Four Seasons (No 11) Limited

Edgeworth House

Inspection report

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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?	Inadequate

Overall summary

We carried out an unannounced comprehensive inspection of this service on 10 November 2014. After that inspection we received information about concerns in relation to the service. As a result we undertook a focused inspection on 23 January 2015 to look into those concerns.

Comprehensive inspection of 10 November 2014.

This inspection was to follow up on our previous one in July 2014, where we had found that the home was in breach of several of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These breaches related to the respecting and involving, care and welfare of people using services, the safeguarding of the people, the safety and suitability of premises, staffing and assessing and monitoring the quality of service provision.

We took enforcement action and issued the home with warning notices. The home had sent us an action plan and updated us regularly, to record improvements.

We visited the home on 10 November 2014. This inspection was unannounced.

Summary of findings

The Home is currently registered to accommodate up to 103 people. At the time of our inspection there were 53 people resident. The home was divided into three main units, called Ground, North and South. These units had been designated as, the 'Ground' floor for younger people with a physical disability, the 'North' side was for people with residential care needs and the 'South' side was for people with dementia and/or nursing needs. However, the home was undergoing some changes to its business model and people in these units now did not completely reflect the previous arrangement and the disability people had.

The home required a registered manager. A registered manager is a person who has registered with the Care Quality Commission (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. At our previous inspection there had been a manager, but they were not registered. They left the post shortly after that inspection. At the time of this inspection, a new manager was in post who had not yet registered with CQC. He was supported by another registered manager, a deputy manager and a regional manager.

We found that the home had made progress and had made improvements. We saw they had met the requirements of the warning notices, but still required improvement in before they could be rated as a good service.

Focused inspection of 23 January 2015.

Following our inspection of 10 November 2014 we undertook a focused inspection to look into concerns about the service. Our concerns were due to a significant safeguarding incident that had occurred within the home and which was subject to a police investigation. We were also contacted by whistle blowers who told us that people were not being offered sufficient fluids and re-positioning and the home was often short of staff. During the visit, we spoke with people, staff and looked at records. We observed the care of people who lived in the home.

We found that people who lived in the home and the staff on duty thought that staffing levels were insufficient.. The rotas showed erratic planning with regards to the number of staff required.

We saw that the records relating to peoples care, including daily records kept in people's rooms, were not completed correctly, if at all. Staff confirmed this with us.

Records were difficult to follow but showed that people were not being repositioned regularly and had insufficient hydration

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

We found the service had made some improvements to its safety. The home had the required safeguarding policies and procedures and the staff were trained and demonstrated their knowledge of those, when we asked.

Some people told us that they did not feel completely safe.

Safeguarding referrals were now appropriately dealt with. Medicine procedures had improved and medicines were generally administered properly and safely. However, we found some errors and omissions.

Staffing levels had improved but were still reliant on bank and agency staff. Staffing needs further improvement and stability.

23 January 2015.

We found the service was not safe.

People who lived in the home and the staff on duty thought that staffing levels were insufficient

Is the service effective?

Requires Improvement

We found the service had made some improvements to its effectiveness.

People told us they were not confident in the staff's ability to communicate their needs.

Most staff received appropriate training, supervision and appraisal. They had knowledge of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and the manager told us that the required applications had been made to the local authority.

People were seen to be asked for their consent and we saw that they were supported to eat and drink according to their preferences and needs.

Is the service caring?

Requires Improvement

We observed that the approach and relationship of staff to people had improved. However, people's right to dignity and privacy was not always respected and their independence was not always encouraged.

The response to call bells had improved but there were still concerns, especially at night

Is the service responsive?

Requires Improvement

The home had made some improvements to its responsiveness. There were still some comments about the lack of activities. One person told us they had told staff that they wanted to be re-assessed as they wanted to live independently and this had taken some time to arrange.

Summary of findings

Care files demonstrated improved care planning.

23 January 2015

We found the service was not responsive.

We found that peoples care and welfare needs were not being met due to staff not having sufficient time to carry out required care and support such as re-positioning.

People's care plans were not reviewed or updated and some had little information about their preferences and choices.

