Monarch KM Ltd

Downsvale Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This was an unannounced inspection and took place of 27 and 29 April 2016.

The service is registered for 35 people. At the time of the inspection there were 31 people living in the service. People had a range of needs. Some were living with dementia; others required nursing care to manage pressure areas and end of life care whilst other people required minimal assistance.

The service had a registered manager. 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.

People were not always protected from harm. Risks to people had not always been assessed and therefore put them at risk of harm. For example, one person had a pressure sore and there was no risk management plans in place.

Care equipment that was provided was not always safe for use. One person had a bed rail, yet they managed to sustain an injury to their head as a result of poorly fitting bed rails. Hoists, commodes and wheelchairs were not always cleaned.

The registered manager and provider had not always identified when there was a safe guarding concern. One staff member had been "quite rough" with a person and this was not reported as a safe guarding concern.

There was not always enough staff on duty to meet people's needs. People told us that they had to wait for staff when they needed something. Half of the staff we spoke to said they felt rushed and they would like to spend more time with people.

People did not always have their medicines administered safely. One person had not received a medicine for six days. Medicines were not always stored and disposed of safely.

Robust recruitment practises were not in place to ensure that staff were safe to work with people. References and applications were not always in place for staff, the registered manager had not ensured staff were of good character.

People's human rights could have been affected because the requirements of the Mental Capacity Act were not always followed. For people who lacked capacity to make decisions about their care, mental capacity assessments and best interests decisions had not occurred.

People did not always receive effective care. The registered manager had not always ensured that staff had

the knowledge; skills and regular supervision to enable to them care for people safely and effectively.

People had sufficient food and fluids. Some people told us that they could not always reach their drinks when they were in their beds. People said they liked the food.

People were not always involved in the care. Some relatives were involved, but others had not been. People and relatives said that the staff were kind and caring. People's privacy and dignity was not always respected. Staff did not knock on people's doors and waited until they were told to enter.

People did not always receive personalised care. Three people, who were newly admitted, did not have their needs assessed, this meant that staff would not know how to support people. People's preferences and wishes were not always recorded in their care plans.

There was an activities programme in place; people said they enjoyed the activities.

People and their relatives knew how to make a complaint. Complaints had been responded to in line with the service's policy.

The service was not well led. There was not a robust system in place to monitor and review the incident and accidents.

There was not a robust process in place to monitor and evaluate the care provided to drive improvements. Record keeping was inconsistent and records were not stored securely.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. For breaches 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 we took enforcement action and issued Warning Notices. You can see what action we 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?

Inadequate

The service was not always safe.

People were not always protected from avoidable harm.

Risks to people were not always managed to keep people safe.

Care equipment was not always safe for people to use.

Medicines were not always administered to people. Medicines were not always stored and disposed of safely.

Staffing levels meant that people were sometimes left waiting for care to be provided. Robust recruitment practises were not always in place.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always have the right training and knowledge to care for people effectively. Staff did not receive supervision.

People's human rights could be affected because the requirements of the Mental Capacity Act were not always followed.

People had enough to eat and drink. People said they liked the food.

People had access to health care professionals to maintain their health needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always involved in their care and their privacy and dignity was not always respected.

People and their relatives said staff were caring and kind.

Staff had developed caring relationships with people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care was not always personalised.

People did not always have their care needs assessed.

People and relatives knew how to make a complaint. Complaints were responded to according to company policy.

People were happy with the activities that were on offer.

Is the service well-led?

Inadequate

The service was not well led.

There was not a robust system in place to monitor and review the incident and accidents.

There were no robust quality assurance systems in place to review, evaluate and improve care.

Record keeping was inconsistent and records were not kept securely.

People, relatives and staff told us that the registered manager was friendly and approachable.

Downsvale Nursing 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.

The inspection was unannounced and took place on 27 and 29 April 2016. The inspection was carried out by two inspectors and an expert by experience (ex by ex). An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed all the information we held about the provider. This included information sent to us by the provider in the form of notifications and safeguarding adult referrals made to the local authority. A notification is information about important events which the provider is required to tell us about by law. Before and after the inspection we contacted the local authority commissioning, quality assurance and safeguarding teams to ask them for their views on the service and if they had any concerns.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR) because we carried out the inspection at short notice. 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.

