Redwalls Care Services Limited

Redwalls Nursing Home

Inspection report

80 Weaverham Road
Sandiway
Northwich
Cheshire
CW8 2ND
Tel:01606 889339
Website: www.redwalls.org

Date of inspection visit: 14 October 2015
Date of publication: 09/12/2015

Ratings

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

Overall summary

This inspection took place on the 14 October 2015 and was unannounced.

Redwalls Nursing Home was last inspected on 9 September 2013 and we found that the service met the regulations we inspected against.

Redwalls Nursing Home is registered to provide personal and nursing care for up to 44 older people. The home has 41 single and two double rooms the majority of which have en-suite facilities. At the time of our inspection the home had full occupancy. Four rooms were used by the clinical commissioning group to provide rehabilitation to minimise a person's length of stay in hospital or to avoid it in the first place.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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 this inspection we found that whilst there were some elements of good care and practice, there were a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

People told us that they felt safe and secure at the service and that they had a good relationship with the staff that provided their support. There were some positive interactions between staff and the people they supported. At times, staff treated people with respect but we also saw examples of poor practice where people's dignity was undermined.

On the day of the inspection, there were enough staff available to meet the needs of those people who used the service and call bells were responded to in a timely manner.

People were offered basic choices in relation to their care and what they wanted to do throughout the day. However, staff did not know the basic principles of the Mental Capacity Act 2005, and would not feel confident making a judgement around a person's mental capacity. The majority of staff lacked a basic knowledge of the Deprivation of Liberty Safeguards and where they may be required. Staff had not been supported to undertake training in these areas. This meant that people were at risk of having their human rights infringed and care and treatment may not always be provided with the consent of the relevant person.

People needed medicines to keep them well and we saw that the registered provider had processes in place to ensure that medicines were ordered and stored safety. However we had concerns about the use of "Thick and Easy" as staff were not aware of the prescribers' instructions and it was not stored safely. This could place people at risk of choking. There were also inadequate measures in place to ensure that a consistent approach was taken with people who had "as required medicines."

Not all people who used the service were fully protected from harm. Accidents and Incidents were recorded but there was no detailed analysis of these undertaken. Risk assessments were not always in place, or implemented following an incident which prevented effective learning and further minimisation of risks. Care plans were not consistently updated where there had been a change of need and information around the risk of harm was not always clearly available to staff. This could have impacted upon the ability of staff to respond appropriately.

People's health and safety was put at risk because parts of the environment were unsecure, unclean and appropriate infection control measures had not been implemented. The Cheshire & Wirral Partnership NHS Foundation Trust made a number of recommendations following an infection control audit in March 2015 but the registered provider had not implemented an action plan or made any changes following this.

We found that recruitment processes were not robust. Adequate measures were not in place to ensure that people were only supported by people of suitable character and skill. Staff received an induction but this required review in order to meet the recommendations of the Care Certificate. Staff received some training relevant to their role but this was not always kept up to date.

Staff said that they worked in a supportive environment and that they had a good relationship with management; however they had not received supervision or appraisals in line with best practice. We recommended that the registered provider review their supervision and appraisal policy in light of current best practice.

The registered provider told us that they had tried to seek the opinion of people who used the service and their relatives but so far this been unsuccessful. We made a recommendation that they explore alternative ways of seeking opinions. People who used the service and their relatives felt that they could go to the registered manager with any concerns, but not all felt confident that these would be addressed to their satisfaction.

The registered provider has statutory obligation to inform the CQC about a range of occurrences that may affect the health, safety and welfare of people who use the service. This is so that CQC can take follow-up action to safeguard the interests of people if required. The registered provider had failed to report all such events. CQC was, therefore, not able to monitor the events that affect the health, safety and welfare of people who used the service.

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

The service was not always safe.

Some medication was not appropriately stored, and information was not available to staff to ensure safe administration.

