Care Enterprises (Temple Ewell) Limited

Temple Ewell Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was carried out on 28 February 2017 and was unannounced.

Temple Ewell Nursing Home is a privately owned care home providing nursing care and support to up to 44 adults who have nursing needs and who may also be living with dementia. The rooms are located on two floors: the main entrance is on the first floor accessed by a lift. There are private gardens with seating, patio areas and parking. On the day of the inspection there were 39 people living at the service.

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

People told us that they felt safe, however, risk assessments to support people with their mobility, skin care and continence were not detailed enough to show how to manage the risks safely. People were left at risk of not receiving the support they needed to keep them as safe as possible.

The deployment of staff on duty did not ensure that people's needs were fully met. Records showed that not all staff had received updates in their training. Staff had not received regular one to one supervisions and yearly appraisals to discuss their training needs and professional development.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). At the time of the inspection there had been no recent applications for DoLS authorisations. Mental capacity assessments had been completed but had not been reviewed since 2015; any changes to people's capacity had not been assessed and considered in relation to DoLS.

When people were unable to make important decisions for themselves, relatives, doctors and other specialists were involved in their care and treatment and decisions were made in people's best interests. However, information was not always recorded to confirm how people had given their consent or been involved in decisions that had been made, for example when bed rails were in place to prevent a person getting out of bed.

Care plans did not contain details about people's choices and preferences. The plans had been reviewed but any changes in people's care had not been recorded in the care plan. Care plans did not record all the information needed to provide care and support to people in a personalised way. Records were not always completed accurately or properly.

People and relatives told us that staff were caring and respected their privacy and dignity. However, this was sometimes compromised as staff were not always deployed effectively to ensure that people's care was provided in a timely way to ensure their dignity was maintained. Staff were familiar with people's likes and

dislikes and supported people with their daily routines.

People received their medicines safely. However, medicines were not consistently ordered, recorded and managed safely. People's health was monitored but it had not always been recognised when other health professionals should be contacted. People were supported to drink and maintain a healthy diet but were not involved in planning the menus.

Accidents and incidents had been recorded and reviewed but further analysis had not been completed to identify any patterns and trends to reduce the risk of them happening again. Checks had been completed on the equipment but there were no environmental risk assessments available on the day of the inspection. The personal emergency and evacuation plan (PEEP) for each person was not detailed enough to inform staff about how to evacuate people safely.

Staff had received safeguarding training and were aware of how to recognise and protect people from harm and abuse. Staff knew about the whistle blowing policy and were confident they could raise concerns with the manager and outside agencies if needed. Staff were recruited safely, there were robust recruitment systems including checks to ensure new staff did not pose a risk to people living at the service.

There were quality assurance systems in place which had not always been effective as shortfalls found at this inspection had not been identified. Health and safety checks and maintenance checks were regularly carried out.

The complaints policy and procedure was available in the entrance of the service, but was not displayed so that people could easily access it. Although there were some planned activities, on the day of the inspection the majority of people remained in their rooms and were not engaged in activities.

Staff told us that they felt supported by the registered manager and provider. The registered manager and provider were approachable and listened to staff and people and their opinions were taken into account.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This is so we could check that appropriate action had been taken. The registered manager was aware that they had to inform CQC of significant events in a timely way.

We found 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people were not always assessed. There was not clear guidance in the care plans to sure all staff knew what action to take to keep people as safe as possible.

Medicines were not ordered, recorded and managed safely.

Staff were recruited safely but not always deployed effectively to fully meet people's needs.

Staff knew the signs of abuse and had received training to ensure people were protected from harm.

Is the service effective?

Requires Improvement

The service was not always effective.

New staff received induction training but this was not linked with the current recommended Care Certificate. Not all staff had completed basic and specialist training.

The principles of the Mental Capacity Act were not being followed in relation to Deprivation of Liberty.

People were not always referred to health care professionals in a timely manner.

People were not involved in decisions about the menus but had enough to eat and drink.