We used a number of different methods to help us understand the experiences of people who used the service. During our inspection we spoke with eight people about their experience of using the service. We also spoke with four relatives. After the inspection we spoke with two health professionals. We also spoke with the provider, the registered manager, two registered nurses and three care staff.

We examined records which included eleven people's care and medicine records, staff training, support and employment records, quality assurance audits, minutes of meetings with staff, menus, policies and procedures, complaints records and accident and incident reports. We asked the registered manager to send us some additional information following our visit, which they did.

We observed care and support being provided in the lounges and other communal areas and we also spent

time observing the lunchtime experience. We also observed part of the medicines round that was being completed.

The last CQC inspection was 26 February 2014 where no concerns were identified.

Inadequate

Is the service safe?

Our findings

People were not always protected from risks to their health and well-being. Not all people had risk assessments in place even though they required them. Three people were newly admitted into the service without risk assessments in place. One person had a sacral pressure sore on admission to the service, however there was no skin integrity assessments in place to identify the risks and there was no plan to manage the risks. It was identified in one person's hospital discharge report that they required regular re-positioning to minimise the risks of their pressure area worsening, this did not occur. Without risk assessments the risks to people and staff would not be managed safely as staff may not know how to support people safely.

One person had a surgical site that was prone to infection. The registered manager advised us that this person was clear from the infection upon admission as stated in their hospital discharge papers. The person's nursing notes stated that the surgical site had become infected again which was later confirmed by the GP. There was a wound assessment and progress record in place, which had not been updated for five days. There was no risk assessment in place to advise staff how to prevent or manage the risk of infection to the person on their surgical site.

For those people who had bed rails in place, bed rail risks assessments had been completed, however they were not in line with guidance from the Health and Safety Executive. This guidance states that the risk assessment should include measuring any gaps between the head board and the bed rail and mattress depth. This is to ensure that the risks of entrapment are minimised. The risk assessments did not include this information. One person had sustained a minor injury to the head as a result or poorly fitting bed rails.

We asked the registered manager and the provider to review people's bed rails immediately; this was done over the two days of inspection. Since the inspection the provider has sent us new bed rails risk assessments have been put in place in line with guidance to help keep people safe from injury.

One person was at risk of choking. As stated in their hospital discharge report they were on a fork mashable diet with normal fluids from a teaspoon. We saw this person being given biscuits that were not softened by a liquid and was given tea that was thickened by a staff member. We told the registered manager who said that this would not occur again. The registered manager confirmed that the GP had made a referral to the Speech and Language Therapist (SaLT). On the second day of inspection we found that staff were still giving the person food that increased the risk of them choking. Therefore staff were not following the guidance given to reduce the risk of choking to the person.

Risks to people were not always managed safely, therefore was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks were assessed for some people. Risks assessments were in place for some people for falls, use of wheelchairs moving and handling.

Equipment was not always suitable or properly maintained. We found one sling that was torn at the hems and fraying, therefore making it unsafe when used. Staff told us it was being used sometimes. We requested the registered manager remove this immediately which they did.

We asked the registered manager to complete checks on all slings and hoists in the service, this was done on the day. The provider told us that they had recently ordered new slings for people. The provider told us that six monthly checks had been completed on all the hoists and we saw relevant paperwork to confirm this.

Some beds had bed bumpers on their bed rails, however we observed that some were ripped, cracked and torn which increased the risk of infection. We pointed this out to the provider and on the second day of the inspection six new bed bumpers were being fitted.

Two beds had two mattresses (one normal on the bottom and a pressure relieving one) on top of another, with bed rails. The registered manager told us that this was to make the bed higher for staff to care for the people when they were in bed. The two beds were divans and not profiling beds. This put the person at risk of falling out as the bed rails were not at an effective and safe height due to the depth of the two mattresses. Two new beds were delivered on the second day of inspection and the two were removed.

