measures such as fire drills and equipment checks were in place to reduce the risk of fire, although the home's fire risk assessment had not been completed fully and people's personal emergency evacuation plans (PEEPs) were located in their care files. This meant in the event of an emergency people's PEEPs would not be to hand to help staff unfamiliar with them to leave the building safely. A certificate evidenced 11 hoist slings had been tested for safety at the home in May 2017 but this did not include serial numbers or other means of identification. In addition, the home did not keep a list of slings and their serial numbers. This meant it was not possible to evidence the slings in use at the time of the inspection had been tested.

We identified aspects of the building which could pose a risk to people. For example, doors to an equipment storage area and sluice room were not always kept locked, and 12 of the home's radiator covers had cracked and broken and had sharp edges which could harm people. Maintenance records for September 2017 showed water in some people's ensuite bathrooms was over 44°C, which is the maximum temperature recommended by the Health and Safety Executive. The boiler temperature had been adjusted following

these checks; however, when we tested the hot water in five bedrooms during this inspection we found it was too hot for handwashing. We fed back our concerns regarding the unlocked doors, radiator covers and hot water to the registered manager and all were resolved by the end of the inspection.

Concerns around health and safety at the home were a breach of Regulation 12 (1) and (2) (a) (b) (d) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care files contained risk assessments and care plans for various aspects of their care and treatment at Chapel View, for example, risk assessments for falls, choking, and pressure ulcers. Other measures were in place to mitigate risks to people, such as discreet signage for visitors on the front door to check people living with dementia did not follow them out of the building unsupported, and hourly checks made on people using bedrails to monitor their safety.

However, we noted some care plans in place to manage risk to people were either not sufficiently detailed to guide staff, or had not been updated when people's needs had changed. For example, information in the room of one person nursed in bed stated they could reposition independently, whereas at the time of this inspection they were being supported to reposition in bed regularly by staff. None of the people using air mattresses to reduce the risk of pressure damage to their skin had the correct mattress setting recorded in their skin integrity care plan, and none of the staff knew what the settings should be. Air mattresses were supplied by community nurses who selected the settings. However, staff at the home did not know if the settings were correct and would be unable to identify if they had been changed in error. If this were to happen, people may be placed at risk. One person using bedrails for their safety had no risk assessment in place for them. People's moving and handling care plans did not always describe what equipment should be used to support them safely to transfer, bathe or shower, or how it should be applied.

We spoke with care staff and asked them to describe the support people needed to move, and to manage the risk to their safety and skin integrity. With the exception of one staff member who we observed supporting a person to eat in bed in a way which put them at risk of choking which we fed back to the registered manager, all staff were seen to support people appropriately to remain safe. In addition, staff we spoke with could describe how to give appropriate support in order to keep people safe, and knew how to recognise and report abuse by other staff or visitors. This evidenced an issue with the quality and accuracy of records and documentation, rather than the support people were receiving.

We checked records of any incidents and accidents to see whether appropriate action had been taken in response to them. We found this had not always been documented. For example, in the weeks prior to this inspection records showed two people had at times experienced behaviours that may challenge others, to the extent they had either struck other people, threatened to do so, or shouted at others. Descriptions of incidents were recorded in people's daily records or in ABC charts in their care files, but they were not always written up on incident forms for the registered manager to oversee. ABC or antecedent, behaviour, consequence charts are used to try and understand the triggers for people's behaviours that may challenge others, in order to reduce the person's distress. When we raised this issue with the registered manager she was not aware incidents of physical abuse had occurred between people in the weeks prior to this inspection. This meant there were issues with both recording and communication at the home.

We looked at records for people who had fallen at the home. These were also recorded on incident forms and we saw the registered manager had checked appropriate action had been taken in response to people's falls, including the use of safety equipment and referrals to GPs and the falls team. However, one person's daily records included brief details of three falls, one as a result of being pushed over by another person, in September 2017 which were not recorded on incident forms and the registered manager was therefore

unaware of. Again, this highlighted an issue with record-keeping and communication at the home. This meant the registered manager did not have oversight of all accidents and incidents at the home due to issues with recording and poor communication with care staff.

The above examples evidenced a breach of Regulation 17 (1) and (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of this inspection we reviewed the process of medicines management at the home. We also checked medicines records and observed a medicines round. A system was in place for the ordering, receiving and returning medicines. Medicines were stored appropriately and securely in a locked trolley and in locked cupboards in a secure store. We checked the stock of four medicines, including one controlled drug to see if they tallied with recorded amounts. Controlled drugs include strong painkillers, and are controlled under misuse of drugs legislation. Three of the four medicines, including the controlled drug, tallied with recorded amounts, however, one did not. This was Paracetamol prescribed and administered 'when required', in other words, to be taken as and when the person needed it. When we checked the person's medicines administration record (MAR) we saw it was not always clear whether one or two tablets had been administered, so an exact stock amount could not be calculated. This meant people's medicine stock could not always be reconciled.