Accidents and incidents were recorded however there was no detailed analysis to ensure learning from incidents. Risk assessments were not always in place to help with effective risk management.

Some areas of the service were not safe, clean or hygienic and action had not been taken to remedy concerns with infection control.

Is the service effective?

Requires improvement

The service was not always effective.

Most people enjoyed their food and were supported to eat and drink.

Staff had not had training in the Mental Capacity Act 2005 and did not know how to assess mental capacity, or identify where Deprivation of Liberty Safeguards may be required.

Supervision was not given regularly and staff did not receive appraisal.

Is the service caring?

Requires improvement

The service was not always caring.

People told us that at times they had to wait a while before being supported by care staff.

People told us that items regularity went missing in the laundry and they had other people's clothes.

People were able to personalise their rooms, and enjoyed spending time in the gardens.

Is the service responsive?

Requires improvement

The service was not always responsive.

Records relating to care and support were not always up-to-date and did not always reflect the current needs of people using the service.

People enjoyed the activities provided and were encouraged to engage.

People told us that they knew how to make a complaint but not all felt that management would be responsive and supportive.

Is the service well-led?

Requires improvement

The service was not always well-led.

Summary of findings

The registered provider failed to inform CQC when Deprivation of Liberty Safeguards were in place, or when incidents had occurred.

Audits were carried out by the registered manager; however these were not robust or effective.

Staff said that they could discuss concerns with the registered manager but that meetings were not held on a regular basis.

Redwalls 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 took place on 14 October 2015 and was unannounced. The inspection was carried out by two adult social care inspectors.

During our visit to the service we spoke to nine people who used the service, four family members, five staff and the registered manager. We toured the inside of the premises. We looked at the care records for seven people. We examined staff records and records relating to the management of the service including policies and procedures. This included three staff recruitment files, audits and safety checks.

Before the inspection we reviewed information we held about the service and this included complaints, safeguarding investigations and statutory notifications. We also contacted the local authority and infection control team for further information and opinion on the service. The local authority informed us that there had been contact with the home following safeguarding matters and were concerned that the registered provider had not engaged with any offers of assistance from the workforce development team. The Infection Control team informed us that they had issued an action plan in March 2015 following an audit but had not yet reviewed the progress made. Following the inspection we again spoke with the local authority and infection control for clarification on their engagement with the service.

We checked to see if a Healthwatch visit had taken place. Healthwatch is an independent consumer champion created to gather and represent the views of the public. They have powers to enter registered services and comment on the quality of care provided. No visit had yet been undertaken by Healthwatch but they informed us that they had received positive feedback on the care provided.

Requires improvement

Is the service safe?

Our findings

People said that they felt "Secure" and "Comfortable" living at the service.

Staff demonstrated an understanding of the types of abuse that could occur within a care setting. They were aware of steps to take if they suspected or witnessed any abuse and were confident that the management team would action any concerns. They were able to identify poor practice and which agencies could be contacted in order to keep people safe from harm.

There was a protocol in place for the ordering, storage, administration and disposal of medicines. We sampled the medication administration records (MARS) of eight people and found them to reflect the medication given. These included controlled drugs. This medication was also stored securely in a locked storage facility or the refrigerator.

However, we found some concerns relating to the management of medication. One person told us that " Staff do not realise that I don't need my tablets all the time" and "Staff try to get me to take them when I don't feel that I need them". Some medicines people were prescribed, needed to be taken only 'when required' (PRN) such as pain killers or sedatives. There was insufficient information available to guide staff as to when and how these medicines should be given which could result in people not receiving their medicines as required.