We found hoists, commodes and wheelchairs were dirty. One sling had dirty marks on and needed cleaning. Staff told us they do not have enough time to clean them.
As the registered manager and provider had not ensured that equipment was suitable for purpose, maintained or cleaned this is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always enough staff to meet people's needs. One person said "There is not enough staff for the size of the place; however staff support you to do what you can within reason." Another person said "It's a close run shave. But pretty good on the whole. There have been moments when I have been embarrassed and left on the commode until recently." Another person said "Staff don't come very often. Sometimes I need something but they don't pick it up so I just do without. I don't often see staff during the day and I would like to see them. I would like to see them two or three times a day."

Staff we spoke with told us that there were not enough of them to meet people's needs. A staff member told us that "When the bell is rung, we often have to go to people to apologise and ask them to wait until staff can come." Another staff member said "There is not enough staff, we are pushed for time, care isn't always the best, (we) don't spend time in the lounge. We are always rushing."

The registered manager told us there are always five care workers and one nurse on shift during the day and at night one nurse and two carers. The rotas confirmed this was the usual staffing level. We observed care in the large lounge, one member of staff entered the lounge in a 40 minute period and drinks were served by a domestic member of staff.

The registered manage did not have a systematic approach to determine the number of staff required to meet people's needs. We asked the registered manager how they knew they had the correct number of staff to meet people's needs, they told us "This is the way we have always done it."
Staffing levels were not always able to meet people's needs; this is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from avoidable harm. The registered manager and provider had not always identified when people were at risk of avoidable harm. There was a record stating that one staff

member had lifted a person without a hoist. The records showed that the registered manager had spoken to the staff member before about making sure they used moving and handling equipment.

Due to the staff member inappropriately lifting people and by doing so putting the person at risk of avoidable harm, this should have been identified as a safeguarding concern and referred to the local safeguarding team but it had not been. We asked the registered manager to raise the above concerns with the local authority safeguarding team, which they did on the day of inspection.

As safeguarding concerns were not always identified by the registered manager or the provider, this is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most staff had knowledge of safeguarding procedures, including the types of abuse that could occur. Staff told us they would report concerns to the nurse in charge or the management. Not all staff knew there were external agencies that could be contacted if they had a concern even though there was a safeguarding policy with contact details of the local authority in it. The provider told us that all staff had training in safeguarding procedures and this was reflected in the training records. There was a safe guarding poster available to people and to staff with contact details on of relevant agencies that people and staff could contact to raise alerts.

People's safety may be at risk because appropriate checks were not always carried out on staff to ensure they were suitable to support the people that lived at the service. The registered manager and the provider had not always checked that staff were of good character. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

The provider had not always ensured that staff references had been obtained. Some staff files did not have any references which meant that the provider could not always ensure that staff that had been recruited were of good character. References also ensure that staff had given the correct employment history.

The registered manager told us that some new staff had a trial period in the service shadowing staff which if successful was followed up with the paperwork. In some staff files there were no evidence that interviews had taken place. The provider told us that they were in the process of reviewing all the staff files to ensure that the appropriate checks had been completed.

Not all staff had the appropriate checks in place to ensure staff were safe to work with people at the service. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were not always administered safely. One person who needed a specific medicine to manage their medical condition had not had their prescribed medicine for six days. Staff had recorded that the person had refused that medicine for two days but did not recorded anything on the medicine administration record (MAR) for four days. We asked the registered manager why this had happened and were told that the person regularly refused their medicines. The MAR showed they had taken some of their other prescribed medicines on the six days. It had not been identified by the registered manager or other nursing staff as a concern. We asked the registered manager to contact the GP for medical advice to discover if the person was at risk of harm. The GP advised that by not having this medicine administered put the person at risk however there had been no effects to their health in this instance.

MAR charts were in place for people using topical creams. However they were not always completed,

therefore indicating that people did not always have their creams applied as per their prescription. The MAR did not also contain the required information to advise staff where the cream should be applied and the frequency of application.

For people who were prescribed an as required medicine such as some pain relief, there were no guidelines in place. Therefore staff would not always know how and when to administer these medicines which could impact on people's well-being if pain is not sufficiently controlled.

Medicines were not always stored, recorded or disposed of safely. For example we found that one person's eye drops did not have an open date sticker on, these must be disposed of 28 days after opening. Another person's liquid medicine for constipation should have been disposed of six months after opening. We asked the registered manager to throw these away.