Is the service caring?

Requires Improvement

The service was not always caring.

People and relatives said people were treated with dignity and respect. However, people's dignity was at risk when they had to wait for staff support.

People and their relatives were able to discuss any concerns with

the managers.

People were encouraged to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff knew people well, however, care plans did not always reflect the care being given.

People and their relatives were not involved in the planning of their care.
Care plans lacked detail to ensure person centred care was being delivered.

People and their relatives said they were able to raise concerns or complaints with the staff or registered manager, who would take action if required.

There were mixed views with regard to the activities provided. Some people were satisfied while other people thought they could be improved.

Is the service well-led?

Requires Improvement

The service was not well led.

Audits and checks on the service were being carried out but were not effective as they had not identified the shortfalls found at this inspection.

Records were not always accurate or complete.

Staff told us that they felt supported by the registered manager and that there was an open culture between staff and management.

Temple Ewell 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 the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 28 February 2017 and was unannounced. It was carried out by two inspectors and an expert by experience who spoke with people who used the service, families and relatives. Our expert by experience had knowledge, and understanding of residential services or caring for someone who uses this type of care service.

The provider had not completed a Provider Information Return (PIR), as the inspection had taken place sooner than planned. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service. We looked at notifications received by CQC. A notification is information about important events which the provider is required to tell us about by law, like a death or serious injury.

We looked around areas of the service, talked to 17 people who live at the service. Conversations with people took place in people's rooms and the activity room. We observed the lunchtime meal and observed how staff spoke and interacted with people. We would usually use the Short Observational Framework for inspections (SOFI) to understand the experiences of people who may not be able to tell us. On this occasion we did not use SOFI because most people were in their rooms and not in communal areas.

We reviewed records including four care plans and risk assessments. We looked at a range of other records including staff files, staff induction records, training and supervision records, staff rotas, medicine records and quality assurance surveys and audits.

We talked with nine relatives who were visiting people, the provider, registered manager, administrator, six staff and one domestic staff. We spoke with a health professional and social care professional.

This was the first inspection since the service was registered by new providers in August 2016.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe living at the service. One person said, "They check me at night which makes me feel safe."

Risks to people had not been consistently assessed and guidance to reduce risks was not detailed or clear. Risk assessments to support people with their mobility lacked detail. For example, one person's mobility assessment dated August 2015 stated the person was unable to weight bear and required a hoist to transfer, there was no guidance about how to move the person safely. This person was living with Parkinson's disease and this was not included in the risk assessment to guide staff how this medical condition affected their mobility. An additional risk assessment dated January 2017, stated that the person did not have control of their left leg, this risk assessment had been completed after an incident in December 2016, when the person was injured while being moved.

Risks around people's health care needs had not been identified. Two people had been identified as living with epilepsy; there were no care plans to give guidance on how to manage their health needs. There was no information about the type of seizures they might experience and when to call for medical assistance. The registered manager told us that the people had not experienced any seizures since living at the service; however there was a risk that staff would not know what action to take if this should happen. Before the inspection healthcare professionals had raised concerns that staff did not know how to care for people with epilepsy. One person was referred to the emergency services following a number of seizures over two days. The person required emergency medicine to treat the effects of the seizures and was admitted to hospital. The staff had not recognised the risks from the seizures and when assistance should be sought.

One person moved into the service, on the day of the inspection, there was no comprehensive care plan for this person. The person was living with diabetes, and was prescribed insulin. There was no guidance for staff about how to monitor the person's blood sugar levels, what their normal level was and the symptoms the person may experience if their blood sugar was too high or too low and how to manage these symptoms if seen.

Some people had a catheter in place. A catheter is a tube that it is inserted into the bladder so that urine can drain freely. The risks of having a catheter in place were not identified. The assessments for the catheter did not state clearly what to do if the catheter was not draining freely and what signs the staff needed to look for that might indicate an infection. Nurses had changed the catheters in line with manufacturer's guidelines and were able to recognise the signs of infection.