Is the service well-led?

Inadequate

The service had made improvements. The home had a new manager in situ who was keen to work through the actions identified by us. The manager was not yet registered with CQC and was being supported by senior staff within the organisation.

The provider had created an action plan. We were updated with the action plan's progress frequently.

We acknowledged that the home was undergoing a time of transition. However, there were still improvements to be achieved mainly relating to the vision and values of the home and the quality of the service.

23 January 2015.

We found the service was not well led.

The care plans and care records were not being audited appropriately as it had not been recognised that records were out of date and incomplete.

Edgeworth House

Detailed findings

Background to this inspection

This inspection report includes the findings of two inspections of Edgeworth House.

We carried out both inspections under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspections checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The first, a comprehensive inspection of all aspects of the service, was undertaken on 10 November 2014. We found the service had met the actions we had identified from our inspection of 02 July 2014.

The second was made on 23 January 2015 and focused on following up concerns. You can find full information about our findings and the action we have told the provider to take, in the detailed findings sections of this report.

Findings from the comprehensive inspection of 10 November 2014.

The inspection took place on 10 November 2014 and was unannounced.

At our inspection in July 2014, we had found breaches of the regulations of the Health and Social Care Act 2008 and had taken enforcement action and issued warning notices to tell the home to make improvements to respecting, involving and the care and welfare of people using services, their safeguarding, the safety and suitability of premises, staffing and assessing and monitoring the quality of service provision.

Because this comprehensive inspection was as a follow-up to that of July 2014, we had not asked the provider to complete a Provider Information Return (PIR), which 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 viewed the current information we held on our systems. The provider had sent us an action plan after the last inspection and had regularly updated us with progress made. We reviewed notifications made to us by the service. We received information from the Local Authority and from the local Healthwatch.

The inspection team consisted of the lead Adult Social Care (ASC) inspector, a second ASC inspector, an ASC inspection manager, a specialist advisor (SPA) who was a nurse and an expert by experience. An expert by experience (ExE) is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at 10 care records, eight staff files, staff duty rosters covering the last three months and the current month and at other records relating to the care of people and the running of the home.

We spoke with 15 people, eight relatives, two registered nurses, one senior nursing care assistant, the regional manager and the home manager. We spoke with a district nurse and a GP. We observed the practice and environment and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We conducted a SOFI in the dining room where we observed five people during lunch.

Findings from the focused inspection of 23 January 2015.

We undertook an unannounced, focused inspection of Edgeworth House on 23 January 2015. This inspection was carried out in response to safeguarding and whistleblowing

Detailed findings

concerns raised with us after the previous inspection. The team inspected the service against three of the five questions we ask about services: Is the service safe? Is it responsive? and Is it well led?

The inspection was undertaken by an Adult Social Care (ASC) manager, an ASC lead inspector and an additional ASC inspector. We visited the home at 06.00hrs in order to see the night and day staff. We spoke with five people, looked at eight care plan records, four weeks rotas, including the current week and various minutes of residents meetings. We spoke with 10 staff from both the night and the day shift, including the home manager and the providers' regional manager. We observed the handover meeting between the night and the day shift.

Requires Improvement

Is the service safe?

Our findings

Findings from the comprehensive inspection of 10 November 2014.

When asked if they felt safe, one person answered, "So-So", but on investigation it appeared she was still worried by an incident which had occurred two years previously. This had an on-going impact on her attitude to safety in the home. A second person told us, "Yes, I feel safe here" and a relative told us that, "[Name] is safe here". However, another person, when asked if they felt safe, told us, "Reasonably". A fourth said to us, "Tell them [the CQC] that I am alright".

With regard to medication, one person said, "They are very good when painkillers are needed, I need them regularly".

When asked about hygiene and cleanliness, one person told us, "Hygiene is not too good, they hoover around the bedroom each day, but they could do more". Another said, "They do their best", but they could not be specific about anything which needed to be improved. A third person told us, "It's quite good, up to a point, but they've got lots to do". About the kitchen and dining area, one person told us, "The hygiene in the home is good. There were kitchen issues but they seem to have been resolved". Another said, "The cleanliness in the kitchen, the cutlery and crockery has not improved, it's up and down".