Medicines were not always managed safely this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff told us how they would respond in an emergency. For example, if a person had a fall, staff told us they would get help from a colleague; reassure the person, offer first aid if necessary and call an ambulance if required. Some people had personal evacuation and emergency plans (PEEPs) in place, some people did not. Since the inspection the provider has sent through PEEPS for everyone. These plans provide staff with information as to how to support a person if an emergency arises.

Requires Improvement

Is the service effective?

Our findings

People's human rights could have been affected because the requirements of the Mental Capacity Act 2005 (MCA) were not always followed. 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's next of kin were often asked to consent to the care on their behalf. The registered manager told us that relatives had made some decisions regarding people's care without having the legal right to do so. This meant that decisions made on the person's behalf may not have always been made in the person's best interest.

One next of kin agreed for a medicine to be administered to a person who had expressed they did not want it. Another relative decided that their family member could have a food type that could have affected their health. There was no evidence in both examples that a mental capacity assessment or best interest decision had been made.

The management told us that they made referrals to the GP to assess to people's mental capacity in relation to care decisions rather than undertake the assessments themselves. Staff did not have a clear understanding of what the Mental Capacity Act meant for people in the service. Staff told us they did not assess people's capacity in any decision making.

There were inconsistencies from care staff asking people their consent prior to giving care to people. For example at lunch time staff were putting tabards (protects people's clothes from spillages whilst they are eating) on them, some staff asked people if that was ok whilst others just put the tabard on without asking the person.

As mental capacity assessments and best interest meetings were not completed for people who may have lacked capacity to make decisions this is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services are called the Deprivation of Liberty Safeguards (DoLS). Some people's freedom had been restricted to keep them safe. Where people lacked capacity to understand why they needed to be kept safe the registered manager had made the necessary DoLS applications to the relevant authorities to ensure that their liberty was being deprived in the least restrictive way possible.

Staff did not have regular supervisions. Staff told us they had regular informal chats with the registered manager and provider and that they felt supported by them. The provider and registered manager

confirmed that not all staff were having supervision. They said that staff had 'job chats' which were recorded discussions of when they needed to address an issue of concern with a staff member. We asked the provider for evidence of staff one to ones and appraisals. No evidence of one to ones could be provided. The service did not have a supervision policy; however it stated in the staff development and training policy "We believe that on-going staff training and supervision will ensure a high quality service is delivered." As staff supervisions did not occur, there was a risk that people may not be effectively cared for as staff were not given the regular opportunity to have their skills and knowledge evaluated, develop skills through the exchange of information or review and discuss individual people's welfare issues.

Staff did not always have the necessary skills to deliver effective care to people. Staff told us they wanted extra 'hands on' and 'practical' training in manual handling, medicines and safeguarding. In the recent staff meeting minutes, staff had requested extra training in dementia and manual handling. The provider and staff told us that the training was on line and e-learning.

We observed a person being moved from one chair to another by staff using a standing hoist. We had to step in as the transfer was unsafe as the staff had not tightened the sling around the person's waist and the slings were coming up under their arms. Both staff members had said they had moving and handling training recently and this had been confirmed in the training records. This meant that the moving and handling training had not always been effective as staff should have known what the correct moving procedure was. We observed the transfer again with the same staff and this time the procedure was carried out safely.

The registered manager has not ensured that staff have the skills and knowledge to enable staff to provide effective care for people. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that ten of the staff have a national vocational qualification (NVQ) three in care and one in NVQ level five, which is a nationally recognised qualification for care workers. New starters had either completed the Care Certificate or are currently undertaking it as part of their induction. This is a certificate that sets out standards and competencies for care workers.

People told us they got enough to eat and drink. One person said "You get plenty of cups of tea" and the "food is very good". Another person said "The food is good. You have a choice of two options when the staff come round in the morning." However some people told us they didn't get enough to drink and that they were placed out of their reach when they were in their bedroom. We saw this happening and asked staff to change the cup at the persons request or to move it to where they could reach.

The cook told us there was a four week rolling menu that was changed in the winter and then the summer with two choices for each meal. We observed a lunch time. There was no separate dining space in the service. People had their meals either in the lounge or in their bedrooms. The two lounges had a table for some people to sit at. Other people ate their meal in their chairs on a table in front of them. In one lounge the main meal was served to people and then staff left for 10 minutes, came back, removed people's plates and then gave people their desserts. The dining experience was very much focused on staff completing tasks and there was little social interaction between staff and people.