The provider did not have sufficient guidance for staff to follow to show how risks were mitigated when moving people and supporting people with their health care needs. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

At the time of the inspection the environmental risk assessments could not be found, therefore we were unable to see if the premises were adequately assessed to minimise risk and make sure people were safe.

After the inspection the registered manager sent the risk assessments to us. However, these were undated and not signed to confirm they had been completed appropriately.

The fire alarm system was tested on a weekly basis from different points in the home to ensure it was working. Fire drills had not been completed consistently to ensure that all staff had been involved in a drill and were aware of the actions to take in such an emergency. People had a personal emergency evacuation plan (PEEP) but these were not detailed enough to guide staff how to evacuate people safely from the premises. The emergency plan was also out of date as this referred to the previous provider. The registered manager told us that they were in the process of renewing policies and procedures to reflect the new provider details.

Staff told us that the new provider was pro-active in providing resources to improve the premises. Accident and incident reports had been completed and the registered manager had signed to confirm they had reviewed them and confirmed what action had been taken. Further analysis of accidents and incidents had not been completed. For example, to look for any patterns, including the place or time of accidents, to try to prevent further accidents. Without this analysis to look at any route cause and common themes the accidents and incidents could continue.

The provider had failed to assess and reduce environmental and other risks including the risk of fire. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

There were policies and procedures in place to make sure that people received their medicines safely. However these were not always followed as people were not receiving their medicines consistently.
One person was prescribed Bumetanide 1mg which is a medicine to prevent the retention of fluid. This had not been available from 14/02/2017 to 21/02/2017 so the person had not received this medicine. Another person was prescribed Lansoprazole 30mg once a day for indigestion, and this had not been available between 19/02/2017 and 23/02/2017 so they had not received it. People had not received their medicine as prescribed. Staff had not taken action to ensure there were enough stocks of medicines.
Medicines were not recorded, ordered and stored safely. Liquids and tablets were being stored together in the medicine cupboard which was not in line with current guidance. Medicines that are supplied in a specific way for an individual are effective for a limited time, and should not be used after that. There were medicines for three people in the medicine cupboard that should have been disposed of as the date had expired; the medicine was no longer effective. There was, therefore, a risk that staff may administer these expired medicines.

Some instructions on the medicine administration records (MAR) had been handwritten by staff. These instructions should have been signed by two staff to confirm the instruction was correct, this had not been completed. There were signatures missing from the MAR chart to confirm medicines had been given. On checking the numbers of tablets available we confirmed the medicines had been administered. On the day of the inspection, a dose of insulin had not been signed to confirm it had been administered by the night staff. As the medicine was a liquid we were unable to confirm the dose had been given. Some medicines have specific procedures such as two staff to witness and sign records when giving these medicines; this had not been completed consistently, there was a signature missing.

The provider had not ensured that medicines were managed safely. People were not receiving their medicines in line with the prescriber's instructions. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored at the recommended temperature to ensure they remained effective.

Checks had been made on the equipment and the premises, such as the servicing of the hoists, boilers, electrical system, nurse call system and temperature of the water. The maintenance person carried out a daily health and safety check to ensure the premises remained as safe as possible.

The provider talked about the rolling programme to improve the premises, such as new carpets being laid by the end of the summer, and how each room was being assessed as to what needed to be replaced or re-decorated. However, this had not been formalised in the form of a maintenance plan. This was an area for improvement.

Staffing levels were consistent and staff told us that they felt supported by the management team. The registered manager told us that staffing levels were based on people's needs. However, the registered manager did not use a tool to calculate the staffing levels but used her judgement rather than an assessment of people's needs. Staff told us that at times, during busy times, the registered manager would help provide direct care for people. The staff rotas showed that in times of sickness or absence the service was always covered and the staff team worked together to achieve this.

