Care Quality Commission

Westcroft Care Limited

Westcroft Nursing Home and Domiciliary Care

Inspection report

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Ratings

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

Overall summary

We carried out this inspection on 14 December 2015 and it was unannounced. This visit was carried out following information received from the local authority safeguarding team about concerns relating to people's safety which they had found to be substantiated. Concerns had also been raised by other people who had come into contact with the service. The safeguarding incidents and other concerns related to poor moving and handling practices and the welfare of some people living with dementia in the home. We had also received concerning information regarding a number of people receiving domiciliary care; we found however that on the day of inspection only one of these people continued to receive domiciliary care from the provider. This was a comprehensive inspection.

The last comprehensive inspection took place in February and March 2015 and at that time there were no

Summary of findings

breaches of the Health and Social Care (Regulated Activities) Regulations 2014. There were however two recommendations made in relation to infection control and records.

Westcroft Nursing Home and Domiciliary Care provides accommodation and personal care for up to 21 older people. The domiciliary care service provides personal care to people in their own home. At the time of our inspection 16 people were resident at Westcroft Nursing Home and the domiciliary care service was providing personal care to 11 people.

At the time of the last inspection there were two registered managers in post; one for the nursing home and one for the domiciliary care 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 2008 and associated regulations about how the service is run.

On the day of this inspection there was no registered manager in place at the home; the manager in charge of the home had submitted their application to the Commission to become registered and was awaiting the outcome. This manager was unexpectedly called away from the home within the first hour of inspection. Senior staff and a representative of the provider were present. There was a registered manager in place for the domiciliary care service.

The overall rating for this service is 'Inadequate' and therefore the service is in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The home was not suitably safe and clean. The hygiene practices of staff did not meet the Department of Health guidance for the prevention and detection of infection.

The management of medicines within the home was not in line with best practice.

The provider did not have an effective system to monitor records made by staff or records that related to the management of the service. The absence of a robust governance system to ensure records were analysed and completed accurately by staff exposed people to risks of unsafe or inappropriate care or treatment

The systems in place for monitoring quality and safety were not sufficient to ensure that the risks to people were identified and managed.

Overall we found that quality and safety monitoring systems were not fully effective in identifying risks to people and the actions to be taken to reduce these.

Statutory notifications had not been made to the Commission for notifiable incidents.

People's rights were not being protected in accordance with the Mental Capacity Act 2005.

Training in the Mental Capacity Act 2005 had been provided, however staff knowledge about the protection of people's rights was variable. There was a lack of

Summary of findings

documentation to evidence that Deprivation of Liberty Safeguards applications had been made for people that lacked mental capacity (these safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty). These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely. There was a risk that people were being unlawfully deprived of their liberty.

We observed occasions within the home where people's care and dignity were compromised. People's independence was not being promoted through support with activities.

Care was not consistently person centred. Care plans were not personalised and did not contain unique individual information about people and references to their daily lives.

Risk assessments did not always reflect actions required to reduce the risk of harm to people. There were not sufficient numbers of staff within the home to support people safely.

Staff supervisions and training were not always undertaken as planned. There was a risk that people were being cared for by staff that were not competent for the role they were undertaking.

The provider had a complaints procedure which people told us they were aware of. However, not all people felt able to make complaints or felt they were resolved satisfactorily.

Appropriate recruitment procedures were undertaken.

People had access to healthcare professionals when required, and records demonstrated the service had made referrals when there were concerns.

We found seven breaches of regulations at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

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?

Inadequate

The service was not safe.

The home was not suitably clean and people were at risk from poor hygiene practices.

The administration of people's medicines was not in line with best practice.

There were not enough staff to meet people's needs promptly.

Staff were trained in safeguarding adults. The service had however failed to report safeguarding events when they occurred.

The provider's recruitment procedures were effective in ensuring only suitable staff were employed at the home.

Is the service effective?

Inadequate

The service was not effective.

The provider did not protect the rights of people living in the home in line with the Mental Capacity Act 2005

DoLS applications had not been made for those people that required them.

Staff did not demonstrate good knowledge of the legislation or the Mental Capacity Act 2005.

Records relating to people's care and treatment were not fully completed to protect people from the risks of unsafe care.