Staff did not recognise that "thick and easy" was a prescribed agent and had to be used safely and correctly. None of the tubs had dispensing labels that gave clear direction as to what amount was required in fluid and neither was it recorded in any of the care plans that we looked at. The amount of thickener required by each person would vary dependent on how much fluid they drunk and what consistency was required. In February 2015, NHS England issued a Stage One: Warning Risk of death from asphyxiation by accidental ingestion of fluid/ food thickening powder. This warning notice was clearly displayed on the notice board at the service but the registered manager had not taken any action in relation to it. Tubs were found on bedside tables, communal areas and in the hallway. Whilst it is important that products remain accessible, all relevant staff need to be aware of potential risks to safety. This meant that people were at risk of harm because people may not be getting their fluids at the right consistency and there was a risk they could choke. We brought this to the attention of the registered manager and asked that they take swift remedial action.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations because registered provider had failed to ensure the proper and safe management of medicines.

The registered manager provider shared with us an infection control audit that had been carried out by the infection, prevention and control team (ICT) from the Cheshire and Wirral Partnership NHS Foundation Trust on 20 March 2015. Failings with the service had been highlighted and a set of action requirements sent to the registered provider. We saw that no action had been taken. Some areas of the home were not visibly, for example in one of the bathrooms the air vents were dirty, dusty and the grab rail was rusty. Other areas required remedial repair such as the replacement of sealant around baths and sinks. Whilst the registered provider had made some improvements such as replacing the carpets, some fixtures and equipment such as chairs and commodes required replacement as they were worn or could not be properly cleaned. Not all liquid soaps were wall mounted or free from perfume and colourant. In two communal bathrooms bars of soap were available for use. Both sluice rooms were unlocked for the whole duration of the inspection which meant that people who used the service could enter them easily and this could place them at risk from electrical or biological hazards. They required a deep clean and contained dirty mops that were left standing head down in dirty stagnant water. One of the sluice rooms contained a box of sharps (used needles) that was not labelled with the date or locality and it was not, as per recommendation, stored at eye level. It was not in a secure room, it was not sealed and neither was the aperture closed. This could also pose a significant risk to someone's health and safety if they were to access or tamper with it. This had also been noted in March 2015 by the ICT. Incontinence pads were stored in the sluice and other communal areas in unsealed packets. Personal protective equipment (PPE) available for staff to use but we observed that staff came out of bedrooms still wearing aprons and gloves whilst looking for additional staff to support.

Requires improvement

Is the service safe?

There were two double rooms on the premises and at the time of the inspection one of those had double occupancy. There was no risk assessment or business continuity plan in place should one of the people in the room have an infectious or contagious condition and require isolation. We discussed this with the infection prevention and control team following our inspection and they confirmed our concerns as there are no "spare rooms" and sanitary facilities were shared. The Department of Health and Health Protection Agency guidance 2013 "Prevention and control of infection in care homes - an information resource" states that " Isolation of residents with an infection may be necessary to prevent further cases of infection. Ideally single rooms should be available for this purpose and registered managers of homes will need to consider how best to achieve this". "Residents who are vomiting should be kept in a single room, as long as symptoms persist".

This was a breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities 2014) Regulations because the registered provider had failed to assess the risk of and prevention of infection, including those that are health related.

Personal evacuation plans had been devised for each person indicating how they could safely be evacuated from the building. However, there were no robust risk assessments in place in respect of other aspects of care: such as how staff should safely assist with mobility, susceptibility to falls or weight fluctuation. Risk assessments had not been reviewed and updated where there had been a change in risk. For example: a person had been able to leave the premises without the knowledge of staff when it had been deemed unsafe for them to do so and a deprivation of liberty safeguards (DoLS) was in place. There was no review of their risk assessment following these events and their care plan for Safe Environment had last been reviewed on 14 February 2014. There was no risk management plan to outline what was required to minimise the risk of this happening again and to keep them safe. We found a number of "concerns" recorded on a post-it note at the front of the care plan of one person who used the service. These included concerns around not taking medication as prescribed, personal care and issues around incontinence that were linked to a physical health condition, amongst others. Not all of these concerns had been formally included in the care plan or been appropriately risk assessed which meant it would not have been clear to staff how this person's needs should be managed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities 2014) Regulations because the registered provider had failed to assess the risks to the health and safety of service users and done all that was practicably possible to mitigate those risks.