One person told us, about security and safety, "There are security lights all around the building and they check that all the doors are locked at night".

At our inspection in July 2014, we had found that there were breaches of Regulation 11, safeguarding people who use services from abuse and Regulation 15, safety and suitability of premises. We issued a compliance action and a warning notice and told the provider to make improvements to ensure that suitable arrangements were in place to safeguard people against the risk of abuse, and to ensure that there were safe and suitable arrangements in place for the operation of the premises. At this inspection, we found that safeguarding arrangements and the safety of the premises had improved but that there were still areas which needed further work.

The home had the required policies regarding safeguarding and whistleblowing. There had been safeguarding notifications made to the local authority and CQC had been informed as required. We saw that safeguarding notifications were replicated in the person's file. Safeguarding training was being maintained with the staff and notices were displayed around the home with information of what to do in the event of an incident.

Medicines were better dealt with and administered. It was noted that the medicine rounds were conducted separately on each unit of the house by a lead nurse for two of the nursing units and by a senior nursing assistant for the residential unit. Two of the house's three medicine storage rooms and trolleys were examined and one medicine round was observed

A registered nurse (RGN) confirmed that medicine administration training was undertaken by 'e-learning' and that staff from the pharmacy which dispensed the homes medication gave the homes' staff a one and a half hour training session, on site, each year. We saw some evidence to confirm this through the training matrix and other records. However, some of the records were not consistent so it was difficult to establish whether all the appropriate staff had had the required medication training. This meant that staff may not receive the correct medication training which meant they may not manage medicines safely.

The RGN confirmed that no 'covert' medication was currently being administered. In the past she explained that a service user did have this in place after a multi-disciplinary team meeting which included health care professionals and the family. She confirmed that she had sought advice from the pharmacy to ensure appropriate administration. This showed that staff knew the correct procedures for the administration of covert medication. The RGN described the procedure for drug administration errors which, we saw, followed the homes' medication policy.

The medication administration records (MAR) sheets we examined were clear and they had patient's photographs on the front covers which were taken annually. The medicine room and the medication trolley were securely locked, however the main office containing the locked medicine room was not secure as we saw care assistants locating the key to the room from 'a secret place'. Our observation confirmed this place was very visible to anyone and not a 'secret place' for the key to be stored, which meant that the room was not secure.

We spoke with the manager about how risks to people's safety and well-being were managed. He was able to tell us

Requires Improvement

Is the service safe?

how they put plans in place when a risk was identified. We saw that comprehensive risk assessments relating to nutrition, pressure areas, moving and handling, and falls, were recorded in people's care plans and that these had been recently reviewed.

Staff records showed that safe recruitment policies were followed. Staff files for people who had worked at the home for a number of years were very cumbersome and it was difficult to find important information. Recruitment to vacancies was actively taking place with up to ten recruits at varying stages of the recruitment process.

Staff rotas showed a total of 14 staff who should be on duty in a morning, including two registered nurses. In the afternoon/evening, there were a total of 12 staff including two registered nurses. At night, there should be two nurses and four care staff. These numbers were maintained with the use of agency staff mainly from two agencies and often the same members of staff. Agency staff were used every day, usually two or three staff per shift, but on 14 November 2014, there were five agency staff booked. Carer profiles and induction records were in place for some agency staff. This meant that the backgrounds, competency and training of some agency staff were not known to the home.

A senior member of staff on South unit said "There has been a big improvement. We can manage fine with four staff, two upstairs and two downstairs. That is enough for the 16 residents we have. Some are quite independent". This staff member was authorised to phone for agency staff to cover any shortfalls. They said "I am very happy with the way things are at present".

We saw that some areas of the building were poorly lit and that there were some 'cold spots' where the temperature was much less than other areas and some of the small windows on the staircases would not close. The home had only one large dining room which meant that a lot of time and effort was spent bringing people from the first and second floors to have their meals. It may also mean that some people chose to stay in their bedroom for meals. There was a smoking lounge, however this was on the second floor of the nursing unit at the furthest end of the building. This meant that people accommodated in other parts of the home went outside to smoke where there was limited protection from the weather.