The hot food trolley in the small kitchen had no temperature gauge so staff could not tell what temperature the food was being kept at. We saw food coming out of the trolley that did not look hot, so we asked staff to ensure the food was an adequate temperature which they did.

We observed care staff give drinks to people in the lounge, but people were not always asked for their

choice.

People were supported to access health professionals. The GP visited weekly and as required. People accessed physiotherapy, psychiatrist and palliative care nursing. One health professional told us "Staff are good at identifying if there is a problem, ringing for advice." Another health professional said "It is the only nursing service that follows exercise programmes, they are very good. I am impressed by them."

However care plans did not reflect healthcare professionals visiting and if advice on the care and support had changed by them this had not been reflected in people's care plans. Since the inspection the provider has told us that when health professionals visit, they record their information on in separate files, which are available for staff.

Requires Improvement

Is the service caring?

Our findings

People said that staff were caring. One person said "It's a good place and a good area. The staff are very friendly and try and help anyone. Everyone's very helpful." Another said "The staff are very good. I like living here."

One healthcare professional told us "Relatives seem happy; I have never seen a patient distressed. Relatives are grateful; it's like a service from service." Another health professional told us "It feels more like a service, less like an institution. It has a friendly warm feel about the place."

We observed staff were task focused. We saw two staff supporting someone to use a hoist to move from one chair to another. The staff member said to the person "We are going to need to transfer you into the chair for lunch." The person was not given a choice if they wanted to sit at the table or not. Staff entered the communal areas often to complete a task without any acknowledgement of people, for example they poured a drink for someone without talking to the person or asking what they wanted.

Staff did not always engage with people when they were supporting them with their care needs. We saw a staff member wheeled a person into the lounge in a wheelchair and left them in the middle of the room. They then walked away without saying anything to them. The staff member came back a short time later to help them move.

Staff did not always uphold people's privacy. We observed staff walked in and out of people's bedrooms without knocking or asking the person if they could come in.

The registered manager had not ensured that staff always treating people with dignity and respect this is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were inconsistencies in how people were involved in their care plans. We looked at care plans to gauge the level of people's involvement in their care. Some people had signed their care plans which indicated some involvement but most people had not. In some instances relatives had signed some care plan documents. By not involving people and their relatives where appropriate it may not always be clear to staff how people would like to be cared for and to ensure their wishes were respected.

Relatives told us that staff let them know when their family member was not well. Some relatives told us they were involved in planning people's care, others said they were not involved.

For people who were at the end of their life, people's wishes, spiritual needs and preferences were not always recorded in their care plan. In two peoples end of life care plan both stated "To follow [person's name] wishes and preferences and maintain their dignity in the end of life." The plan did not state what the person's wishes or views were. The registered manager told us that there were two other people in the service who were at the end of their life, but we found that they both had no care plans in place. This meant that staff could not always provide the care that people wanted in respect to the end of their life.

We recommend that the registered manager reviews how it involves people in their care planning in line with current guidance.

Relatives said that staff were approachable and friendly. One relative told us "The staff are friendly and polite, which is the main reason I chose here. The staff are always offering to do stuff and asking what else they can do. I couldn't ask for anything more." Another relative told us "The staff are very friendly; they always pop in to ask if we want a drink and see if we are okay." People's bedrooms were personalised and decorated to their taste. We saw that people had bought in their own furniture and pictures to decorate their rooms. Relatives told us they could visit their family member at any time and there were no restrictions. We saw this happen on the day.

When people had asked us for drinks or other assistance, staff responded to these requests and provided the person with what they required. On one occasion a person was calling out for his wife. Staff responded and spoke to them in a calm manner, reassured them and explained that his wife would be there soon.

Staff told us how they would ensure that a person's dignity was maintained whilst they were having a wash. Staff said that they would close or lock the door and where appropriate use a towel to cover parts that weren't being washed.