Staff supervision and training had not taken place as planned and records were not up to date.

Is the service caring?

Requires improvement

The service was not always caring.

We observed occasions where people's care and dignity were compromised.

Is the service responsive?

Requires improvement

The service was not responsive.

Care plans were not personalised and did not contain unique individual information and references to people's daily lives.

People were not supported in promoting their independence through activities.

Risk assessments did not always reflect actions required to reduce risks to people.

Summary of findings

There were systems in place to respond to complaints however not all people felt confident in using them.

People were supported to use healthcare services.

Is the service well-led?

Inadequate

The service was not well led.

Statutory notifications had not been made to the Commission for Notifiable incidents.

The systems in place for monitoring quality and safety were not sufficient to ensure that the risks to people were identified and managed.

The provider had failed to act on feedback from people for the purposes of continually evaluating and improving the home.

Westcroft Nursing Home and Domiciliary Care

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 December 2015 and was unannounced. The inspection was completed by three inspectors and an expert by experience. The expert by experience made telephone calls to people and relatives that used the domiciliary care service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed previous inspection reports and all other information we had received about the service, including notifications. Notifications are information about specific important events the service is legally required to send to us.

During the visit to the care home we spoke with five people who use the service and nine staff, including the registered manager for the domiciliary care service, nurses, care assistants and housekeeping staff. We spent time observing the way staff interacted with people who use the service and looked at the records relating to care and decision making for six people. The expert by experience spoke with five people or relatives of people receiving a domiciliary care service.

We looked at records about the management of the service such as the staffing rota, policies, incident and accident records, recruitment and training records and audit reports.

In addition to this whilst in the home we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us to understand the experience of people who could not talk to us.

Inadequate

Is the service safe?

Our findings

The Department of Health (DH) published guidance; The Health and Social Care Act 2008 Code of Practice On The Prevention And Control Of Infections And Related Guidance ("the Code") sets out the basic steps that are required to ensure the essential criteria for compliance with the cleanliness and infection control requirements under the Health and Social Care Act 2008 and its associated regulations.

The provider had not followed the DH code of practice; people living in the home were not always protected from the risk of the spread of infection because the provider did not maintain a clean environment that facilitated the prevention and control of infections.

In the kitchen of the home we observed that food storage was unhygienic and this put people at risk of eating contaminated food. The lunchtime meals were left uncovered on the work surface at 10.30am. There was a trifle on top of one of the fridges which we were told was to be disposed of. Inside the fridge, there were plates of food that were only partially covered with cling film and which had not been dated. This meant that staff were unable to tell when food had been put into the fridge. This put people at risk of eating food which had passed its usable date. In the freezer section, there was food debris on the bottom, the drawers were visibly dirty and there were opened bags of food which had not been re-sealed. In the food storage cupboard, there were dirty trays, the floor was dirty and had food debris on it. In the chest freezer, there were opened bags of meat that had not been closed to prevent contamination.

The utility room skirting boards were dusty and visibly dirty. The walls by the fridges and freezers were dirty. The utility room flooring was not clean and was torn in the area adjacent to the chest freezer, which meant it would be difficult to keep the area clean. In the main kitchen area, the shelves where pots and pans were stored were also visibly dirty. All of these areas prevented effective cleaning and could harbour germs that posed a risk of cross infection.

Although food temperature logs and freezer and chiller temperature logs had been maintained, it was not clear how the cleanliness of the kitchen was routinely monitored by the provider as there were no up to date infection control audits available.

Infection control audits were not being routinely undertaken. The latest audit that we saw was not dated and was incomplete. A staff member said they thought it was done during February 2015. The last completed audit was dated 16/09/2014 and referred to Department of Health guidance from 2010 which was now out of date. New guidance for the Prevention and Control of Infection in Care Homes was published in 2014. This meant the provider was not following the latest guidance and hadn't been for at least one year.

Senior staff told us that an environmental action plan was in place to address some of the cleanliness issues, but this had not been implemented on the day of the inspection. We showed a member of senior staff our findings in the kitchen and informed the provider. The kitchen was subsequently cleaned during the afternoon.