We reviewed five people's MARs; they evidenced people had received their medicines as prescribed. People prescribed 'when required' medicines had medicines care plans in place to guide staff as to when, how and how often the person could take their 'when required' medicine. We also observed a medicines round. The care worker administering medicines did so in a person-centred way; they explained what the medicines were for and did not rush the person taking them.

At the last inspection in August 2016 the registered provider was in the process of implementing a system of cream charts and body maps to record the application of people's topical creams. At this inspection we found this system was not working well. We checked the rooms of three of the five people's whose MARs we reviewed with the deputy manager to see if cream charts were in use; we found they were not. Each room contained the prescribed creams which were clearly in use, and one person told us the care workers applied their creams for them. However, there were no records to evidence people received their topical creams as prescribed. This meant most aspects of medicines management and administration were done safely, but issues remained in terms of the recording of topical creams and 'when required' medicines.

As part of this inspection we reviewed the recruitment records for seven staff employed by the home to see whether all the necessary pre-employment checks had been made. Records showed most aspects had been checked in accordance with the regulations, including taking up prospective employee's references, completion of a health questionnaire, and a DBS check. The DBS, or Disclosure and Barring Service, helps employers make safer recruitment decisions. We found three employees with gaps in their employment history which had not been investigated in accordance with the regulations, although one of these staff members had been recruited by the home's former registered provider. We fed back our concerns to a director for the registered provider; they immediately amended the application form to highlight the requirement for a full employment history for all prospective employees.

Requires Improvement

Is the service effective?

Our findings

People told us they thought staff had the knowledge and experience to provide effective care. One person said, "I've never had a problem with being looked after", and a second told us, "They are trained enough for me." Relatives agreed; comments included, "Yes (they are trained) for what they do. They are so helpful", "They seem to know what they're doing and have a good attitude", and, "I think they are (well trained)."

At the last inspection in August 2016 we found care files lacked information about people's ability to consent to their care, and staff knowledge about the Mental Capacity Act 2005 (MCA) was at a basic level. We recommended the registered provider ensured training was completed such that the home became compliant with the MCA.

At this inspection we asked people if staff sought their consent prior to offering support or gave them choices to maximise their own decision-making. Feedback was mixed. Comments included, "They do explain things and ask if it's alright", "They ask me what I want", "I choose my day for myself", "They don't ask before they start but they do at the end, if it was OK", and, "They just do stuff. We don't discuss it." During the inspection we observed staff giving people choices over what to eat and drink, and which activities they wanted to do. However, there were times when people were not given choices; for example, people being assisted to walk to the lounge were not always asked where they wanted to sit.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards or DoLS. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found people who lacked capacity to consent to living at Chapel View had DoLS authorisations in place or applications for DoLS submitted for them. None of the DoLS we reviewed had conditions for the service to abide by.

Documentation relating to the MCA at Chapel View evidenced a continued lack of understanding of the legislation on the part of the registered provider and registered manager. New MCA documentation had been introduced shortly before this inspection, and of the care files we reviewed in detail only one contained mental capacity assessments for aspects of the person's care and treatment. However, we saw these assessments were not decision-specific in accordance with the legislation. For example, they included capacity assessments for 'attending to all personal hygiene and dressing', 'maintaining nutrition and hydration', and, 'continence promotion and management.' Each capacity assessment concluded the person

lacked capacity, although there was no information recorded as to how the assessment had been carried out. There were also no accompanying best interest decisions to evidence what decisions had been made for the person on their behalf and who had been involved. The deputy manager said the capacity assessments were new, and were in the process of being put in place for all people who needed them.

Other people's care files we reviewed did not have these capacity assessments, but did include statements around their mental capacity. For example, '[Name] lacks capacity to understand what [their] medicines are for', and, '[Name] lacks capacity to make [their] own decisions relating to [their] care needs, therefore [name's relative] makes the best decisions for [name].' There were no capacity assessments to support these statements or best interest decisions to show how decisions had been made and who was involved. We saw some people's consent forms had been signed by their relatives although there was no evidence they had been granted Lasting Power of Attorney, and therefore had the legal right to do so.

Staff knowledge about the MCA was variable. Two care workers we spoke with could tell us nothing about the MCA, whereas others could demonstrate a general understanding of mental capacity and best interest decision-making. A director for the registered provider told us they had sourced training on MCA for staff, records showed MCA knowledge checks had taken place in supervisions, and DoLS had been discussed in staff meetings. MCA had also been added to the provider's list of 'mandatory' training courses for staff. Our findings showed staff training on MCA had not been effective, people were not always given choices so they could make their own decisions, and records evidenced the registered provider was not compliant with the MCA.