Staff told us how they like to offer choice to people, for example offering people a choice of what to wear or whether they would like to go into the lounge. One person told us "I always get asked what I am going to wear today in the morning." They went on to say "I wash what I can as I am a little more independent than others. I wash myself where I am able to, and then that staff help me with the rest." Staff addressed people by their preferred names.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us that staff were meeting people's needs. One said that staff were meeting their relative's needs. "They are shaven, clean, they got a new shirt on – what more can you say? [Name of relative] needs are being met. The staff crush [name of relative] medication, which they didn't do in hospital. It's just little things like this which make his life easier." One relative told us how well they had looked after the person when they were unwell.

Despite the above comments, we found that people's care needs were not always assessed. Three people had been newly admitted to the service. The registered manager had visited all three people prior to them moving in, however they had not completed a pre-admission assessment and there were no care plans in place for them. The registered manager said "It takes us a week to do people's care plans."

Another a relative told us "I have not been asked about [name of person] likes and dislikes yet or been asked about them." This meant that care staff could not always be able to provide the care that people needed as people's needs were not identified.

People did not always receive personalised care. People's views and preferences were not always recorded in people's care plans. Some people's care plans contained a 'profile sheet' that recorded people's histories, family information, past employment, past and present activities and likes and dislikes. One person's profile stated in personality "Normally ok – confused quite a lot." In other care plans the 'profile sheet' was incomplete or there was not one at all. This meant that staff could not always provide care to people as they were not aware of people's wishes and preferences.

Generic information was sometimes recorded in people's care plans. For example, in two people's care plans for bed and rising times stated "[Name of person] is up in the lounge for breakfast after 8am and goes to bed after supper at 7pm. Review [name] choice at regular intervals."

We asked staff to tell us about a person they cared for. Staff told us about how the person needed to be washed and dressed and what care they needed, rather than talk about the person, their past life, likes and dislikes. Staff did not know what some people's diagnosis was.

Staff told us that they do not get involved in writing peoples care plans. They wrote up people's daily notes and would tell the nurse in charge if a person's needs have changed. One staff member said "I don't know what goes into the care plans; we notice the changes as we have more dealing with the residents." Another said "I don't write care plans the manager and deputy do that." Another said "We ask the nurse about their [peoples] care, It is easier."

People did not always receive a personalised service this is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that when a person's needs had changed, they would report this to the nurse in charge. There

was a handover at each change of shift were staff would attend to discuss people's wellbeing and any changes required in their care. This was evidenced in a day and night report for people to review.

People told us that activities had improved now that a recreational therapist had been recruited. One person said "The activities person gets me my library books." Another said "Sometimes had quizzes, sometimes sing-songs and sometimes plays." They pointed out the decorations around the lounge and said that they were from the Queen's Birthday celebrations the previous weekend. They told is there was "Always something going on in the afternoon in the big lounge." Another person told us about a game of scrabble that had played the afternoon before and had won some hand lotion.

The service had a recreational therapist who worked Monday to Friday, four hours per day. There was a weekly activities timetable ranging from bingo, book clubs, and crosswords to musical entertainers coming in. The recreational therapist visited people when they were being cared for in bed for chats.

We observed a game of giant snakes and ladders run by the recreational therapist. People were enjoying the game and there was a lot of laughing and joking going on.

People and their relatives told us what they would do if they needed to make a complaint. A person said "'I call the nearest nurse. I only use an official complaints procedure if I have to wait an unusually long time, which has only happened very rarely." One relative said "I don't have any concerns as of yet. If I had a problem I would go to [the name of the registered manager]."

Staff told us how they would respond to a person making a complaint. Staff said that they would listen to the person, fill out the complaints form in the office and tell the nurse in charge. We reviewed the complaints and spoke to the provider and found that the complaints had been responded to appropriately.

Inadequate

Is the service well-led?

Our findings

People and relatives told us the registered manager was very approachable. A person told us "Oh yes you can talk to the manager easily and most of the staff who are not too hard pressed." The registered manager is knowledgeable about people's needs. One relative told us "The provider is very approachable. I was talking to him yesterday about his [family member]."

The registered manager had a number of compliments and thank you letters from people's relatives. Compliments included "We felt so welcome and cared for as a family" and "We would like to thank all the staff for their care and kindness."