In the lounge of the home the carpet was stained in many places. One person was sat in a chair that was visibly dirty and stained, other lounge furniture was also dusty. The furniture had not been effectively cleaned and presented a risk of cross infection. In the ground floor bathroom, the bath enamel was chipped which meant it would be difficult to ensure it was thoroughly clean. Several pedal bins throughout the building did not work which meant staff and people would need to lift the lids by hand to dispose of paper towels after washing their hands. The carpet was also worn and torn at the top of the main staircase leading to the next floor.

There were two sluices in the home and there was a particularly strong and unpleasant odour in the main sluice room, which staff said had been present for several months. In the sluice room on the first floor there was a dirty toilet brush and holder, and the bedpans were stained. Neither sluice room was kept locked which meant there was a risk that people could gain access to harmful chemicals because the sluices were not secure. On one occasion we observed a member of staff carrying a used commode pot to the sluice; they were wearing one glove only and no apron. This demonstrated a lack of good hygiene practice or staff compliance in controlling and preventing the spread of infection.

Inadequate

Is the service safe?

There was one housekeeper on duty responsible for keeping the building clean. They said they were "not sure" if they had completed any infection control training. They said they did not work every weekend, which meant that on some occasions there was nobody responsible for housekeeping in the building on Sundays. However, they said they thought the building was "clean". They said the manager checked the building daily. There were cleaning schedules in place in the communal bathrooms; the schedules included a list of tasks that required a signature to show the tasks had been completed. We found that the cleaning schedules were not signed every day which indicated the communal bathrooms had not been cleaned every day. For example, in the first floor bathroom the schedule had not been signed on the 27th to 29th November, the 4th to 6th December and the 12th and 13th December 2015. This showed that the arrangements in place for monitoring cleanliness were not being consistently followed.

Two of the bedrooms that we looked at had stained carpets and one was malodorous. Although the room was being used by someone who was incontinent, an adequate cleaning schedule should ensure there are no odours.

All of these instances demonstrated a lack of cleanliness and infection control and prevention practices within the home. This exposed people to a risk of infection.

A person receiving domiciliary care told us that staff did not wear personal protective equipment such as gloves and aprons when delivering their personal care. This person told us they had been telling the service for months about the issue and was told that uniforms were going to be provided shortly. The person told us they provided the care staff with pinafores and insisted they wear plastic gloves during personal care. This was a failure of the management to prevent infection risk and contamination by ensuring personal protective equipment was used by staff.

These failings amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

Medicines were generally stored safely; however not all bottles of liquid medicines had been dated and signed to indicate when they had been opened. This meant there was a risk that people could be given medicines that had expired.

There were photographs of people in the medicines administration record (MAR) charts; however although these had been dated to indicate when they had been taken, some of the photographs were in excess of six months old. One photograph was taken in 2013 and was no longer an accurate representation of the person. This meant there was a risk that staff who were unfamiliar with people using the service might not be able to identify who they were.

When people had been prescribed PRN (as required) medicines, for example for pain relief, people were asked if they needed it. However, the reason for administering PRN medicines was not documented on the reverse of the MAR chart, which meant it was difficult for staff to identify any trends or common themes in relation to when people required this. This also meant there was a risk that some staff may not realise a person routinely required PRN pain relief at a certain time of day because it had not been documented.

These failings amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014).

There were not sufficient numbers of staff to support people in the home.

The senior staff told us that the staff numbers were based on the needs of people (dependency) and that more staff could be employed if the dependency need arose. The senior staff had carried out a needs analysis as a basis for deciding sufficient staffing levels. We looked at the dependency tool used by the senior staff and found that the information submitted to form the analysis was based on a scoring system for levels of individual people's dependency. We found however that the information used about people's individual levels of dependency for the tool did not correlate with the levels of dependency stated in people's care plans. It did not take into account the more complex information about people's needs or the building layout as required by the tool. These details would have increased the number of staffing hours calculated. The way in which the dependency tool had been used was not an effective way of calculating the number of staff required for the service to meet people's needs in a person centred way.