Staff were aware of their roles and responsibilities. The staffing structure showed that in the main two registered nurses were on duty each day, but at times there was only one registered nurse and an 'associate nurse' on duty. The registered manager told us that they had appointed senior staff as associate nurses to support the registered nurses to carry out their role. They told us that the associate nurses did not replace the registered nurses. However, at the time of the inspection one associate nurse was responsible for the first floor and there was one registered nurse responsible for the ground floor. Two student nurses were also supporting. The associate nurses had not received any additional specialist training to give them the skills they needed for the role.

The staff numbers matched the levels needed according to the registered manager's calculations. . However, at lunch time we observed that staff were rushed to ensure that people were being supported to eat. This was because two members of staff were still providing personal care to people reducing the staff availability. We raised this with the acting deputy manager who came out of the office with a student nurse to help people with their lunch. The deployment of staff needs to be reviewed to ensure that people have their needs fully met and are not waiting for their personal care or to be supported at lunch time. This was an area for improvement.

New staff had been recruited safely. Application forms had been completed together with a full employment history, proof of identity, satisfactory written references, and police checks. A record was kept of the interview process and staff had job descriptions and contracts so they were aware of their role and responsibilities as well as their terms and conditions of work.

Successful applicants were required to complete an induction programme and probationary period. The registered manager told us that in the past people had been encouraged to be part of the interview panel when new staff were being recruited, but this had not happened recently.

Staff were able to tell us how they would recognise and report abuse. They knew about the different types of abuse and had received training on keeping people safe. Staff were confident that any concerns they may raise would be dealt with promptly and people would be protected from harm. Staff were aware of the whistle blowing policy and told us they would not hesitate to tell the registered manager if they observed poor practice.

Requires Improvement

Is the service effective?

Our findings

People and relatives told us they were happy with the care they received. One relative told us, "I am grateful (my relative) is here."

The training programme was a mixture of on line training, DVD's and face to face training. The senior member of staff leading the training was aware of the shortfalls and further training had been arranged. There was only three staff that had completed 100% of their training, with 6 staff achieving 90% and five 80% the remaining staff numbers varied. The training matrix showed that not all staff had received the updates in their training according to the provider's policy, for example, ten staff required a training update in Health and Safety, 12 Food Hygiene, and seven Infection Control.

Staff worked through an induction when they started work at the service but this was not linked to the Care Certificate. This is an identified set of standards that social care workers adhere to in their daily working life. As part of the induction training staff shadowed established staff to get to know people and be aware of the care and support they needed.

One person told us that they were not happy with how a member of staff used the hoist to move them, "For the past three nights (staff) on duty has attempted to hoist me and this has caused me discomfort." We discussed this with the registered manager who told us they would investigate this matter and take appropriate action to ensure that staff had the competencies to move people safely. They also told us that a senior member of staff, responsible for training, was a trainer for moving and handling and updates were in the process of being arranged. This training included competency assessments to ensure that staff had a good understanding of moving people safely. Each month there were two training sessions of various topics available from an outside provider, and staff had been booked to attend.

Staff were not receiving the supervision they needed to ensure they had the opportunity to discuss their roles with a manager. There was a lack of staff appraisals to discuss staff's individual training and development needs. This included clinical supervision for the nursing staff. The registered manager told us that they had received only one clinical supervision since they came into post in 2016. One staff member said, "I have had one supervision in two years and have not received an appraisal either".

The registered manager told us that they were aware of the lack of supervision and were implementing an action plan to ensure that staff would receive three supervisions and an annual appraisal each year. However, records did not confirm when this programme would be implemented and it had not been started at the time of the inspection.

The provider was not ensuring that all staff received appropriate training to enable them to carry out the duties they are employed to perform. Staff were not receiving supervision or appraisal to discuss their training and development needs. This was a breach of Regulation 18 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). We checked the service was working within the principles of the MCA.