There were areas of the home which had stained or missing ceiling tiles which indicated that there had been or were some leakages and also meant that it allowed dust and other contaminants, from the roof and joist spaces, into the environment which people were living in, for example, one lounge on South unit had a hole in the ceiling.

Equipment such as hoists and fire equipment was generally kept tidy and that it had been regularly serviced, however we brought to the manager's attention a wheelchair which had been left whilst it was being charged, partially obstructing the corridor with a trailing wire to the electric socket. This was a trip hazard.

The kitchen was clean, tidy and well ordered. It smelled fresh and all the equipment was clean and grease and residue free. Bins were tidy and had been washed and the floors were clean and uncluttered. The fridges, freezers and storage rooms were clean and had had regular temperature checks.

We saw that there were a number of cleaning staff on duty, the general areas seemed clean and tidy, beds were made up and that there were no nasty odours.

On entering the building, we noticed that under a small table in the reception area on which there was a drinks dispenser, there was a small puddle and that there was an electric extension socket on the floor by it. This showed that there was an unsafe practice which had occurred which should have been noticed and resolved by staff. We brought this to the managers' attention and he immediately arranged for the puddle to be cleaned and the extension socket removed.

Findings from the focused inspection of 23 January 2015.

One person told us, "There are definitely not enough staff. I ring my bell and sometimes I have to wait an hour. They are always short staffed and they have agency staff who I don't know. Things are not good at the moment. There are not enough staff on days or nights". Another said, "The staff are really good but not enough of them. I am always telling them. I can be kept in bed on a bad day when staff low and have to wait to get up. I go to the residents meetings and put it [staffing levels] on the agenda every time. They just scribble on a piece of paper". A third person sought us out

Is the service safe?

to tell us, "Staff are wonderful, never enough though. I can be left in bed to wait because there are more people in greater need than me. They have been short staffed since [current provider] took over, I am always telling them".

A whistle-blower told us, by phone after our inspection, that the situation we found on the day of the inspection regarding the staff numbers was not unusual; they told us it had been only three or four care staff plus the two registered nurses (RGN) on at night, for about a month, contrary to what the rotas said. Another staff member told us that the rotas were falsified.

A third staff member said to us, "Some days we are short. Three people can't do the work of four". Another staff member told us about staffing, "To be honest, it's not enough. It's because they are very demanding. [Name] wants the toilet every 30 minutes and they don't need it".

One staff member told us, "We are short staffed and I have to do repositioning and personal care in the person's bed, on my own". My back hurts and it's not safe".

On the day of our inspection, we visited at 6am and observed the staff working the night shift. Staff told us that they did not have time to complete all the care they should do.

We saw a printed memo in areas staff used which stated 'No overtime for four weeks for any staff member going off sick'. Staff told us that this was not conducive to encouraging or allowing staff to work additional time when needed.

There were 47 people in the home at the time of our visit. We found that there were two registered nurses and three care staff on duty. The staff told us that one carer who had been due to work, had called in sick. The manager had been told but had been unable to provide a replacement.

We looked at the rotas and saw that staffing levels were very erratic. We saw different numbers of staff and skill mixes on shifts and the staff did not understand why this was the case.

The regional manager showed us the provider's dependency tool which calculated a recommended ratio of staff to people. The dependency tool showed that the home was staffed over the tool's recommended levels. This tool showed that five staff were sufficient for the night shift. However, we found that this was not reflected in people's experiences.

This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because the provider had not taken the appropriate steps to ensure that there were numbers of suitably

Requires Improvement

Is the service effective?

Our findings

One person told us, “There had been a lot of agency staff, but there has not been a big influx recently”, but another said, “There’s lots of agency staff. They send in young girls who don’t know what they’re doing”. Another person told us about the staff, “I’ve got no complaints, the staff are excellent, they tell me exactly what they’re doing and why”. However, a fourth person told us, “When the staff don’t know you, it’s really hard and difficult”. A fifth resident told us, “There’s a lack of communication between the day and night staff, you tell the day staff something, but they don’t pass it on to the night staff. If I need or want a shower, I just have to wait until they‘re ready to give me one, which might be the next day”.