On the day of the inspection there were three care staff on duty in the morning and a nurse. In the afternoons there were two care staff on duty and one nurse. At night there

Inadequate

Is the service safe?

was one care staff member and one nurse on duty. The accommodation in the home was on two levels. The senior staff on duty explained that of the 16 people at the home, at least eight people required assistance to eat and that at least 12 people required two members of staff to assist them to mobilise; there was only one person in the home who was independently mobile. We were also told there were a number of people who were nursed in their rooms; it was not clear from looking at their care plans whether this was through the choice of the individuals concerned or for another reason. Many of these people were unable to tell us their views due to their level of dementia

We saw that at lunchtime two of the three care staff on duty were in the lounge supporting people to eat and serving the meals. A further member of care staff was assisting people in their rooms. This meant that if any person required the urgent assistance of two staff to use the toilet or for other emergency personal care the staff that were supporting people to eat would be required to stop and assist elsewhere. During this time we noted malodours in the home where people's continence needs were not being met. One person told us during the inspection "There's not enough staff. They come and change my pad every two hours; the staff said I can go in the pad three or four times before it needs changing". The level of staffing within the home did not ensure that people's needs were being met.

All of the home staff we spoke with described their roles in relation to tasks and told us they had little time to spend with people. Staff said "There's not always enough staff and then we aren't able to spend enough time with people" and "I think it would be beneficial if there was another member of staff around" and "It's difficult to help mobilise and assist people in the afternoon with just two staff if there is an emergency".

There was mixed feedback from people, staff and visitors on whether there were enough staff on duty in the home. Some people using the service were positive and said "The staff are very rushed, but if I ring the bell they come quickly" and "Yes, I think there is enough staff. I never have to wait". A visitor said "I feel there are enough staff on duty". However, some people were not as positive and said "The staff are very rushed, especially at night. They rush from bell to bell".

These failings amounted to a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the domiciliary care service made mixed comments about the staffing levels. People said that appointments were generally on time. One relative told us of a missed appointment but this had been resolved and had not occurred again. Another said their relative felt safe because the care staff were reliable, and "give or take 15 minutes" they turn up on time.

The staff had completed an assessment of people's risks and had recorded guidance on how to manage identified risks. The risk assessments showed that assessments had been completed for areas such as the environment, nutrition and falls. Levels of risk had been updated at reviews when people's level of risk had noticeably changed. In the nursing home, people's records did not always demonstrate people's risks were regularly reviewed. We raised concerns with the senior staff that some risk assessments and associated plans had not been updated on a monthly basis as required by the provider. The senior staff acknowledged that reviews should be undertaken as required by the care plan and told us that some reviews had fallen behind due to a change in manager and a change in the care planning system which was in the process of being changed from a paper to a computerised system of recording.

Staff knew the processes to follow if they were concerned about poor practice or the safety and welfare of people living in the home. Staff had received training in safeguarding adults and the prevention of abuse. Staff told us they knew how to identify abuse and their role in preventing abuse from happening. All of the staff we spoke with knew how to report any concerns and all said they were confident they would be listened to. One said "I would happily speak up if I was worried". We found however when incidents had occurred in the home which had later been substantiated by the local authority safeguarding team that these had not been reported by staff or the provider to the Commission.

Safe recruitment processes were completed before new staff were appointed. Staff had completed an application form and provided appropriate details for employment and character references. The files showed these references had been obtained. Proof of the person's address and identity had been obtained. A Disclosure and Barring Service (DBS) check had been completed for staff which ensures that people barred from working with certain groups such as vulnerable adults are identified. We saw

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Is the service safe?

evidence the recruitment process was effective. A potential staff member had failed to declare previous convictions during interview and these convictions were disclosed during the DBS process. The potential staff member who had been offered a post subject to references and a DBS check was not employed by the service.

Incidents and accidents were recorded and cross referenced to the care files of people involved in the incidents. We saw that preventative measures were also identified by the provider wherever possible in relation to falls.

Inadequate

Is the service effective?

Our findings

We found that pre-admission assessments were undertaken to gather information about a person's individual needs prior to their admission. These assessments were a pro forma document which covered a number of areas such as mobility, activities and continence. In the care plans we looked at some of these assessments were fully complete and others were lacking in any detail. We found that this corresponded with the quality of information within the eventual care plan.