This was a breach of Regulation 11 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in August 2016 we found the home's menu lacked variety and we identified concerns around the recording of people's food and fluid intake. As a result, we recommended the registered provider seek guidance on best practice and ensured staff recorded actions taken when people lost weight.

At this inspection most feedback from people about the food and drinks at Chapel View was positive. Comments included, "No complaints, happy enough. Satisfactory – very enjoyable", "Plain, simple, domestic Yorkshire. There is enough to eat", "It's good, if repetitive", and, "It's alright here but the food is always cold." Relatives gave us positive feedback about the food at the home. One relative said, "They (the meals) are very good", a second told us, "[My relative] has put weight on since being here", and a third commented, "[My relative] says the food is good and the carers are nice."

We observed four mealtimes during this inspection. We noted tables were set nicely with tablecloths, cutlery and condiments. Care staff were task-focused, in that conversation focused on people's meals and there was little meaningful interaction with people in the dining room. At times care workers also talked between themselves about their personal lives, over the heads of people who were eating. There was some chatting between people at tables, and a radio in the room played pop music, although we did not observe staff asking people if that was their preference. We also observed three times when people were supported to eat in bed. Each time interaction between the member of staff and the person was very limited, consisting of occasional prompts and no other meaningful conversation. When people are nursed in bed, mealtimes are a valuable opportunity to enrich a person's life with one to one support and conversation. This meant the mealtime experience required improvement.

After one meal the cook came out and spoke with people to ask what they thought of the food and if they had enjoyed it. We saw the people complimented the cook and said they had enjoyed their meals. This was

a good example of a positive interaction.

We spoke with the cook and found they had good knowledge of the nutritional needs of people at the home. A new four-weekly menu was in the process of being agreed with the registered manager, which was based upon people's feedback. The cook could describe how food was modified to meet people's specific needs, for example, for people with diabetes, swallowing issues, and those who needed fortified foods. The cook also explained how they met the needs of a person who required gluten-free foods, and a kitchen assistant described how the home had catered for a person who chose to eat a vegan diet. This meant kitchen staff had the knowledge and information they needed to meet people's nutritional needs.

At 8am on the second day of inspection one person told us they had not had a drink since the evening before. We noted the seven other people who had been up in the lounge when we arrived at 7am also had no drinks. We raised this as a concern with the registered manager, because breakfast was served from 8.30am onwards and this was a long time since supper, which was served the night before between 8pm and 8.30pm. The registered manager ensured people received drinks straightaway and we saw people up when we arrived early on the third day of inspection had drinks. The registered manager said she would speak with night staff to ensure people getting up early were offered drinks and breakfast, if they did not want to wait until 8.30am.

As at the last inspection, we identified issues with the recording of action taken when people had lost weight or were not drinking sufficient fluids. For example, on the second day of inspection we noted one person had drunk very little fluid over the preceding three days. When we raised this with the registered manager she was not aware of this. However, upon speaking to the deputy manager and senior care worker on duty, it became clear the person's GP was aware of the situation and was monitoring the person's condition. A second person's daily records evidenced a poor food and fluid intake over several weeks prior to this inspection. Their nutritional care plan dated August 2017 stated the person should be weighed weekly, although there were no records for this. The care plan had not been updated to inform staff the person was at nutritional risk. When we raised concerns the registered manager informed us the person's GP was aware of the person's condition; this was evidenced by records of healthcare professionals' visits at the back of the person's care file. The registered manager could not explain why the person had not been weighed and said they would make sure the person's weight was monitored going forward and their care plan updated.

We also noted food and fluid records did not always contain the level of detail required for staff to support people safely. For example, we were told one person ate normal consistency foods when they were seated at a table, and soft consistency foods when they were supported to eat in bed, to reduce their risk of choking. This was not recorded in their nutritional care plan. Kitchen records showed a second person was served soft consistency foods, but this was also not recorded in their nutritional care plan. Staff we spoke with could describe people's nutritional needs and the measures in place to reduce people's nutritional and choking risk, however, documentation did not always contain this information.

This meant people's care plans did not always describe the support they needed from staff to keep them safe. This was a breach of Regulation 17 (1) and (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most feedback from staff about the quality of supervision they received and their access to regular supervision was positive. One care worker told us, "They tell you how you can improve and ask you to explain what things mean. They ask if we think something's wrong", and a second said, "I haven't had one in a long time. The template they have is quite good. When you do get them (supervision sessions), they're good." The registered provider's policy was for staff to receive quarterly supervision and an annual

appraisal. Records showed most staff had received an annual appraisal and all staff had received supervision, but this had not been quarterly. Supervision documentation evidenced supervision and appraisal was a supportive and two-way process. The registered manager said there had been several months in 2017 where she had been acting manager for another home owned by the same registered provider and this had meant some slippage in this area. Now she was focusing fully on Chapel View, she planned to increase staff access to supervision back to the frequency required by the provider's policy.