With regard to the food, one person told us, “The food here is lovely. Before coming here I was used to good meals. I’ve put on weight here”. Another said, “The food is excellent, you have three choices and if you don’t like anything they’ll get you something else". A third informed us that, “The food has vastly improved since the new chef came two months ago. It‘s too good, I‘ve put on weight!” Another person told us, “It’s improved since the last CQC visit in July. The new chef is much better. There’s more choice and you can say if you don’t like it and have something else”. However, one person complained, “You get mince and mash too often. They might call it Shepherd’s Pie, or Cottage Pie, but it’s still mince and mash!” Another person told us, “The food’s c**p! It’s just cheap rate food, there’s no choice!”

We asked people about staff and their training. One person told us, “I think the staff are sufficiently trained. I used to assess staff (when I was working) so I know what I am doing and the majority of them are good”. Another person said, “They’re doing a good job”.

At our inspection in July 2014, we had found that there was a breach of Regulation 22. The provider had not taken appropriate steps to ensure that at all times, there were sufficient numbers of suitably, qualified, skilled and experienced persons on duty to meet people's needs. We took enforcement action and issued a warning notice. At this inspection in we found that the warning notice had been met but that the service still required improvement.

We viewed supervision records but these were not consistent. One member of staff said that they had a supervision meeting last week and had “had a couple over the last 12 months”.

We found that that staff were sufficiently well trained. We saw the homes’ training matrix which identified that staff were ‘booked’ in to complete various training courses throughout the following months. It also identified which staff had already received training that year, although this was sometimes not reflected in the staff training records.

Staff themselves told us that training had improved. We saw a member of staff completing e-learning at a computer terminal outside the manager’s office and another staff member confirmed she had completed her medication training via the pharmacy training session and had also completed e-learning.

People had been provided with long length call bells in order that they were accessible at all times within their rooms and they confirmed that this was the case. However there were still some concerns that in some situations, bells were not being answered in a timely manner. This meant that people were not at times, able to communicate with staff in a timely manner.

At lunch, we observed that the food looked and smelled appetising and people seemed to be enjoying it. We sampled two of the dishes and found them to be hot and palatable.

We toured the kitchen and dining room after lunch. We saw there were no signs of spillages, soiled or dirty areas. The kitchen was tidy and well-ordered as was the storage room, fridges and freezers. We were told that temperature checks on food and the various storage facilities were done daily and saw records which confirmed this. We spoke with the chef and her assistant who told us they were very proud of the work they had done and the standard they had achieved. Staff told us they were waiting for a new dishwasher which we were later told by the manager, had been installed about three weeks after our inspection. The kitchen had recently been awarded a five star rating by the local council.

CQC has a duty to monitor the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). At

Requires Improvement

Is the service effective?

Edgeworth House, we saw that proper policies and procedures were in place relating to this. Most staff told us and we saw from the records that they had been trained in the MCA and DoLS. Others were booked to attend training.

We saw that applications had been made for DoLS to the local authority (the 'Supervisory Body') and some had been processed and returned. We saw that one person had been deemed to have the capacity to make certain decisions. We noted that where people whose mental capacity was in doubt, their wishes had been considered in a best interest meeting and action taken appropriately.

We also saw that there was a DoLS audit form to track and record which of the people in the home had a DoLS in place.

We had identified in July that there had been access issues to and from the home for some people and had been told that this would be addressed. However, on this visit we found the door entry system was still the same. We were told that this was because the incorrect door system had been delivered. The home was waiting for new doors to be installed which would have a key fob system for ease of access. We did see evidence that purchase orders had been processed for this. The delay needs to be addressed as soon as possible.

A wide doorway had been created in the reception area which gave access to the garden and a smoking area. However, there were still some general decorating and repair works to be completed.

Requires Improvement

Is the service caring?