The quality of person centred information was not consistent within the care plans. The provider did not maintain accurate, complete and detailed records in respect of each person using the nursing home and domiciliary care service. Care plans were not personalised and did not contain unique individual information and references to people's daily lives. There was no detailed information about people's life history or information about their family relationships. This meant there was a risk of people not receiving person centred care, because staff did not have the information available in relation to all of the people they were caring for. This is significant in a service for people with dementia as the information can aid staff in communicating and assisting reminiscence with the person. This information is of particular relevance when new staff are employed at the service to aid these staff in knowing and understanding people.

We also found instances where significant information relating to people's health needs was not recorded. For example there was no information within a care plan in relation to a person's catheter other than a record that the person had a catheter in situ. There was no information in relation to the type of catheter or its management. This meant that staff did not have access to information to ensure that the person's needs were met in relation to their catheter care.

These failings amounted to a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff said they had completed on line training in areas such as infection control, moving and handling and dementia. They said they felt they had the necessary skills to enable them to undertake their roles. We looked at the staff training records and matrix and found they did not match. Records had not been updated in line with the training required or undertaken and therefore it was difficult to establish whether staff had received the required training. We also noted there had been delays in ensuring that regular refresher training had been undertaken as required by the provider.

Prior to the inspection we had received information of concern relating to poor moving and handling practices within the home. People living in the home gave us variable responses in relation to how they were assisted by staff. We were concerned that two people felt that they were not handled safely. We discussed this with the senior staff during feedback following the inspection and also shared this information with the local safeguarding authority.

Moving and handling training had been provided to staff by the registered manager of the domiciliary care service. We asked to see information which verified that the registered manager was qualified to deliver this training. We were shown the training certificate for the registered manager but no further information which showed how they were qualified to deliver training to staff despite asking for further evidence. We were not assured that the provider had provided staff with training to enable them to carry out the duties they were employed to perform.

People also commented that communication with the nursing home staff was difficult as some did not have English as their first language. We spoke with some of these staff who were within the auxiliary, care staff and nursing staff. We found we were unable to make ourselves understood with some of the staff and could not establish how they would be able to fully understand and communicate with people living in the home particularly those living with dementia. Another member of staff was required to translate for us. A senior staff member we spoke with was not able to understand questions asked about care plans, DoLS, medicines and mental capacity. We raised this issue with the provider's representative who explained that the staff members identified were actively undertaking activities to improve their English. This did not however detract from the fact they were currently unable to understand questions we asked them about people's care or converse as would be expected with us and people living in the home. Some of these staff were unable to undertake their role effectively.

Inadequate

Is the service effective?

People using the domiciliary care service were mainly positive about the staff members' skills however one person felt that the staff were not well trained to carry out their duties. This person said "Only a few of my carers know what I need, I have to tell them and I shouldn't have to".

We were told by senior staff that all staff were supported through performance supervision and received an annual appraisal. Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff. Staff also had a personal development plan that helped to ensure annual objectives were set. Staff said they received supervision sessions, although they were not always sure when the last one was. One member of staff thought they had last been supervised in September 2015. We reviewed the supporting documents and found that supervisions for some staff were completed periodically and focused on performance and care delivery. It was difficult to establish if supervision sessions were being undertaken as planned as the supervision matrix record was incomplete. By checking staff individual records it was clear that some staff had not received supervision.

These failings amounted to a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not act in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS): Code of Practice and the Mental Capacity Act 2005 Code of Practice. Providers must at all times act in accordance with these Codes. Staff we spoke with had undertaken MCA and DoLS training but did not demonstrate a good knowledge of the legislation in relation to people living in the home. Some staff demonstrated knowledge of the Mental Capacity Act and how it related to consent to care, but not all. Some staff did not understand the link between mental capacity and being understood by people.

The provider did not protect the rights of service users living in the home in line with the Mental Capacity Act 2005. We saw that mental capacity assessments had not been completed for all people who lacked the mental capacity to make an informed decision, or give consent. We were told by senior staff that a number of people lacked mental capacity. We looked at the care plans of three of these people and found that there were no mental capacity assessments in place. There were also no examples of best interest decision making on behalf of service users who lacked capacity in relation to the delivery of their care.