Staff training was a combination of computer-based learning and face-to-face courses for subjects such as moving and handling. An electronic system logged staff progress with those courses deemed mandatory by the registered provider. Such courses included dementia awareness, first aid, food safety, infection control, and safeguarding. The registered manager explained new staff must complete all the courses prior to working at the home, and a director for the registered provider told us staff could not work at the home unless they had completed 95% or more of their allocated training courses. No staff new to health and social care had been recruited to the home since the last inspection; the registered manager told us the Care Certificate had been incorporated into the home's induction process and new staff were enrolled onto recognised health and social care qualifications as part of their professional development. The Care Certificate is an introduction to the caring profession and sets out a standard set of skills, knowledge and behaviours that care workers follow in order to provide high quality, compassionate care. This meant staff had access to supervision and training to support them in their roles.

People's records evidenced they had access to a range of healthcare professionals to help meet their wider health needs. These included dieticians, speech and language therapists, dentists and opticians. During our inspection we observed GPs and community nurses making routine visits to people which were then documented. After the inspection we spoke to four healthcare professionals who visited people at Chapel View on a regular basis. They told us the referrals they received from the home were appropriate, and that staff were helpful and knew people's needs. During the inspection we observed a senior care worker updating a community nurse about a person's condition; their interaction showed a good working relationship had been established. This meant people were supported to maintain their holistic health.

As discussed earlier in this report, décor and facilities in parts of the building were tired and required updating. The registered manager explained how good practice in environments for people living with dementia had been put in place as improvements were made. For example, replacement carpets had a neutral design, toilet seats and doors to toilets were brightly coloured so people could see them more easily, and new handrails which were about to be fitted would be a contrasting colour to the walls they were attached to. The registered manager told us of plans to create a sensory room in the home for people living with dementia, and the registered provider had implemented a monthly dementia practice and environments audit shortly before this inspection. This meant consideration was given to design adaptation for people living with dementia when improvements to the building were made.

Requires Improvement

Is the service caring?

Our findings

People told us they thought staff at Chapel View were caring. One person said, "They are kind and caring and treat me with respect", and a second person commented, "They are kind people." Most people's relatives also told us staff were caring. One relative said, "They go that bit further if they can", a second told us, "[My relative] likes the staff. They are all very nice", and a third relative commented, "[My relative's] privacy and dignity are respected when we are here." A fourth relative said of the staff, "Some are job-centred, some are person-centred."

People's relatives had also posted positive comments on a care home feedback website. Comments included, 'A lovely atmosphere where nothing is a problem and staff very friendly', 'All the staff care and look after my [relative] in a caring way', and, 'Staff here are very caring and patient. They treat everyone individually to their needs.'

During the three days of this inspection we observed some positive and caring interactions between staff and people. For example, when one person became confused and upset a care worker provided reassurance, gave the person a hug and said, "Come and sit by me." The person appeared much happier. On another occasion a person approached the registered manager about getting their morning paper on a day that was very windy. The registered manager offered to either walk with the person to the shop, or go for them, so they would not need to go out in the windy weather.

We also witnessed many interactions which were not positive or caring. For example, on two occasions when we visited people who were in bed in their rooms, a member of staff pulled the bedclothes off the person to expose them without the person's consent and without our asking. Staff used derogatory language to describe people, for example, when we asked a care worker if a person who needed help to eat had received their lunch we were told, "I don't know. I'm not on feeds (meaning people who required assistance to eat their meals)." We observed care staff discussing the need to obtain a urine sample from a person within the hearing of other people. When one person called out for help to go to the toilet a member of staff shouted from across the room, "Well go on then!" Many times during the inspection staff were heard to shout, "Do you need the toilet?" very loudly at people in communal areas, when a discreet question in the person's ear would have been more respectful. On several occasions we overheard care staff talking about people who were living with dementia when they were present; when we challenged this in the presence of one person a care worker responded, "[They] wouldn't understand, [they] just grunt at you."

One relative told us, "There are times when I have noticed dirt (faeces) under [my relative's] nails." During this inspection we noted one person had faeces under their nails on two separate occasions and had to bring it to the attention of staff. They responded immediately by supporting the person to wash their hands. The person's tendency for soiled fingernails was noted in their care plan and the registered provider told us they were monitored regularly throughout the day. However, despite this we needed to bring the issue to the attention of staff on two occasions during this inspection.

Some interactions evidenced a lack of staff understanding and knowledge of care for people living with

dementia. For example, when one person walking around the dining room before a mealtime was seen moving cutlery on a table a member of staff responded, "Don't touch other people's cutlery. Don't mess with that cutlery please", in a stern manner, which sounded like a telling off. A member of staff who found a person folding napkins in the dining room told the person, "Leave that alone and come with me"; they took the person's hand and led them into a toilet but did not ask the person if they needed the toilet or wanted to go there. Shortly after lunch a third person, who we had seen eat lunch, was heard to state they had not had a meal and became most insistent this was the case. Instead of offering the person more food, staff repeatedly told the person they had already had lunch. After about 10 minutes the person was given a choice of sandwiches and received a ham sandwich. Another person told a care worker they wanted to go home. The care worker replied, "You live here with us. Your [relative] wants you to stay here." This showed staff lacked knowledge of how to support and reassure people living with dementia.