Our findings

One person told us, “The staff are kindness itself, I’m treated with the greatest of respect. I can be private if I want to be and the staff always knock before they come into my room.” Another said, “They’re such a happy staff. I get on better with the staff than the other residents! They‘ve time to chat with me”. A third told us, “They spend time with me and treat me as an individual”. However, another person told us, “They’re not really respectful, I’ve had young men who want to give me showers. When I’ve told them that I’d prefer a female helper, they seemed put out”.

Regarding call bells, one person told us, “They answer the call bell quickly, unless there‘s an emergency somewhere and then they explain why”. Another said, “Some mornings, I need a bit of help getting up, I press the emergency button and they come quickly, they’re very good”. A third said, “It’s improved since you (CQC) last came”. However, a third said, “Some people abuse the buzzer and keep pressing it, so then you don’t get help when you need it”. Another person said, “I buzzed for an hour once, before somebody came. Usually it’s 20 minutes. If I need the hoist, but somebody else is using it, then they tell me that I just have to wait, which could be a couple of hours”. A further person said, “Some people abuse the buzzer and keep pressing it, so then you don’t get help when you need it”. One person told us that they did not receive any care, “It’s just a roof over my head”.

When we spoke with people they gave us mixed views about the way they were treated, about the staff approach and about the dignity and respect shown to them. This meant that people’s well-being was being compromised because the staff did not have the correct approach and understanding to meet people’s needs.

At our inspection in July 2014, we had found that there were breaches of Regulation 9, care and welfare of people who use services. The provider had not taken proper steps to ensure that people were protected against the risks of receiving unsafe or inappropriate care as the planning and delivery of care did not meet people's individual needs or ensure their welfare and safety. We took enforcement action and issued a warning notice. At this inspection, we found that the warning notice had been met but that the service still required improvement.

We timed the response time to call bells and these were acceptable, although some people continued to tell us that they were not, particularly at night. One person told us that it was because people pressed them continuously and for trivial reasons, that staff had adopted the approach of delaying their response to the bell. This meant that people may not be responded to when there was a genuine need.

We were told that residents who were able to go out had been given the key code to the key pad at the door, however, the pad itself was still situated at a height which wheelchair users could not access. This meant that these people were unable to go in and out of the building independently.

Requires Improvement

Is the service responsive?

Our findings

Findings from the comprehensive inspection of 10 November 2014.

We found mixed views about peoples' experiences of choice. One told us, "I'm a fussy eater, if I don't like what's on offer the chef can do me a special, like a bacon butty", but another said, You can't have a bath when you want one. 'Bath' is a swear word. They bought a fancy bath but you don't get a chance to sit in it. I'm here for my comfort, not for a quick in and out shower".

Regarding peoples requests and complaints, one person told us, "We need at least one other hoist. I've complained through the Residents' Committee but it seems to go in one ear and out of the other. You don't get any feedback.

When asked about the activities provided, one person told us, "Bingo, crosswords and quizzes and they are not very stimulating" and continued, "We watch TV in our room because there's nothing to do. My wife takes me home once or twice a week to break up the time".

We found mixed views about peoples' experiences of choice. Some people told us they could choose what to eat, but others told us they were not able to have a bath when they wanted. Another told us that they did not like having breakfast in bed.

At our inspection in July 2014, we had found that there were breaches of Regulation 17. The provider did not provide appropriate opportunities, encouragement and support to people to promote their independence and community involvement. We had taken enforcement action and issued warning notices about these breaches. At this inspection, we found that the warning notices had been met but that the service still required improvement.

We viewed care files and saw that improvements had been made to recording and content. Files had been recently reviewed including risk assessments and updated where necessary. Some files, however, did not have photographs on the front covers and some photos inside the files had not been updated as the provider required, every six months. This meant that new agency staff might find it difficult to readily identify the people they were supporting. The files did show evidence that the involvement of people and their relatives had improved, in the design of peoples care plan. Consent had been obtained and the current daily notes which were kept in people's rooms, were mostly completed correctly.