We looked at the records of one person who was receiving their medicines covertly. This is when medicines are disguised in food or drink. The National Institute for Health and Care Excellence (NICE) guidance Managing Medicines in Care Homes 2014 states that the process for covert administration should include an assessment of the person's mental capacity, a best interests meeting, a documented record regarding the reasons for presuming mental incapacity, the proposed management plan, and regular reviews. Staff were not following this guidance.

There was no supporting documentation in place to assess the person's mental capacity or to evidence any discussions with the GP, the next of kin or the pharmacist. The medicines administration record (MAR) chart had been amended to state that tablets should be crushed and given with food. The involvement of a pharmacist is important when considering crushing medicines in order to ensure that the medicine's mode of action is not altered. This meant that the person's rights were not being protected because no assessment of mental capacity and best interest process had been followed. There was also the risk that the medicine was not working effectively if guidance not followed

These failings amounted to a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. We found that there were a number of people living in the home for whom DoLS should have been applied for; senior staff had told us that these people lacked mental capacity. However none of the senior staff were able to tell us for whom DoLS authorisations had been sought or where the records that related to these applications were. This meant there was a risk that people were being deprived of their liberty unlawfully.

These failings amounted to a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During meal times in the home we saw that there were a range of preferences and choices were made by people about what they wished to eat. Some people ate independently and some required full assistance Some people remained in their rooms for lunch, people in the

Inadequate

Is the service effective?

lounge area were sat in the lounge chairs eating from plates on side tables. We were unable to establish if this was the preference of the people as people were unable to tell us, although staff told us that this was people's choice. We observed however that people found it difficult to eat independently sat in the lounge chairs due to the height of the accompanying side tables on which their plates were placed. None of the people living in the home used the dining tables. There was very little social interaction between people and staff.

People had different hot and cold meals and choices of drinks. Where people had changed their mind from wanting the meal on the menu people told us that they could ask for an alternative.

People's opinions on the food were variable. One person said "The food is not very good; we get the same menu over and over again". Other people said "The food is quite good, we get a good choice and if you don't fancy it, they make you something else" and "The food is much better than it was. We get a good choice and get offered plenty of drinks".

Requires improvement

Is the service caring?

Our findings

People's dignity and respect were not always protected. We observed several examples of people's dignity being compromised within the home. Our observations over the lunch period found these resulted in mixed experiences for people. We saw a staff member supporting a person with their meal in an impersonal way. This staff member was assisting a person to eat, however there was very limited interaction and almost no communication during a seven minute period.

We also observed the same staff member approach another person who was sitting in a chair. The staff member removed the person's main meal plate (which the person had finished) and swapped this plate with a dessert. There was no interaction or conversation during this time. The staff member did not ask if the person wanted any more food or explain what the dessert was. The staff member simply swapped the plates and walked off with the dirty plate towards the kitchen.

People's support was not always discreetly managed by staff so that people were treated in a respectful way. We observed a person receiving support in the lounge of the home. A screen was put in place to protect the person's dignity however this was not done with attention and the person could still be seen receiving their care as the screen did not cover them.

We also observed positive interactions in the home from one member of staff who communicated well throughout a person's dining experience. Comments heard from the staff member included, "Have you finished that one" and, "Are you ready for some more." The staff member was also heard asking the person if their food was nice and tasty.

Task orientated routines and the way which staff were allocated did not allow staff to be as caring as they would like to be. Staff told us they knew the importance of ensuring people had choice in their day to day lives but said this was difficult to achieve given their numbers. Staff said "I really enjoy my job. I respect people and have been thanked by families for the way I treat their relatives".

People and relatives who used the domiciliary care service gave mainly positive feedback about the caring attitude of the staff. They told us that their privacy and dignity was respected when they received personal care. One person said "They always close the door to my bathroom when they give me a bath". Relatives said "One of the carers my relative has is very good. I'm not saying the others aren't but this one is especially" and "The care my relative receives is very good".

Requires improvement

Is the service responsive?

Our findings

Care and treatment was not always planned and delivered in line with people's individual care plans. In every care plan we looked at we found that reviews had not taken place as planned and that key information relating to people's health, lifestyle and preferences had not been recorded accurately or updated when required. We found that care plans had not been reviewed on a monthly basis in line with the provider's procedures; the plans we saw had sections within them which had been reviewed between one to three months however none of the care plans had been fully reviewed as required.