Derogatory and judgemental language was also used to describe people in 'handover' meetings between staff coming on duty and those going off duty. For example, one person was described as being "noisy" the evening before, and "not too shouty" during the night. We also saw, '[Name] has been nasty' written in the daily records of a person living with dementia who had been distressed.

People we spoke with told us staff at Chapel View respected their privacy. One person said, "They knock on the door", and a second replied, "They do (respect my privacy and dignity), they knock and close the curtains." However, we observed this was not always the case. When we arrived at 7am to start the inspection we noted six people's doors were open and they could be seen lying in bed. Throughout the inspection we saw people who were nursed in bed some or all of the time had their doors open, except when they were receiving personal care. Care staff we spoke with could not explain why people's doors were open. The registered manager gave us reasons why two people's doors were open, but this was not recorded in their care files. Most staff knocked when entering people's bedrooms or going into bathrooms when people were inside, but we saw there were times when staff did not knock. We also noted the ensuite toilets in people's bedrooms had no locks, so they could not ensure their own privacy when using the toilet. This meant people's privacy was not always promoted or respected.

Concerns around respect for people's dignity and privacy constituted a breach of Regulation 10 (1) and (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We fed back our concerns around respect for people's privacy and dignity to the registered manager on the second day of inspection. On the final day of inspection we did note some improvement in the way staff interacted with people. We concluded from our observations that issues stemmed from a lack of awareness on the part of staff in terms of how their behaviour was disrespectful to people, rather than there being any intent to cause people upset or harm. At the end of this inspection the registered manager and a director for the registered provider said further training on dignity would be sought for all staff at the home.

People and their relatives told us staff at Chapel View supported people to remain independent. One person said, "They leave you to do things for yourself", and a second person told us, "They don't interfere. They let me do what I want." People's relative's agreed. One relative told us, "They leave [my relative] to do what [they] can, but it's very little." We saw people's care plans described how staff could support people to remain independent and during the inspection we observed some people popping out to the shops, using electric shavers, and helping staff to tidy up after meals. Another person was supported by staff to administer one of their own medicines; a risk assessment was in place to ensure the person was competent to do this. This meant people's independence was supported by staff.

We asked people and their relatives if they had been involved in developing and reviewing people's care

plans. One person said, "I have never seen it (their care plan)", a relative told us, "I involve myself in [my relative's] care but I've never seen any plan", and a second relative replied, "I haven't. [Another relative] has, I would like to see it to check up on the recording." The registered manager told us they liked to involve people and their relatives in care planning as much as possible, and this has been raised at the last relatives' meeting. However, apart from the care plan of one person with capacity where it was clear they had been involved and had signed various sections of their care file, it was not clear how other people had been consulted about their care plans. After we raised this with the registered manager we observed a meeting between her and a person from the home, where they discussed the person's care plans and made amendments to them. The registered manager said they intended to do this for all people and evidence how they or their relatives, if applicable, had been involved. This meant it could not always be evidenced how people had been involved in their care planning, but a plan was in place to improve this.

People were supported with end of life care at Chapel View if this was their preference. Such care was provided in conjunction with GPs and community nurses who visited the home. Care workers could describe to us what was important in terms of end of life care, but we noted people's care files did not include end of life care plans or any record of future wishes. In some care files a preferred place of death and funeral arrangements had been recorded, but this did not include information about the person's wishes as they approached the end of their life. The registered manager said end of life care plans were put in place when it became clear a person was approaching the end of their life, however, this often means the person themselves is not well enough to make their feelings known. The registered manager said they would include a discussion about end of life care when people's care plans were reviewed with them and their relatives (if applicable), so that care could be planned. She said she would also document any refusals to engage in such care planning. This meant staff were knowledgeable about end of life care, but people's end of life wishes were not routinely sought and recorded in their care plans.

People had access to advocates if they needed them. The registered manager could describe the referral process. Most people had relatives who were closely involved with their care and support and so they acted as advocates for them. This meant people could receive independent support with decision-making if they needed it.

We asked the registered manager how she ensured the home was welcoming and inclusive, in terms of faith, culture, religion, disability and sexuality. She said people at the home were supported to access church services if they wished to, and the home was open to admissions of people from any background as long as their needs could be met. Questions about such needs formed part of the home's pre-admission assessment. The training list for staff at the home showed a course on equality and diversity was mandatory for all staff. A kitchen assistant explained how they would meet requests for religious or cultural foodstuffs by speaking with the person and their family and researching on the internet. They also told us how they had provided meals for a person who chose to eat vegan foods. This meant the service was inclusive in terms of equality and diversity.