There was a process in place for staff to record accidents and incidents. These included such things as slips, trips, falls, skin tears and medication errors. Accident books were completed and the registered manager then collated this information on a monthly basis. However, they did not analyse these occurrences in detail in order to identify themes and trends, to learn from them or take steps to minimise the risk of further harm. This meant that the registered provider would not be aware if adjustments were needed to the premises, equipment or staff practices as the result of similar occurrences.

People we spoke to had varying opinions on the staffing levels. Comments included "When there is an emergency, there is not enough staff" and "They don't always come within five minutes when you ring the bell, I often have to wait". Other people stated that staff were responsive "I have a buzzer around my neck and staff come when I press it". There were sufficient staff on duty during our visit to meet the needs of people, call bells were responded to and we did not observe anyone that had to wait for care. A registered nurse was on duty with support from care assistants. Staff told us that there was enough staff on duty although there were times when they were under pressure given an increase in the dependency of any individual."

We looked at the recruitment files of three staff. Disclosure and Barring service (DBS) checks form a vital part of the recruitment process, enabling employers to assess if an applicant is of suitable character for a particular role. Records indicated that a staff member had commenced employment on 14 May 2015 but their full DBS check was not received by the service until the 29 May 2015. An adult first check had been received and the registered manager said they were aware that staff needed to work under supervision until full DBS had come through. Decisions to appoint before receiving the certificate should be made

Requires improvement

Is the service safe?

only after a risk-based assessment, and safeguards should be put in place to manage that person. There was no evidence that this had taken place and the rota indicated they had been on shift. Concerns about this practice had first been brought to the attention of the same registered manager at the inspection in January 2013. The second staff member had a DBS check from a previous employer. People taking up a new position who are currently working in services regulated by CQC can satisfy the expectation that they will have an appropriate DBS check if they can provide evidence of a check, at the right level for their role, that is less than three months old at the point of application. This check was outside of that timescale. Another staff member did not have any reference taken from their last employer. This meant that there was not satisfactory evidence of conduct in a previous employment.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations because the registered provider had failed to have adequate that processes were in place to ensure that that only "fit and proper" staff were employed.

The registered provider had processes in place to ensure that the required checks were undertaken in respect of gas, electricity and water services. There were also checks evident for equipment such as hoists, lifts and fire. Staff were aware of what to do in the case of an emergency and the registered manager ensured that we were aware of the fire evacuation procedure upon our entry to the building.

Requires improvement

Is the service effective?

Our findings

Over lunch, comments about the quality of food were not consistent. Positive feedback included "Its good food" and "I am never hungry" whilst others felt that "Food has gone downhill" and "It's not always warm". Ten people sat at the tables for lunch with many people preferring to have their meals in their bedrooms. The dining room had sufficient seating to cater for those who wished to use this facility. A menu was on display and people told us that they had to pick their main meal the night before. One person said, "I can never remember what I have ordered so just wait to see what they give me on the day".

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005(MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA 2005 is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. DoLS is part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

Staff had not received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and as such did not have an understanding of the basic principles and had not always put this into practice. Not all of the people who used the service were able to make complex decisions for themselves and their mental capacity had not been taken into consideration when planning their care. Staff were unable to tell us how they would assess mental capacity in their day to day work or to understand that sometimes they were making a decision in a person's "best interests". The registered manager told us "We do not assess capacity that is for the mental health team to do". Some people at the service were subject to a DoLS but staff were not aware of what this meant and its implications for a person's care. The registered provider had failed to inform the CQC of these authorisations.