The registered manager had knowledge of MCA and DoLS and was aware of their responsibilities in relation to these. However, the principles of the MCA had not been consistently applied. The registered manager had applied for DoLS for some people within the service and three had been authorised. The registered manager told us that there had been no applications since August 2016. One person was admitted in November 2016, they were living with dementia and had been assessed as not having capacity to make straightforward decisions. The person was under constant supervision and during the inspection, asked to go home. Staff had assessed if a DoLS application should be made but had not used current guidelines which state that a DoLS application should be made if a person is under constant supervision and does not have capacity to agree to their care.

Most people's capacity to consent to care and support had been assessed and assessments had been completed. The capacity assessments for people who had lived at the service for a long time had not been reviewed since 2015. There was, therefore a risk that any changes in the person's capacity had not been updated. Some people did not have capacity assessments in their care plan, these people when spoken to, appeared to have capacity to make decisions, but this had not been formerly assessed and recorded.

Staff were aware that decisions made on behalf of people who lacked capacity should only be made in people's best interest and once a best interest meeting had been held. There was a lack of information to show how people had agreed with their care being provided. Care plans did not show if and how people had been involved in their care planning and consent forms had not been signed to show that they had agreed with the care to be provided.

The provider has not made sure that care and treatment of people was provided with the consent of the person and had not acted in accordance with the Mental Capacity Act 2005. Regulation 11(1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People's health was monitored and when it was necessary health care professionals were involved to make sure people were supported to remain as healthy as possible. People had access to GP's, dieticians and speech and language therapists. People had regular appointments with chiropodists, dentists and opticians.

People who required support to help keep their skin healthy used specialist mattresses and cushions to sit on. Staff were recording that the mattresses were working correctly but there was no guidance on what setting the mattresses should be set at to check that it was correct. This was an area for improvement.

Care plans showed prompt action was taken to address people's symptoms and doctors and health care professionals had been consulted to ensure that people received the care they needed. However, staff had not referred people consistently for emergency care quickly following incidents and when they became

unwell. The registered manager told us that they had investigated these issues and new paperwork had been put in place.

Nutritional assessments were completed to make sure people were receiving the food they needed. When people had lost weight appropriate action had been taken to inform health care professionals so that people would receive the advice and support they needed with regard to their dietary needs. We observed people receiving thickened fluids and pureed food in line with the guidance given.

We observed lunch and saw all the food was freshly cooked, people told us that they did not always have a choice of food and did not have any input into the menus. However, people had the four weekly menus in their rooms to help them to choose their meals. One resident said, "I don't care for the food as it is rather bland and I am used to a bit more taste."

The main meal looked appetising, but the meal was served on cold plates and there was no heated trolley for staff to keep meals hot once the meal left the kitchen. People told us that at times the food was cold. We spoke to the registered manager who told us that they had recognised that this could be improved and were purchasing hot trolleys to resolve this issue.

Staff were not deployed effectively to ensure people received their meals in a timely manner. Most people ate their meals in their rooms and staff had to go back to the kitchen on a number of occasions, this meant that people were waiting between courses. Staff assisted people who required assistance with their meals after all the other meals had been given. People were not rushed and encouraged to eat as much as possible.

Requires Improvement

Is the service caring?

Our findings

People and relatives told us staff were kind and caring. One relative told us, "The staff are very gentle and kind, they treat (my relative) with dignity and respect." Staff told us they were kind and caring, they said, "There is a good atmosphere in the service, we make sure people are well cared for". "I am happy working here, the staff are supportive of each other".

The service was part of the dignity champion national scheme. Dignity champions ensure that everyone is treated with dignity as a basic human right, not an optional extra. The member of staff who was the dignity champion, told us how they gave extra support to people when they first came to live at the service, so they would know what to expect from the service.