Requires Improvement

Is the service responsive?

Our findings

People told us they thought staff were responsive and knew what their individual needs were. One person said, "They know me", and a second told us, "In general terms, yes."

People's care files contained a range of care plans which were based upon an assessment of their needs. We saw most care plans were person-centred and included details about people's likes, dislikes and preferences, and covered aspects such as mobility, skin integrity, medicines, nutrition and hydration, and activities.

As described earlier in this report, some care plans did not contain the level of detail staff unfamiliar with a person would need to provide effective care and treatment. We noted the care plans of people living with dementia did not include details of how their dementia affected them, as each person's experience of dementia is different. In addition, the care plans of people who experienced behaviours which may challenge others lacked useful information for staff on how recognise the triggers for people's behaviours and the distraction techniques which may help calm the person down. For example, one person's mental health care plan stated 'Due to my cognitive dysfunction I can become agitated or aggressive. I require reassurance for this.' We saw one person had a specific care plan for seizures which stated, 'When [name] has an epilepsy fit [they] require staff to monitor [them] and make sure [they are] in safe surroundings.' This poor level of detail would not be useful for a member of staff not familiar with the person. This meant some people's care plans lacked person-centred detail.

Because some care plans lacked detail, we asked care workers to describe the needs of people whose care files we reviewed as part of this inspection. We found care workers could explain people's needs and the support they required with aspects such as moving and handling, nutrition, continence, and decision-making in terms of their mental capacity. They could also describe people's personalities, their preferred routines and personal histories. When we raised the issue of care plans with the registered manager she agreed their content could be improved and committed to making improvements in this area. We will check this at the next inspection.

Care plans were evaluated by staff on a monthly basis. The form used for this had space to write one or two lines only, and for this reason most evaluations we saw were very brief. For example, 'Care plan remains effective at this time', and, 'Care plan unchanged.' The registered manager said she had already flagged this issue to the registered provider and asked for the form to be updated so staff could write a fuller evaluation.

Care workers also evaluated care plans on a daily basis by recording the support they provided to people in daily records. Records showed the format of daily records had changed in September 2017 and then again around the time of this inspection in October 2017, as the registered provider sought to ensure care workers recorded the correct level of detail required to evidence people received care according to their care plans.

Most daily records we reviewed evidenced people were receiving the support they needed, such as help to reposition in bed and support to eat and drink. However, we did identify some issues. Food records we saw

included the amount a person had eaten as 'all', 'half' or 'three quarters', but not how much they had been offered. This therefore rendered any records meaningless. The registered provider modified the daily record sheet in response to our feedback and spoke with staff about the information they were required to record.

Care workers recorded incidents of challenging behaviour people experienced on 'ABC' charts. ABC or antecedent, behaviour, consequence charts are used to record potential triggers for people's distress and the techniques used to help support the person to calm down. Their purpose is therefore to gather information for analysis so people's distress can be reduced if at all possible. The registered manager told us information on people's ABC charts was not analysed and therefore not used to update and improve their care plans. This was therefore a missed opportunity.

Most feedback about the activities provided at Chapel View were positive. One person said, "I like pool, playing cards, dominoes. There are enough (activities) for me", and a second person told us, "Sometimes I would like more. Sometimes I don't want to join in." Comments from relatives included, "They try to involve [my relative]. Now and then [they] will dance", "I have seen the activities coordinator working really hard to engage with them (people)", and, "They tried to get [my relative] to join in as much as [they] could." Another relative told us the activities coordinator for the home had left in July 2017 and since then the provision of activities had not been as good, although they said of the activities coordinator who was covering some days, "[Name's] got some really great ideas." The activities coordinator covering the home during this inspection informed us a new coordinator was starting the week following this inspection so provision would increase again to five days a week.

During this inspection we observed people had a choice of activities to take part in. There were games of pool and cards, arts and crafts, quizzes, sing-a-longs, and games of balloon tennis. Most people seemed engaged and happy to take part. Other people chose to sit in a quiet lounge and watch the news, or pop out to the shops nearby. People's activity records evidenced their regular uptake of activities both inside and outside the home. One person had been out for lunch and a drink in the pub with staff, another person had sung karaoke, and a third had played bingo and carpet bowls. Records showed the activities coordinator also spent one-to-one time with people who were nursed in bed; this involved conversation and reading books aloud to people.