We had found there had been limited activities when we inspected in July. The situation had improved slightly but there was still room for improvement. We spoke with the activities organiser had been employed at the home for five years and worked 42 hours per week over six days, with a further 10 hours provided by another member of staff. They showed us a weekly plan which was in place with detailed, illustrated records of what had taken place and what was planned.

The activities organiser told us that mornings were spent on planning, record keeping and one to one visits. The activities organiser attended the daily management meeting and in this way found out about anyone new to the home. He then made a point of visiting them and finding out their interests.

A group activity was provided in the afternoons. The activities included crosswords, bingo, quiz and visits from community groups. Two church groups were involved with the home. One held a service twice a month. There were also good links with two local schools and with Tranmere Rovers football club. All of these provided activities with people coming into the home. There was also a link with a local pub where people went for meals out.

The home had a small film theatre. A film was advertised as being shown on Friday. The activities organiser arranged the residents committee which currently consisted of six people, but told us others were welcome. This met at least once a month, with a full residents meeting also once a month. They also arranged a quarterly relatives meeting.

The home used to have a minibus and had regular trips out, but this was sold when the home changed ownership. Transport has to be booked and paid for now so there were fewer outings than previously.

However, people's perception of what was available was mixed. We did not see any activities on the day of our visit and people told us that there was little of interest to them. This meant that some people remained under stimulated according to their needs and wishes. People needed further and more varied opportunities, support and encouragement to promote their independence and community involvement.

Requires Improvement

Is the service responsive?

The home had a complaints policy. We saw that there had been no formal complaints in the last year. However, one person, when asked if they knew how to complain, told us, "I don't know how or who to complain to, and it wouldn't make any difference anyway. I had a kettle in my room and they removed it with no explanation. Explanations do not exist in this place".

On the day of our inspection we were made aware of a complaint that had not been responded to appropriately. We spoke with the complainants and later to the manager who agreed to investigate this. The manager has since notified CQC about the complaint and has taken appropriate action.

Findings from the focused inspection of 23 January 2015.

One person asked us for a cup of tea. They told us they were thirsty. We checked their fluid charts. These were difficult to follow as they were erratically completed but indicated that they had had insufficient hydration.

We found concerns with care and welfare, mainly related to the inability of staff to respond to peoples care needs through lack of time. An example was that it was difficult to get accurate figures of peoples' fluid intake because of erratic recording. This meant that it was difficult to assess their hydration needs.

We saw that people were not repositioned as the care plans advised. One care record had a moving and handling risk assessment which stated that it was completed on two dates spanning a year apart, so it was unclear how old the assessment was. The assessment stated that the person should be repositioned every two hours. A mobility assessment stated that they were checked hourly in bed, however, the skin integrity/tissue viability care plan stated that the person's position should be checked four hourly. This conflicted with the moving and handling risk assessment.

We saw a skin integrity/tissue viability care plan that was completed in July 2012 and was only reviewed once in November 2014. The two scores did not correspond. There was no explanation of why this might have happened or what could be done about it. The scores were very high risk scores and the care plan stated it should have been reviewed monthly to check for changes in the person's condition. We found no record that this had been done. This meant that the person's skin integrity and tissue viability was not monitored appropriately.

Another care plan showed the most up to date assessment for the person was May 2013. The persons file had very little other information. There was no social information or personal preferences recorded but it was recorded that they had capacity to make decisions and choices. This meant that the persons' care and welfare could be compromised through lack of information.

We listened to a staff handover. One staff member told the new shift that one person did not have a buzzer as it had broken. She could not find a replacement and thought the maintenance person had a supply. This meant that the person had been without a buzzer to call for help if needed, throughout the previous night.

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

Inadequate

Is the service well-led?

Our findings

Findings from the comprehensive inspection of 10 November 2014.

One person told us that they had regular residents meetings with the manager, once a month. They went on to say, "The new manager is very approachable. He has a lot of straightening out to do". Another said, "We've got to give him a chance to improve things. He is saying all the right things to us". A third person said, "Since the manager has been here, things have been ticking over well. Let's see if it's kept up" and a fourth person told us, "The manager seems to have got control of the place. We see him most mornings and he seems to listen to us". A fifth person said, "I've been wanting to move rooms for a long time as I was on the first floor. Now that I'm on the ground floor I'm much more independent as I don't have to wait for the lift. The manager seems OK, he wants to involve you."