People told us they were treated with respect and dignity and staff always respected their wishes. However, we observed that one person had not received personal care before lunch and was in a soiled bed. Staff left the person in a soiled bed while they gave people their meals. Staff had not maintained the person's comfort and dignity. We spoke to the nurse, who asked two staff to support the person. The acting deputy manager was informed and they went to assist staff. The registered manager told us that a member of staff had left her shift due to an emergency which had led to the person having to wait for support. The registered manager had not put in place a plan to ensure people's needs were met.
People said, and we observed, that staff knocked on their bedroom doors before entering. The staff member who was the dignity champion told us that, if family were not available, they would accompany people to hospital to reassure them until family members could arrive. They also gave people and their relative's additional support when people were receiving end of life care. One relative told us, "The staff are very gentle and kind, they are very kind to me and bring me refreshments and keep me informed. I am glad (my relative) is here." Relatives are encouraged to stay with their loved ones if they wish.

People's rooms were personalised with their own belongings, people had small pieces of their own furniture and photos of family in their rooms. Staff spoke to people in their rooms, they introduced themselves and explained the purpose of their visit. Staff approached people differently and adjusted their approach according to the person's needs. Staff touched people to get their attention if the person was hard of hearing, using hand gestures to help explain what was happening.

Staff treated people with kindness, one person was upset and confused, staff needed to support them with personal care. The member of staff spoke calmly and quietly and guided the person back to their room, reassuring them throughout. Staff made sure the person was comfortable and offered them a cup of tea, the person was relaxed and settled when staff left.

Staff were observed making sure people had their mobility aids near them., One staff member was encouraging a person to walk, they spoke to them sensitively saying "Make sure your frame is not too far away, walk slowly". This gave the person reassurance to continue walking with their frame.

We overheard one member of staff encouraging a person to be independent transferring from the chair to

their bed, staff reassured the person and gave them encouragement, recognising when they achieved their goal.

Relatives told us that they were made to feel welcome. A relative told us, "As a family we brought in fish and chips so we and our relative could eat together. They laid up the dining room for us and provided drinks."

End of life care plans showed people's preferred place to be cared for at this time and their preferences for cremation or burial. Staff had received end of life care training and maintained links to the local hospice. There were systems in place to ensure that people approaching the end of life, and their relatives were aware of the care to be provided. Some people had made advanced decisions such as 'do not attempt to resuscitation' orders to ensure their last wishes were recorded.

Requires Improvement

Is the service responsive?

Our findings

People told us, "The staff are excellent, I am well looked after." and "I feel well cared for and they answer my bell quickly."

There had been occasions when staff had not responded to people's needs. Before the inspection a social care professional told us that they had concerns about how staff responded to incidents and how quickly people were referred for emergency care. We looked at an incident that had taken place in December 2016. One person had hurt their foot while in a wheelchair, the nurse had assessed the person's foot immediately afterwards, and decided that there was no need to refer the person for emergency care. The person continued to complain of pain in their left leg. Staff did not refer the person to the GP until a week after the incident. The person was taken for an x-ray, which revealed they had an injury that required treatment. The delay in seeking treatment had led to the person being in pain for longer than necessary. The registered manager told us that the incident had been investigated. The outcome was new pain charts being introduced, as staff had not recorded the person's level of pain.

People's needs were assessed before they moved into the service. The registered manager told us that they, together with the registered nurses and associate nurses, carried out the assessments. They said that if an associate nurse carried out the assessment they triaged the information before they visited the person and carried out their own assessment. The associate nurse had not received specific training to assess people's clinical needs and had not been assessed as competent to undertake the role. We noted that one assessment carried out by an associate nurse had details of the person's complex clinical needs but had not identified how the service would manage these.

We looked at four care plans, the plans contained a document called 'My life before you knew me', which had been completed by families, giving information about the person before they needed support. This information had not been transferred to the care plan for staff to refer to so they could get to know people. People should be involved in and agree with the care provided. People and relatives were unable to confirm that they had seen and agreed to the care plan, one person said, "They probably sorted that out when I came from hospital."

Care plans lacked detail about people's preferences and choices, for example what time people liked to get up. One person told us, "They ask me in the morning if I want to get up but usually it is too early for me, when I feel I want to get up they don't ask me again." There was no information in the care plans about how much people could do for themselves so that staff knew how much support to give. For example, if they could manage a drink or wash their face.