We were given conflicting information which demonstrated a lack of knowledge around a person's mental capacity. Two members of staff and the registered manager stated that they did not think a person had the ability to make decisions, however the care plan stated "[name] is mentally alert and can understand and is aware what's been happening". The person was sat in a "bucket-seat" that was at an angle preventing them from getting out. Staff and the registered manager did not recognise that the use of such equipment could be viewed as a restriction and could possibly constitute a Deprivation of Liberty if that person was not able to consent. A mental capacity assessment had not been completed and there was conflicting information about this person's ability to consent.

Staff also felt that it was acceptable for "Families to decide" where a person was not able. For example, there was no evidence to demonstrate that people, who appeared to lack capacity, had made an informed decision to share a room and were aware of the associated risks such as, cross infection and disturbed sleep. Family had made this decision on their behalf. A number of people had bedrails in situ, but there were no mental capacity or risk assessments in place to demonstrate if a person had the ability to consent. We spoke with the registered manager about the importance of knowing which people using the service had representatives that held a Lasting Power of Attorney. This document gives the appointed person/s the legal authority to make decisions in regards to finances and/or health and welfare.

This was a breach of Regulation 11 of the Health and Social Care Act 2008(Regulated Activities) Regulation 2014 as the provider had not ensured that care and treatment was provided with the consent of the relevant person.

New staff underwent an induction that consisted of an orientation to the service and shadowing another member of staff. The current induction programme for staff did not follow the Care Certificate standards. This is an identified set of standards that new health and social care workers should adhere to. The training, learning, developmental needs of staff must be carried out at the start of employment and reviewed at appropriate intervals. We asked the registered provider to review the induction programme as they should follow the Care Certificate standards.

Staff told us that they received some ongoing training but could not recall what this consisted of in detail. The registered provider had a training matrix but this was not kept up to date and the registered manager was not able to tell us what staff had received training in key areas such as safeguarding, moving and handling or when this was due to be updated. Following the inspection a revised copy of the training matrix was forwarded to us and we were told that it reflected the training received by staff; it detailed the

Requires improvement

Is the service effective?

training completed by 49 staff members from the beginning of 2014 until present. This highlighted that some staff had not completed training in key areas, for example 33 staff had not completed infection control training, 29 staff had not completed moving and handling training and 34 staff had not completed safeguarding training. Training in dementia awareness and mental capacity had not been offered to staff.

Not all staff could recall having supervision and some said this was maybe only about twice a year and that they had "Never had an appraisal". The registered manager confirmed that they did not carry out appraisals. The registered provider had a supervision policy that stated that supervision was only to be provided once a year but the service user's guide assured people that "Key Workers are offered regular supervision". A CQC publication, Supporting information and guidance: supporting effective clinical supervision, states that supervision should take place "regularly to ensure safe and competent care for people who use services". The use of both supervision and appraisals to maintain high standards and people's wellbeing is also promoted in the Cavendish review, which was completed following the inquiry into the Mid-Staffordshire NHS Foundation Trust to look at the performance of unregistered frontline staff in hospitals and care homes.

We recommend that the registered provider review the support, training, professional development, supervision and appraisal made available to staff in light of best practice guidance and recommendation.

Requires improvement

Is the service caring?

Our findings

In the entrance to the service, we saw there were a number of cards from relatives, whose family had lived in the service, expressing gratitude and thanks for the care that had been received. They included comments such as "Thanks so much for the support you have given mum over the years" and "Thank you for your support during mum's last days".

People's view on the service and the care that they received differed and therefore this demonstrated that there was not a consistent approach from staff. Some people were positive when they spoke about the interactions they had with care staff; "Everyone is very kind and helpful", "Staff are very good", "Staff are always walking past my door and saying hello" but others felt "Some staff are good but to others it is just a job", "I am not always treated like me".

Staff interacted with people, spoke kindly and had developed a good rapport with the residents. Some people told us that they were treated with respect during personal care interventions "Yes, they respect my dignity". We observed care staff knocked on the door and introduced themselves prior to entering someone's room. People's care plans were stored safely in two locked offices, which ensured that people's information was kept safe.