In one care plan we saw that a person used a personal aid; there was no detailed information in the person's care plan as to how this aid was to be managed, cleaned or looked after to ensure it worked correctly and efficiently for the person. This was despite there having been a concern raised by the person's relative that the aid was not being properly maintained by the staff.

People with pressure ulcers had care plans in place to guide staff in how to promote healing. These contained photographs of the wounds; we found however that some of the photographs were loose in the care file and undated, others were of poor quality and none had a measurement rule so that staff were able to see the size of the wound. Staff would not be able to assess these photos for signs of improvement. We also found that wound dressing records were not being made as required by the care plan. For example for one person daily recording of the wound care dressings was required. We found however the wound dressings were recorded sporadically one to three times a week and not as directed by the care plan. When we asked staff about this they told us that this was due to poor recording rather than the wound dressings not being changed.

Activities were available for people but not on a daily basis. Activities were not advertised in the nursing home and therefore there was no plan to which people could organise their day. During the inspection we spoke with the activities co-ordinator for the nursing home who worked part time five days a week; there were no activities at all on the weekends The coordinator said they worked during the afternoons as people were more alert then. They said they ensured people who preferred to stay in their rooms, or those that were unable to go to the lounge were not socially isolated because they provided 1:1 sessions each day. They discussed the type of activities available to people such as bingo, outside entertainers and carol singers and said that the local church minister visited regularly to run a service for people who wanted it. They showed us some reminiscing games they had recently purchased and said they hoped to be able to arrange some trips out in the new year if a driver could be arranged. During the inspection we observed them interacting with people, talking and doing puzzles.

We looked at the activities records for people who were unable to leave their bedrooms. We found that very little had been recorded in respect of activities provided by the home for these people. For example for one person we found that over the previous four week period they had not been involved in any activity other than a daily five minute visit from staff and their lunchtime meal when they were assisted with a meal; these were both recorded as an activity. We also found that this person's social isolation part of their care plan had not been reviewed as required in March 2015 and did not take into account their current isolation.

We looked at another person's activities records and saw that time spent by staff performing checks on people was counted as an activity. We found that activities were not monitored by the provider for their suitability or for their provision particularly for people who were nursed in bed. People's social needs were not being met.

These failings amounted to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a complaints procedure which provided information about how to escalate a complaint should the complainant not be satisfied with the investigation by the service. We reviewed the complaints record within the service that showed a total of nine separate formal complaints had been received during 2015. The provider had responded to these complaints to reach a resolution in line with their policy. We saw evidence that these complaints had been responded to in writing, and also that on occasions, people and their relatives had been involved in meetings with senior staff to resolve a complaint. Everybody in the home we spoke with confirmed they knew how to complain. However two people told us they did not feel confident enough to complain about poor care they had received.

Requires improvement

Is the service responsive?

There was a mixed response from people and relatives who used the domiciliary care service. One relative of a person receiving domiciliary care told us they had been concerned about an issue in their relative's house. They had asked the care staff about this but told us the staff member seemed to be "lost in her own thoughts". The relative said that the issue had now been resolved but that they had to complain two or three times to the service for the complaint to been sorted out. Another person told us that they had an ongoing complaint with the service which had not been resolved for months. A relative also said "We have not used the service long but we've no complaints, in fact it's the opposite, they are very good".

People were supported to use healthcare services. People had regular health reviews with their GP and other healthcare professionals. People had regular access to a dentist, opticians and chiropodists when they needed to. People could see their GP when they needed them. We saw within everyone's support plan that regular visits or appointments with dentists, opticians and chiropodists happened when required.

Inadequate

Is the service well-led?

Our findings

There had been no registered manager in place at the home since mid September 2015**.** A new manager had been recently employed and had applied to be registered with the Commission.

All services registered with the Commission must notify the Commission about certain changes, events and incidents affecting their service or the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. We had not received statutory notifications in relation to safeguarding including allegations of abuse and neglect. The provider had failed to report a number of incidents that the local authority safeguarding team had investigated, as statutory notifications to the Commission. This meant that the Commission had been unable to monitor the concerns and consider any follow up action that may have been required.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

The provider's quality assurance systems and processes did not ensure that they were able to assess and monitor the quality of the service and mitigate the risks relating to the health, safety and welfare of service users.