A care plan to prevent a person's skin for becoming sore stated 'change position as frequently as necessary'. The plan did not state how often this should happen, what re-positioning was required for the individual and how often this should take place, therefore, we could not be sure that this was being carried out effectively.

One person had wounds to both their legs, these wounds were long standing and the nursing staff had been dressing the wounds since May 2016. The dressing to be used had been decided in May 2016, there had been no review to assess if the wound had improved and if the type of dressing was still suitable or if further professional advice should be sought.

Care plans had been reviewed monthly, however, some people who had been living at the service for a long time had not had any changes made to their care plan since 2015 even though their needs had changed. One person's care plan had been reviewed; the change in the person's needs had been recorded in the review but had not been changed in the care plan. Staff would not, therefore, have the updated information they needed when reading the care plan.

The provider was not ensuring that person centred care and treatment was meeting the needs of people and care plans had not all been updated. There had been a lack of response to people's needs. Regulation 9(1)(a)(b)(c), 9(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Staff attended daily handover meetings at shift change so they were up to date with people's care needs. Staff told us communication was good, they said, "We have verbal handovers, and staff allocation sheets, so we know what is going on". "Communication is good; it keeps us up to date".

Most people remained in their rooms and did not visit the communal areas of the service. There was a part time activities co-ordinator who was sitting with two people in the communal lounge supporting them to colour pictures. Other activities included hand massaging, reminiscing, knitting and chatting to people in their rooms. Outside entertainment, such as singers and musicians were also booked monthly. People told us that they could choose whether they wished to join in or remain in their rooms.

The service was having an additional router fitted to ensure that people and staff would have an improved signal to access the internet. One person had their own tablet computer to access the internet and keep in touch with their family.

Relatives told us that they would take any concerns they had to the registered manager and were confident that they would act on issues they raised. There was a system in place to record and respond to complaints and action taken to resolve issues to ensure that there were positive outcomes for people. How to complain was on display in the foyer of the service; however this was behind a compliments file and not in easy access to people and visitors. The administrator had an office in the foyer and was accessible to speak with people and visitors should they require further assistance.

Requires Improvement

Is the service well-led?

Our findings

One staff member said the provider and registered manager 'supported staff really well, they really care about the people who live here'. Another staff member said, "If you needed anything or anyone the management team would be there for you".

Audits and checks on the service were being carried out but were not effective as they had not identified the shortfalls found at this inspection. The medicine audit had identified some shortfalls and what action to take but there was no indication when the actions had been completed and who was responsible for this. For example, it was noted on the audit that the fridge was unlocked and the action taken was that this had been addressed with the nurses and care staff. The audit did not show who was responsible for this and there was no record to confirm the fridge was now locked in line with current guidance. It was also noted that the audit recorded 'the medicine room and handling of medicines and record keeping were of a reasonable standard'. Handling of medicines and storage should be in line with current legislation and guidance and recording 'reasonable standard' did not confirm that this was the case.

The audits had not picked up that some stocks of medicines had run out and had not been replaced so people had not received the medicines they needed. The provider had not picked up that some medicines had expired, that hand written entries on medicines records had not been checked and counter signed and that there were unexplained gaps on medicines records.

Monthly audits were carried out on pressure relieving equipment such as air flow mattress. There were details of what to look for if they were not working properly but there was no record of the setting to be used for each person, which would vary depending on their weight and whether they were nursed sitting up or lying down. People could therefore be at risk of developing pressures areas. After the inspection the registered manager told us that most of the air flow mattresses did not have pressure settings to check but this information was not recorded in the audit. As the setting could not be set to the correct weight for each person, there were no further checks to monitor how effective these were to reduce the risks of people developing pressure areas.

The infection control audit stated that the service was 80% compliant and an action plan had been put in place to address the shortfalls. However there was no information to confirm that these areas were now compliant.