Discussions with staff showed that they understood in principle the importance of treating people with respect and compassion but we saw that this was not the experience for all people who used the service. When we arrived at the inspection, the registered manager greeted some visitors and proceeded to hold a discussion about personal matters in respect of the person. This was a public area where we were stood waiting to introduce ourselves. There were large notices that contained personal information, on the outside of some bedroom doors, and one being visible from the entrance lobby. "Ensure fluids are given every couple of hours", "Prefers hot drinks instead of juice". This information was not deemed appropriate to be on public display as it did not afford dignity or confidentiality.

People told us that at times there could be a delay between pressing the call bell and staff managing to attend to them; "Sometimes they're quite quick, but other times I have to wait for a bit", "Sometimes it's around a ten minute wait" and "The worst thing is waiting when I press the bell and I need the toilet. At times I have to wait twenty minutes". One person told us that "I would like to have one or two people who are responsible for my care, not lots of different people. I have asked the person in charge but they told me this was not possible".

People told us about their experiences of using the laundry service. One person stated "I've lost more stuff in here than ever", whilst a relative said, "Things tend to go in but don't come out. There was also concern raised by a relative that sometimes their loved one, on occasions, had clothes on that did not belong to him. Another person told us that they had lost so may items that they asked for reimbursement but this was not readily accepted. This told us that better systems need to be put in place to ensure that people's personal belongings were kept safe.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider had not ensured that people were treated with dignity and respect at all times.

Some people had chosen to personalise their rooms by placing photographs and ornaments around the room. People told us that they felt at home in the service; "yes, I feel like this is my home" and "I feel right at home here, I am really relaxed". There were quiet spaces around the service where people and their relatives could sit and talk in private. Relatives were welcomed by staff and were offered drinks during the time they spent visiting. There were also gardens surrounding the home which looked well maintained, which people told us they liked to spend time in when the weather was nice.

Requires improvement

Is the service responsive?

Our findings

People we spoke to told us that they did not remember having been involved in the development of their care plans, however felt on the whole that the care they received was meeting their needs.

Some people "Seemed to recall" that they had been involved in discussion at the point of admission about care that was required but in most cases that had been "A while ago". Records did not make reference to discussions with people who used the service about their care and treatment. Care plans contained little information as to how a person wished their care to be delivered, what they preferences were (for example when to get up, go to bed, preferred gender of carer) or the things that they could do for themselves. Care Plans were not always reviewed when there was an identified change of need.

One person told us that they were continent but had to wear pads as staff did not always come in time and so they had these "In case". The elimination care plan reviewed by staff on 30 September 2015 confirmed that the person was "Continent but uses pads as staff can't always respond quickly enough". Another gentleman who had only recently moved to the service told us "I don't wear a pad normally", they've put a pad on me now but I don't really need it. No, It wasn't discussed with me". Promoting the use of pads where they are not needed could increase the risk of infection and skin conditions such as pressure sores. This is regarded as poor practice. This is also disrespectful and undignified.

This was a breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 because the registered provider must assess the risks to the health and safety of service users and do all that is practically possible to reduce those risks.

Records were kept to document specific areas of care such as diet and fluid intake as well as repositioning but these were not always completed. Two of the people we looked at required their position altering every two to three hours, but it was not consistently documented that this had taken place. For one person there was no reference in the documentation for a period of 16 days that the person's position had been changed whilst in the documentation for the other individual their change of position had only been recorded a total of five times over a nine day period. One of these individuals was able to confirm that staff had supported them to alter their position regularly. The other had a cognitive impairment and we could not be sure that the necessary support had taken place. Staff assured us that they had been offering this individual support to alter their position and that it was an omission in their recording.