In 2017 people at the home had been involved in a poetry project called Hear My Voice, in partnership with a local museum and the mayor. People at the home had worked with project workers to compile a bound anthology of poetry based on their observations and life stories, which included photographs of the people and home. We saw selected poems were displayed around the home and people had attended events outside the home to read their poetry to others. The home had worked in partnership with the local football club to arrange an exhibition of memorabilia at the home, followed by a visit for people to the football ground for a reminiscence day about the club, its history and former players. In addition the home engaged with a local supermarket's community outreach workers. They had visited the home to help people decorate cupcakes for the Alzheimer's Society's cupcake day, and people went to the store to take part in activities there. This meant people had access to a wide range of activities both inside and outside the home.

None of the people or relatives we spoke with had ever made a formal complaint about the service, but some said they had raised concerns. One person said, "I haven't made one (a complaint). I would just go into the office and bang on the desk", and a second person told us, "I once complained about my bed not being made. They made it." Comments from relatives included, "Only little things. I talk to the manager", "Not really (complained). I had a talk with the senior carer and was reassured that action would be taken", and, "I tend to mention things as they come up." We reviewed the records of complaints and concerns received by

the home since the last inspection in August 2016. We saw each complaint had been documented, investigated and the complainant responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

We asked people and their relatives if they thought Chapel View was well managed and feedback was mixed. One person told us, "I can't see it managed any other way", and a second person said, "Yes, in my opinion." Comments from relatives included, "It appears to be (well managed)", "I have seven out of ten confidence in how well it's managed", "No, because of the staff attitude to engagement", and, "I think it's fairly well managed. Communication sometimes isn't the best."

We also asked people and their relatives if they knew the registered manager, and if she and other staff were approachable. One person told us, "No, I don't (know the registered manager), but I know the ones in the office. They are easy to talk to", and a second person said, "I talk to [the registered manager] in the office. She is approachable-ish". Relatives' feedback included, "I don't know who they (the registered manager) are. I talk to the office staff, they are friendly", "I talk to her (the registered manager), she is easy to talk to", and, "[My relative] goes to chat with [the registered manager]. [My relative] feels [the registered manager] is approachable too."

When we asked people what they thought about the home and its atmosphere, one person told us, "It is a friendly place. I get on with the staff", and a second said, "I would recommend it." Relatives asked the same question told us, "The atmosphere is cheerful", "It's pleasant", "It's good – all very nice", and, "Yes, I would (recommend the home), and have done." As discussed earlier in this report, we identified concerns around staff culture in terms of their lack of respect for people's dignity and privacy which we felt was due to a lack of training and awareness. We also noted a failure to communicate between staff and the registered manager, such that she lacked oversight of some aspects of the home. One relative told us, "There's a lack of communication in this place. It's a big bug bear. You get told different things or nothing." During this inspection we met with the registered manager and a director for the registered provider. They were very receptive to our feedback and committed to improving culture and communication at the home.

A system of audits was in place to assess the safety and quality of the service. The registered manager told us audits had changed shortly before this inspection, "It's a lot more in-depth." As discussed earlier in this report, the registered manager did not have oversight of all accidents and incidents at the home, because they were not always logged on the appropriate forms. We saw audit of accidents and incidents included checking appropriate action had been taken. Analysis also included the types of incidents and whether they happened during the day or at night, but not their location within the home.

Medicines were audited on a weekly basis at Chapel View. We found there were often gaps in these audits, particularly for questions around people's 'when required' medicines and the recording of topical cream application, both aspects we found issues with during this inspection. In the months prior to this inspection, care plan audits had been undertaken by the deputy manager; however, we noted the deputy manager had written a large proportion of people's care plans, which meant they were auditing their own work. This is not good practice, and had not highlighted the issues we found with the lack of person-centred information in some people's care plans. Care plan audits had identified an issue with a lack of detail in people's daily records; the deputy manager said they had provided training for care workers on this issue and the

registered provider had updated the format of daily records to ensure the correct level of detail was documented by staff. This meant some action had been taken in response to audit findings to improve the service.

The registered manager completed a monthly environmental audit; this was a general audit which included checking the building's facilities, cleanliness and documentation. Each audit had an action plan which evidenced action had been taken to update the décor and fittings in various parts of the building. In addition to this, the registered manager was expected to carry out and document a 'daily walk-around' of the building. This was to check the home was clean, and involved looking at people's daily records to ensure they were receiving appropriate care and treatment, evaluating whether people looked well cared for, and had their glasses on, hearing aids in, or dentures fitted, if required. Records showed these audits and checks had not identified the broken radiator covers, mouldy grout in a bathroom and open doors to storage areas which we found as risks to people that needed to be addressed.

Records showed the registered manager's daily walk-arounds had been sporadic between October and August 2017, and had not taken place at all in June or July 2017. The registered manager said this was because she was overseeing another nearby home for the same registered provider in addition to Chapel View at this time, so some aspects of management had slipped. This was also the case for monthly mattress audits, which were missing for May, June and July 2017. The registered manager said this would improve going forward as she was now focusing on Chapel View. We saw the daily walk-around document was amended to include a check of people's topical cream charts in response to our findings. This meant audits and checks were not always carried out and had not identified some risks to people.