At our inspection in July 2014, we had found that there were breaches of Regulation 10, assessing and monitoring the quality of service provision. The provider did not have an effective system in place to regularly assess and monitor the quality of the service or to identify, assess and manage the risks to people's health, safety and welfare. We took enforcement action and issued a warning notice. At this inspection, we found that the warning notice had been met but that the service still required improvement.

The service required that there should be a registered manager in post. Shortly after our visit in July 2014, the manager left the home. A new manager was now in post although was not registered with CQC at the time of our visit. The regional manager was supporting him in the new role.

The manager told us that he walked around the home each day to check security, the environment and the people. One person told us that they had regular residents meetings with the manager, once a month.

We viewed the records which showed that audits had been completed in relation to all areas of the home, the staff and the people living there and their care. There were regular quality audits completed by the regional manager, with actions identified and who and by when, the actions were to be completed.

The home had produced an action plan in response to the issues we raised at our last inspection and had provided additional management support to help implement it. The provider had regularly updated the plan as things had been accomplished. The manager told us, "It's a work in progress, we are getting there". This meant that not all the actions had been fully completed by the provider.

We acknowledged that the home was undergoing a time of transition. There were still improvements to be achieved mainly relating to the vision and values of the home and the quality of the service.

We recommended that the new manager registers with CQC as a matter of priority.

Findings from the focused inspection of 23 January 2015.

We saw that the daily care records were left outside people's rooms at night, for staff to fill in. During the day they were kept inside the room. One staff member told us this was done for ease. The daily records contained observation, re-positioning, fluid and food charts.

One person's position chart for the previous night showed that the position changes were recorded as; 24.27hrs, 02.25hrs, 04.23hrs, 06.22hrs. On their request we showed the records to the person. They said that they were untrue. They told us they were not repositioned at these times and never were. They told us "I laugh with the day staff at the times the night staff record. They are not true."

Staff told us they completed records retrospectively and that some were not accurate or true.

We saw a staff member completed records and re-sited them in peoples' rooms. We went to one room where this had happened. We viewed the records which were up to date with entries made throughout the early hours of the morning. We asked the worker when they had written these entries and they told us that they had just done so. We clarified with the staff member that they had retrospectively completed these entries and they told us that they had. They also told us that most of the records were completed in a similar way.

We viewed other care records, with the daily records held in each person's room. We found major errors in these records. Records were clearly not made at the time of giving the care and we found several which were completed retrospectively. One person had to have

observations every hour. On one day, there were no observations recorded for eight hours. One of the inspectors looked at one record at 06.25hrs, which showed that an observation had had been recorded as being carried out at 06.35hrs.

We found that fluid and food charts were inconsistently filled in. They recorded that people were receiving below the usual recommended fluid amounts per day. There were mistakes in the running totals which gave untrue final totals. This meant that people were at risk from insufficient hydration.

We saw that position changes were recorded in one file as being required to be done hourly but being completed as done at 01.00hrs and at 06.40hrs. Another showed that the two hourly repositioning for one person was not being done consistently. We shared some of our findings with the regional manager. They agreed that the records were incomplete and had been completed retrospectively which identified that people were at risk from not receiving the appropriate care.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because the provider had not ensured that people were at risk of receiving poor or inappropriate care due to a lack of proper information recorded about their care.

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	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Service users were not protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of the carrying out of an assessment of the needs of the service user; and the planning and delivery of care and, where appropriate, treatment in such a way as to meet the service user's individual needs and ensure the welfare and safety of the service user. Regulation 9 (1) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010. Staffing. There was not always sufficient numbers of staff employed to safeguard the health, safety and welfare of service users. Regulation 22

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 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Service users were not protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in relation to the care and treatment provided. Regulation 20 (1) (a)

The enforcement action we took:

We have served a Warning Notice