Staff kept records of what someone had eaten or drank if this required close monitoring. These records were not always completed at the time. For example, we noted at midday that a person had two beakers of juice and a beaker of cold coffee on their bedside table. When we returned at 17.15 the same beakers were evident .There had been no entry made on the person's fluid chart since the morning to demonstrate that fluids had been offered and the notes reflected that only 50mls had been taken over a period of 7.5 hours. Records from the previous day indicated that no fluids had been offered or consumed from tea time to breakfast time. Following the inspection, the registered manager forwarded a copy of the document that had retrospective entries made on it for the day of the inspection and assured us that care had been delivered: this indicated that these records had not been completed at the time of care delivery. Staff were not aware of the recommended daily intake and did not monitor consumption on a daily basis. These charts were not checked or monitored in order to analyse and utilise the information to make decision on care, support or medical assessment.

Care Plans and risk assessments varied in their detail, content and standard, which demonstrated a lack of consistency. Not all were kept up to date or illustrated where there had been a change in need. For example: The mobility of a person had deteriorated and they required a stand aid. However, their pressure prevention plan indicated that no equipment was used and a mobility care plan indicated that they could walk short distances. The moving and handling assessment had not been undated since 6 July 2015 to reflect the changes. This meant that the person and staff could be placed at risk through inappropriate moving and handling. The registered provider used the Malnutrition Universal Screening Tool (MUST) to assess risk of malnutrition. A person's MUST record indicated no weight loss but their weight had decreased from 56.2 kg in January 2015 to 53kg in March. The MUST indicated that the person was independent with eating whilst the daily notes indicated that the person required prompting. Likewise, their personal care plan

Requires improvement

Is the service responsive?

indicated independence but the monthly review clearly showed a need for increased supervision and promoting. The lack of accurate records meant that people could be placed at risk receiving inappropriate care and intervention.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 as the registered provider had failed to ensure that people were protected from the risks of unsafe or inappropriate care as there was not a contemporaneous and accurate record held in respect of each person

Not everyone who used the service was to communicate verbally. Both the registered manager and one of the nursing staff told us they had made initial attempts to communicate with one person using picture cards but had been unsuccessful. Both felt that behavioural issues displayed by this person were linked to their "frustration" at not being able to communicate their needs; however there was no information provided on whether avenues had been explored to understand and communicate with this person. This highlighted that more support was needed for people with communication issues to enable a personalised approach.

The registered provider had ensured that people had an air mattress to minimise the risk of developing a pressure area where required. However, there were no instructions for staff as to how to correctly set the pressure. This meant that a person could be at risk of further skin damage from lying on a mattress that was too hard or soft. Staff told us that the maintenance man ensured they were correct. We asked the registered manager how staff knew the correct setting and they told us "They are set by the supplier based on weight and we ring them if we think it needs to be altered". The settings were not recorded anywhere and therefore staff could not check if the pressures were set correctly or required altering. It is essential that staff are aware of the correct pressure for both lying and sitting and that there is a process in place to review this as a person's weight increases or decreases. We asked the registered manager to review the use of pressure mattresses as a matter of priority.

An activities co-ordinator was employed by the service, they had a good rapport with people in the service and people spoke fondly of them. One person told us that they were not a very sociable person but the co-ordinator always made an effort to involve them. Everyone whom we spoke with knew who they were and said that the person was "Fab" and "Enthusiastic". They took the time to find out what people liked to do and kept a record of what people had done and participated in. The activities programme was available and was varied from an exercise class consisting of light chair exercises, to board games and films. Trips out were also organised to the zoo, shops and seaside. Every Tuesday a number of people were supported to attend a coffee club that was held within the local hall. This enabled people to maintain links with the local community.

The registered manager kept a detailed record of compliments and complaints that were received. In one instance we saw that concerns had been expressed by a relative, following which the registered manager had made a referral to the G.P and physiotherapist for support. Some relatives and people using the service told us that they would go directly to the manager with their concerns and felt confident that these would be dealt with "If I have any complaints I'd go to the manager and she sorts it. CQC and the local authority had been contacted by other relatives who felt that they did not have confidence in the registered manager to resolve issues to their satisfaction

Requires improvement

Is the service well-led?