Audit at the home did not cover aspects such as pressure ulcers and weight loss. This was considered on an individual basis during care plan audits but not across the home to identify any trends or patterns. The registered manager told us she would implement such audits on a monthly basis.

Concerns around the efficacy of audit at the home demonstrated a breach of Regulation 17 (1) and (2) (a) (b) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and deputy manager sent a weekly report to the registered provider and this was discussed at a weekly conference call. Directors for the registered provider visited the home on three or four days each week and carried out monthly and quarterly audits of care plans. They also reviewed the registered manager's environmental audit, as well as any complaints and issues raised by the daily walk-arounds. Records showed this information was discussed at the weekly conference call between the registered manager and directors, and actions were recorded and signed off when complete. A director for the registered provider told us they planned to amend their audit process such that the manager from their other home would audit Chapel View, and vice versa. They had also implemented new dementia environment, infection control and activities audit in October 2017. This meant the registered provider played an active role in monitoring the safety and quality of the service and was taking steps to improve the audit process.

Registered providers and managers have a responsibility to report specific incidents to the Care Quality Commission (CQC). Notifiable incidents include safeguarding concerns, police call-outs and serious injuries. As discussed earlier in this report, we identified at least seven incidents of abuse between people using the service the registered manager was not aware of because they had not been recorded on incident forms. None of these incidents had been reported to CQC. During the inspection we observed an altercation between two people where one person struck another with a television remote control. This was also not reported to CQC. When we raised this with the registered manager she could describe which incidents

needed to be notified to CQC, but could not explain why this had not been done.

The failure to notify CQC of incidents of abuse between people living at Chapel View was a breach of Regulation 18 (2) (e) of the Care Quality Commission (Registration) Regulations 2009.

Registered providers have a legal duty under the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015 to display the ratings of CQC inspections prominently in both their care home and on their websites. We saw ratings from the last inspection were clearly displayed on the registered provider's website. At the home we found information about the last CQC inspection was not conspicuously displayed on the first day of inspection, as is required by the regulations. However, the previous inspection ratings were placed on the residents' noticeboard as soon as we brought this to the registered manager's attention.

Records showed people and their relatives were given opportunities to feedback about the service at meetings and by completing surveys. Cards were available in the reception area for people to use to give feedback via an online care home website, and there were also printed feedback sheets next to a suggestion box. One person told us, "We have meetings in the lounge, talk about activities and the food", and a second person said, "They have responded to one or two things." A monthly newsletter was produced which covered Chapel View and the nearby care home owned by the same registered provider. It included updates around activities, staff, planned events, and celebrated the achievements of people and staff, and was written in a very engaging and positive style. This meant people and their relatives were consulted and kept informed about changes and events at the service.

Staff also had meetings although these had not been held regularly in 2017. One care worker told us, "They're constantly cancelled because staff don't turn up." A second care worker said of staff meetings, "They give us feedback and ask us if we've got any suggestions." Staff meetings are an important way of communicating with and motivating staff. The minutes of staff meetings showed agendas had focused on issues with practice and documentation and had a negative tone. The registered manager and a director for the registered provider said they would consider ways to improve staff meetings to make them more of a two-way discussion.

The registered provider was keen to utilise technology to improve record-keeping at the home, and to facilitate staff access to training and the service's policies and procedures. A director had recently attended an exhibition to investigate options for electronic care planning and medicines records and was in the process of deciding which system to purchase. Staff at the home already had access to the registered provider's policies and procedures on their smartphones or a computer at the home, and the time they spent accessing policies was monitored. The registered provider was also trialling a new online training system which had options to improve accessibility for staff with dyslexia or literacy issues, such that the benefit of training was maximised. This meant the registered provider aimed to use technology in order to improve outcomes for people at the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider and registered manager failed to notify the Care Quality Commission about incidents of abuse between people at the home. Regulation 18 (2) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service was not compliant with the Mental Capacity Act (2005). This was a finding at the last inspection. Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people posed by the building and facilities had not always been assessed and managed. Regulation 12 (1) and (2) (a) (b) (d) (e)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Care staff were not always respectful of people's privacy and dignity. Regulation 10 (1) and (2) (a)

The enforcement action we took:

We served a Warning Notice on the registered provider. They must be compliant with the regulation by 18 February 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People's care plans did not comprise a complete and contemporaneous record of the control measures required to ensure their safety. People's care plans were not always updated when action was taken in response to changes in their condition. Regulation 17 (1) and (2) (a) (b) (c) Audit at the service was not always an effective means of driving improvement and had failed to identify concerns raised at this inspection. Regulation 17 (1) and (2) (a) (b) (f)

The enforcement action we took:

We served a Warning Notice on the registered provider and the registered manager. They must be compliant with the regulation by 18 February 2018.