The registered manager kept a diary of when compliance visits were made to the service. The last visit was dated 7 January 2017. The registered manager had observed the night staff administering medicines but there was no record of what had been observed or if any action needed to be taken. On 11 January, 2017 an entry had been made that they had discussed monitoring dignity with the care staff. However, there was no further evidence of how this was to be achieved or what the goal was. The registered manager also walked around the service regularly but this was not formally recorded to show what the outcomes were.

There had been 12 accidents/ incidents in February 2017. The registered manager had signed the forms but

there was no analysis in place to look for patterns or trends to reduce the risk of them happening again.

There was an audit of people developing pressure areas, which clearly stated that people had developed these within the service. When people had developed sores, there was no further analysis to indicate why, or what, if anything, could have been done to prevent such incidents. There was no learning from incidents.

Accurate and complete records in respect of each person were not maintained. Risks relating to people's care and support had not been consistently assessed and documented. Clear guidance had not always been provided to staff about how to mitigate risks to people. Care plans had been reviewed but not updated to reflect people's changing needs.

Quality assurance surveys were sent to people in August 2016. However, the results had not been summarised and people had not been informed of the outcome. The surveys had not been sent to, staff, relatives and other stakeholders. Therefore, there was no evidence to confirm how people's views and opinions had been used to continuously improve the service. The registered manager told us that this everyone would be sent quality assurance surveys in the near future.

The provider had not ensured that the systems in place to quality assure and check the care being provided were effective. The provider had not actively sought the views of a wide range of stakeholders, including, staff and visiting professionals to ensure the continuous improvement of the service. The provider had failed to ensure that records were accurate or fully completed. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

Staff told us they had staff meetings where they were able to voice their concerns or issues. One staff member said, "They listen to our views and take action if needed". However, the last staff meeting in November 2016, there was no agenda to give staff an opportunity to add to it.. In August 2016 a resident meeting had been held to inform every one of the new provider. Another residents meeting had been carried out in October 2016 but minutes showed that this was purely a nutritional summary of each resident and there was no agenda for people to have the opportunity to voice their opinions or to discuss the service they were receiving.

Staff told us this was a very positive meeting and things had improved since the new provider had taken over. They said staff morale had improved since the new provider brought the service. There was less sickness which had reduced the turnover of staff. They told us "They (the provider) listens to what we say, they are very good and if we need something for the service we get it". "There is planned maintenance and we care currently having a new bathroom downstairs by the kitchen, we have redecoration and new beds". "The provider is excellent". "The provider visits us regularly; they are really interested in improving the service".

Staff understood the visions and values of the service they said, "We treat people with respect, and treat them how we would like to be treated". However, this had not always been put into practice. There were times when people's dignity was compromised. Staff had not recognised when people needed to be referred to health professionals. These shortfalls had put people's health at risk.

The service had links with the local community including local schools who would visit on holidays such as Christmas and Easter. The service also has links with the university as student nurses carried out their eight week placements at the service.

The registered manager told us that they networked with other local managers to discuss practice and

attended local authority workshops to keep updated with current legislation.

All services that provide health and social care to people are required to inform CQC of events that happen in the service so CQC can check appropriate action was taken to prevent people from harm. The registered manager notified CQC in line with guidance.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider has not made sure that care and treatment of people was provided with the consent of the person and had not acted in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not ensuring that person centred care and treatment was meeting the needs of people and care plans had not all been updated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have sufficient guidance for staff to follow to show how risks were mitigated. The provider had failed to ensure that the shortfalls in the systems to keep people safe and reduce the risk of fire had not actioned. The provider had not ensured that medicines were managed safely. People were not receiving their medicines in line with the prescriber's instructions.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that the systems in place to quality assure the care being provided were not yet effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider was not ensuring that all staff received appropriate training to enable them to carry out the duties they are employed to perform. Staff were not receiving supervision or appraisal to discuss their training and development needs.