Our findings

There was a registered manager in post and she had been registered at the service since 21 January 2011.

The registered provider had policies and procedures in place in order to reflect the requirements of the business and also to direct staff in their day to day work. However, these did not reflect current legislation, policy and best practice. This was required in order to ensure that staff had up to date knowledge and for them to provide effective and safe care. For example, the infection control audit had highlighted that the current policy referred to East Cheshire NHS and needed updating to include recent changes in guidelines. The complaints policy directed people "in the event of making a complaint to contact CQC" and did not reflect the roles and responsibilities of the local authority or local government ombudsman.

We reviewed accidents and incident records and it became apparent found that the registered provider had not ensured that the CQC were notified about key incidents within the service that affected the health and welfare of people who used that service.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4) because the registered person must notify the Commission without delay of specified incidents.

The registered manager was not fully aware/ familiar with the current method of inspection and the key lines of enquiry. She was also not aware of the changes to the Health and Social Care regulations that came into force in April 2015. We referred her to the guidance on the CQC internet page and reminded her of her responsibility to keep up to date with changes applicable to the service.

We made a recommendation that the registered provider and the registered manager review the conditions of their registration.

The registered manager undertook a series of audits but these did not include key areas such as infection control or supplementary documentation such as risk assessments and food and fluid charts. Audits that had been carried out were not robust as they did not highlight some of the issues raised on the inspection such as those with care plans and medication. The registered manager had not taken any action following the recommendations made by the infection control team and told us that she had "In all honesty, put the report in the drawer and had forgotten about it". This meant that she failed to take remedial action without delay.

The registered manager had not ensured that adequate checks were in place around care planning and that a consistent approach was taken by staff. We found that different documentation was being used and the registered manager was not always aware of this. For example, the registered manager provided us with a bowel monitoring chart that she said should be found in all care plans although it was not. Following the inspection, we were provided with daily evaluation sheets where in fact people's bowel movements were being recorded.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider must have systems in place that enable them to assess, monitor and improve the quality and safety of the service.

The registered manager had not ensured that staff had received regular supervision or appraisal. This meant that staff were not supported with their learning and development to enable them to fulfil the requirements of their role. Staff that we spoke with could not recall staff meetings or supervisions being held on a regular basis. The registered manager provided us with the last group supervision that was held in June 2014.

The registered provider had recently undertaken a quality survey and sent questionnaires to residents/relatives of those who used the service. They informed us that the response numbers were poor with only seven being returned. The registered manager informed us they had tried to engage families and residents in meetings but these had been poorly attended and so she had stopped arranging them opting for a regular "managers surgery". These also were not well attended. Relatives and people who used the service told us that they would welcome the opportunity to have their opinions heard.

We made a recommendation that the registered provider explore alternative ways to seek the opinions of those people who may not be able to

Requires improvement

Is the service well-led?

complete a questionnaire or want to attend a meeting. Feedback should also be actively sought from other stakeholders including staff, visiting professionals and commissioners.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The registered provider had failed to ensure the proper and safe management of medicines. The registered provider had failed to assess the risk of and prevention of infection, including those that are health related. The registered provider had not assessed the risks to the health and safety of service users and done all that was practically possible to reduce those risks.

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 How the regulation was not being met: The registered provider must have systems in place that enable them to assess, monitor and improve the quality and safety of the service. The registered provider had failed to ensure that people were protected from the risks of unsafe or inappropriate care as there was not an accurate record held in respect of each person.

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 How the regulation was not being met: The registered provider had not ensured that people were treated with dignity and respect at all times.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

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 How the regulation was not being met: The provider had not ensured that care and treatment was provided with the consent of the relevant person.
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 How the regulation was not being met: The registered provider had not taken adequate steps to ensure that people were supported by staff of suitable character and skill.