Despite these comments we found that the service was not well led. There was not a robust system in place to audit incidents and accidents. The registered manager had ensured that incident and accident forms were completed, and had completed accident audits. However, the reporting and the auditing of the accidents did not record or include information such as the outcome of the injury, how the injury may have occurred or how to minimise the risks of the incident occurring again to people. For example, from one audit, the registered manager had identified seven skin tears 'sustained whilst being attended.' A further three audits identified that skin tears 'sustained whist being attended' were two, five and one. As there was a continuation of people receiving skin tears whist being 'attended too' the registered manager had did not have a process in place monitor or review safe systems of working to minimise risks and impact on people.

Processes that the provider had put in place to assess and monitor health and safety and risks to people and staff were not always effective. It was identified in the last two months of infection control audits completed by senior care staff that "hoists, wheelchairs and commode surrounds and pots all need cleaning." The housekeeper told us that care staff were responsible for cleaning care equipment however this had not been done. Staff meeting minutes document that wheelchairs and commodes needed to be cleaned in May 2015, January and April 2016. Infection control audits from January and February 2016 stated that hoists, commodes and wheelchairs were unclean which put people at risk of infection.

Furthermore, it was identified in staff meeting minutes 11 months ago that staff were hurting their backs as beds in two rooms were too low. We asked the registered manager about this and they told us that the beds were not profiling but to address the risks to staff the provider had placed a mattress on top of the existing mattress to make the bed higher. The provider had not taken into account the risks to people. This system was still in place 11 months after the problem was identified. The registered manager had not always assessed and managed the risks of injury to people and staff.

There were no robust systems in place to audit the quality of care provided. The services quality assurance policy stated "Although we have not engaged in an external process of verification, we audit our own services on a regular basis and monitor ways in which we may improve our service." The policy did not give guidance as to what processes were to be used and how regularly or what quality assurance systems should be used. Therefore the registered manager and the provider were unable to monitor, evaluate and improve the quality of care that was provided. The concerns that we found during this inspection should have been

identified had there been an effective quality assurance process in place.

Discussions with staff, observations and evidence in records confirm that the culture of the service was task focused, for example, when we asked staff to talk about people, they spoke about what tasks they needed to support people with, rather than the person themselves. The staff were not supported by the provider or registered manager to question or develop practise in line with current guidance, already highlighted in the report.

Record keeping was inconsistent. These included generic information in some care records, missing information in risk assessments and missing information in some people's MAR charts, as already identified in the report. Peoples care records were not stored securely. People's care plans were not locked away and accessible to anyone in the service. People's medicine records were kept on the trolley in the hallway and accessible to everyone.

The above evidence demonstrated that robust systems were not being operated to assess, monitor, mitigate and improve the quality and safety of the service for people and that record keeping was not consistent. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before the inspection, the provider had organised for an external organisation to complete an annual health and safety audit which had not yet been completed.

The provider had completed a complaints audit in November 2015 and had reviewed all the complaints received. There was one action recorded and the provider stated that this will be reviewed in one year time.

The provider had completed a safeguarding log audit completed in November 2015. The provider has listed the number of safeguarding alerts since 2014 and their outcomes. The provider had not identified trends or a date for review.

The registered manager told us that they had recently sent out feedback forms to people and their relatives to obtain feedback on food, the admission process and privacy around your care. They were waiting for responses to be returned before analysing and acting upon the information.

The provider told us that a residents and relatives meeting was to be held in May 2016 and that they were held six monthly.

Staff told us that they felt supported by the registered manager who was approachable but that they were not always working well together as a team.

The registered manager had ensured that appropriate and timely notifications had been submitted to CQC.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive a personalised service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered manager had not ensured that staff always treating people with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent mental capacity assessments and best interest meetings were not completed for people who may have lacked capacity to make decisions about their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safe guarding concerns were not always identified and reported by the provider and the registered manager.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered manager and provider had not ensured that equipment was suitable for purpose, maintained or cleaned

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Not all staff had the appropriate checks in place to ensure staff were safe to work with people at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels were not always able to meet people's needs.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always identified and managed safely.

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Robust systems and processes were not being operated to assess, monitor, mitigate and improve the quality and safety of the service for people and that record keeping was not consistent.

The enforcement action we took:

Warning notice