A number of the shortfalls at this inspection related to matters which had been brought to the provider's attention on previous occasions. The provider had failed to act on the risks that had been identified. These related to key aspects of the service, such as infection control and the maintenance of accurate records. At the last inspection, two recommendations were made in respect of infection control and checking that care plans were up to date and contained sufficient information for staff to be able to meet people's needs. We found however that neither of these recommendations had been completed to a satisfactory standard.

There were some systems in place within the home to monitor quality and safety, however these had not been fully effective in ensuring consistent and good quality care was delivered throughout the service. We looked at an action plan dated December 2015 which had been produced by the provider and the senior staff and which included areas monitored such as health and safety, recruitment and quality assurance. The staff were unable to find the previous action plan. The audits which fed into the action plan were intended to be completed on a monthly, quarterly or annual basis according to the type of audit. We found that the audits had not been undertaken within the timescales set by the provider and had not identified all of the shortfalls in the service provision so that action could be taken to rectify these.

The audits of home cleanliness and infection control had not raised the concerns which were prevalent across the home. No infection control audit had been completed in full since September 2014.

During the inspection senior staff were unable to provide us with the latest medicine audit and we were told this would be sent to us. We did receive this or any other information which evidenced that there was a system in operation to monitor how medicines were being managed.

The provider did not have an effective system to monitor the quality of people's care records and ensure the service held current and accurate records about people. Records did not always contain enough information about people to protect them from the risk of unsafe care. There was a failure to identify recording errors and omissions in the care records and to analyse concerns as highlighted in this report.

We were told by the senior staff that daily records were monitored to ensure that changes in people's behaviour and health were analysed to prevent issues and poor recording from occurring. We found however these checks were not recorded and had failed to pick up on the poor recording we found. The absence of a robust governance system to ensure records were analysed and completed accurately by staff exposed people to risks of unsafe or inappropriate care or treatment.

The provider had failed to act on feedback from people for the purposes of continually evaluating and improving the home. Annual customer satisfaction surveys were sent out to the people using the service and their family and representatives. The last survey had been sent out in June 2014. At the time of our inspection a further annual survey was in the process of being sent out 18 months since the last survey; the provider's representative told us there had been a delay due to the change of management in the service. Residents and relatives' meetings were also due to be held every six months for people living in the home. We noted however there had been an eight month gap

Inadequate

Is the service well-led?

between meetings; we were again told this was due to a change in the management of the home. The surveys and meetings were to provide people and their relatives with an opportunity to discuss their concerns and raise issues. The surveys and meetings had received a good response and a number of issues had been raised. We found however the provider had failed to initiate actions as a result of these processes. We looked at an action plan produced as a result of the surveys and meetings dated January 2015 and found it was incomplete and did not have set timescales for completion. We checked with the staff and found that the actions had not been completed. This meant that the provider had failed to ensure that the progress of actions were reviewed and these were met in a timely way.

These failings amounted to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that the manager and provider would listen to their views and that they felt able to raise concerns or issues. People living in the home and visitors were aware that a new manager was in post. They knew who they were and what their name was and all said they'd met them. One person said "I've met the new manager and they seem to be very dynamic" and another said "The new manager seems really nice".

People using the domiciliary care service told us that registered manager was approachable if they were contacted.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). Safe care and treatment.** **Medicines were not managed in a safe way.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). Staffing** **There were not sufficient numbers of staff to support people safely.** **The provider had failed to provide staff with supervision and training.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). Person Centred Care** **People's care was not planned in a person centred way.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

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 Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). Good governance. The provider had failed to assess, monitor and improve the quality and safety of the service provided to people. The provider had failed to assess, monitor and mitigate the risks relating to people's safety and health. The provider had failed to seek and act on feedback from people and staff for the purposes of continually evaluating and improving the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents. The provider had failed to make appropriate notifications.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). Safe care and treatment. The home was not suitably clean and people were at risk from poor hygiene practices

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). Need for consent. The provider had failed to act in accordance with the Mental Capacity Act 2005.

The enforcement action we took: