Mr Amin Lakhani

Glen Heathers

Inspection report

48 Milvil Road, Lee-on-Solent
Hampshire, PO13 9LX
Tel: 02392 366666
Website: www.saffronlandhomes.com

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Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection of this home on 24, 25 March and 2 April 2015. Multiple breaches of the legal requirements were found in relation to the safeguarding of people, the requirement to notify CQC of incidents, failures to ensure adequate numbers of staff who were appropriately supported and trained, and a lack of robust quality assurance. We issued warning notices requiring the registered provider to be compliant by 4 June 2015 for breaches in the standards of care and welfare for people who used the service, the unsafe management of medicines, the manner in which people were treated and a failure to ensure consent was gained and where appropriate the Mental Capacity Act 2005 was applied correctly.

We undertook this focused inspection on the 30 June 2015 to check the provider had taken action and met the legal requirements in relation to the warning notices served. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Glen Heathers on our website at www.cqc.org.uk.

A registered manager was not in place at the time of this inspection. 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

Summary of findings

Act 2008 and associated Regulations about how the service is run. The registered manager stopped working at the home during our last inspection. The provider has been recruiting for a person to become the registered manager since this time.

At this inspection we found the registered provider had made some improvements to standards of care they provided but had not met all the requirements of the warning notices and remained in breach of two regulations.

Care records had been individualised and plans of care provided clear detail about people's needs and any risks associated with these. People and their relatives confirmed they were involved in care planning and staff had discussed with them their needs, wants and wishes. Handover records contained information to support nursing staff, and care staff said they were kept informed of peoples changing needs during shift handovers. Further work was required to ensure people continued to be involved in the planning of their care and embedding and sustaining this practice.

Whilst the risks associated with people's care had been assessed and detailed plans were in place to reduce these, we observed that not all staff followed these. Medicines were managed in a clean and tidy environment, however we still found gaps in the recording of medicines and there was no evidence these had been investigated. Liquid medicines and some creams had been opened without noting the date of opening making it difficult to determine when they should be disposed of. Records of the temperature checks of medicine storage facilities were inconsistent and did not show these took place daily.

Staff had a good understanding of safeguarding people from abuse. They knew what to monitor for and who to report concerns to. They were confident to raise concerns and would report to the local authority directly if needed. The provider reported any concerns of a safeguarding nature to the relevant authorities.

There was evidence people's consent was sought. Staff knowledge and understanding of the Mental Capacity Act 2005 had improved and we saw assessments of people's capacity had been undertaken and best interest decisions had been completed. However, there was still further work to be done to ensure the Act was applied correctly at all times. Action had been taken to address concerns about the use of locked doors within the service. Keypad locks had been disabled and access to a garden was freely available to all people if they chose to use this area. Staff had received training about what may constitute a potential deprivation of liberty and had a good understanding of this.

Care plans which related to people's nutritional needs had improved and were more individualised. Further work was needed to enhance these plans and ensure monitoring of nutritional intake was effective. We have made a recommendation about the planning and monitoring of people's nutritional intake.

Our observations of how people were supported by staff were mixed. We saw some staff treated people with dignity, respect and kindness, whereas other staff demonstrated a lack of respect and consideration of people.

We found 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 this report.

At the last comprehensive inspection this provider was placed into special measures by CQC. This inspection found that there was not enough improvement to take the provider out of special measures.

CQC is considering the appropriate regulatory response to resolve the problems we found.

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.

Risk associated with people's needs had been assessed and detailed plans of care were in place. However, these were not always followed by staff.

Medicines were stored in a clean environment, however temperature checks were not consistent and gaps in the recording of medicines continued with no evidence these had been investigated.

Staff had a good understanding of safeguarding people and their responsibilities. They knew what action to take if they had concerns and the provider was reporting concerns of a safeguarding nature to appropriate professionals.

Is the service effective?

Requires improvement

The service was not always effective.

Staff understanding of the Mental Capacity Act 2005 and the need for consent had improved although further work was required to ensure this was embedded and sustained.

Action had been taken to address concerns about the use of restraint in the form of locked doors. Staff had received training about what may constitute a potential deprivation of liberty and had a good understanding of this.

Care plans regarding nutritional needs had improved and we saw times when action was taken due to concerns. Further work was needed to enhance these plans and ensure monitoring of nutritional intake was effective.

Is the service caring?

Requires improvement

The service was not always caring.

We saw some improvements in the way people were treated but this was not consistent. Some staff demonstrated kindness and respect. They encouraged people's independence and gave good, clear explanations and guidance to people.

At times people's privacy and dignity was not maintained or respected. Some staff spoke to people in an inappropriate manner.

Is the service responsive?

Requires improvement

Care records had been individualised and plans of care provided more detail about people's needs and preferences. Handover records had improved and provided more guidance to staff. Staff had a better understanding of people's needs at this inspection.

Summary of findings

People and their relatives confirmed they were involved in care planning and the provider had introduced a “This is me document” to gather information about people’s preferences.

Further work was required to ensure care planning and involvement of people was embedded and sustained in the home.

Is the service well-led?

The provider was meeting the requirement to notify CQC of incidents that occurred in the home.

No other areas of this question were reviewed at this inspection and the rating has not changed from the previous inspection.

Inadequate

Glen Heathers

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of Glen Heathers on 30 June 2015. This inspection was undertaken to check that improvements to meet legal requirements had been completed by the registered provider after our comprehensive inspection of the service on 24, 25 March and 2 April 2015.

The service was inspected against elements of the five questions we ask about services: Is the service safe, effective, caring, well-led and responsive? This is because the service was not meeting some legal requirements that related to each key question. However, not all elements of every question were inspected.

The inspection team consisted of two inspectors and an expert by experience in the care of older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In addition the inspection was supported by a nurse specialist advisor who had specialist knowledge in the care of frail older people, in particular people who lived with dementia and those with end of life care needs.

Before our inspection we reviewed the information we held about the home, including previous inspection reports. We reviewed notifications of incidents the provider had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law.

We spoke with eight people who lived at the home and five relatives to gain their views of the home. We observed care and support being delivered by staff in all areas of the home. We spoke with the general manager and eight members of staff, including two registered nurses and care staff. We looked at the care records for 13 people who lived in the home and the medicines administration records for everyone who lived in the home. We also looked at records of staff meetings, training and some audits the provider had undertaken since our last inspection.

Inadequate

Is the service safe?

Our findings

During our last inspection on 24, 25 March and 2 April 2015 we found that the management of medicines was not safe. Gaps were found in the recording of medicines with no evidence these had been investigated. Medicine storage rooms were very hot and the temperatures were not being checked meaning we could not determine if medicines were stored safely. Liquid medicines had been opened and not dated meaning it was difficult to determine when these should be disposed of. Expiry dates were not checked and we found medicines that were out of date. Medicines prescribed to be given on an as required (PRN) basis were being given regularly and the staff at the home had not requested this be reviewed by a GP. Prescribed medicine labels had been removed and then the medicine was being used as a homely remedy. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice to the provider requiring them to be compliant with this regulation by 4 June 2015.

At this inspection people and their relatives told us they felt safe. They said they received the medicines when they needed it and that permanent staff had a good understanding of their needs and the support they required. Whilst we received positive feedback from people our observations and findings did not reflect that the service was always safe and the provider remained in breach of the regulation.

Medication administration record (MAR) sheets showed gaps in the recording of medicines for seven people. There was no recorded explanation to identify the reasons for these gaps. The Registered Nurse was not able to tell us why there were gaps and when we highlighted this to the general manager they did not offer an explanation. Rooms for the storage of medicines in the home had been relocated and were clean and tidy. Thermometers had been placed on the walls to support staff to monitor the temperature of the room that medicines were stored in and ensure this was within a safe range. A record book was in place to check the temperatures of rooms containing medicines fridge's every day, however this was inconsistently carried out. For 26 days during 25 April 2015 and 28 June 2015 the room temperature had not been recorded and for 21 days between 21 April 2015 and 28 June 2015 the medicines fridge temperature itself had not been recorded. Neither of the registered nurses we spoke with could tell us the actual temperature of the fridge as they said they did not know how the thermometer worked. The medicines audit conducted on 27 May 2015 stated that the temperature inside the fridge was monitored and recorded. However we found no entries for 21 and 22 April and no entry for 5 days in May prior to this audit. This audit was not effective in ensuring that medicines were stored safely. As at the previous inspection, we continued to find that bottles of opened liquid medicines and tubes of creams had not been dated when opened to allow staff to identify when they should be disposed of, despite the providers policy stating this should happen. The nurse on duty was not able to tell us when the medicines had been opened. The failure to follow the guidance provided meant medicines that may require disposing of were still being used as the date of opening could not be determined. People were at risk of receiving medicines that may not work as prescribed as there was a risk they had been stored and used incorrectly.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The nurse on duty told us that nurses check the expiry dates of medicines on each medicines round but they did not record these checks. We found no medicines out of date at this inspection. Homely remedies were in place and approval from GP's for individuals had been sought. No labels had been removed from prescribed medicines. Medicines stock received to the home were recorded on people's individual MAR sheets. Controlled medicines were stored and recorded appropriately.

During our last inspection we found that risks associated with people's care were not managed safely. This was a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponded to Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014. We issued a warning notice to the provider requiring them to be compliant with this Regulation by 4 June 2015.

At this inspection we found improvements had been made to the care records for people. Where there were risks associated with people's needs these were clearly identified and plans of care provided detailed information

Is the service safe?

about what staff should monitor for and the action they should take. However, these were not consistently adhered to by staff. For example, for two people whose care records identified a specific need in relation to their eating and drinking ability, staff were seen not to follow these. One person's care plan clearly detailed they received a pureed diet however they were not provided with a pureed diet and the kitchen staff were not aware of this. The kitchen staff said they were receiving a soft diet, however the meal provided would not constitute a soft diet. The staff attempted to provide this meal, however the person refused it. The failure to adhere to the plan of care placed the person at risk of choking.

For a third person their care plan indicated they were at risk of falls. The plan of care was clear about the actions staff should take to ensure this risk was minimised, including ensuring appropriate footwear. However we observed a staff member supporting this person to another area of the home. Whilst the person was in a chair with wheels we noted they did not have any footwear on. The evaluation of this person's care plan also stated that a falls alarm mat was in use. We visited this person's room on two occasions. On one occasion they were seated in their arm chair and this alarm mat was folded up and placed on the bedside cabinet. The second time the person was seated in the lounge and the alarm mat was folded up and placed on the bedside cabinet in the person's room. We spoke to the General Manager about this who stated the alarm mat was only used at night. The care plan did not reflect this and we were not clear why this would only be used at night when an accident record dated 26 April 2015 showed this person had fallen during the day when standing up from a chair.

The failure to adhere to plans of care to reduce risks for people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had been made in others areas. For example, people who had a diagnosis of diabetes had clear plans in place guiding staff about how to monitor this condition and the actions to take if any concerns arose.

Where people required the use of equipment to keep them safe in bed, for example, bed rails, care plans had been devised and these identified the risks associated with using the equipment. Staff told us how they checked the equipment each time they entered the room and when people were in bed. Whilst they told us how they checked the equipment to ensure its safety, no formal records of these were kept. Moving and handling practices had improved and staff were seen to be using equipment safely, supporting people in a competent manner. Staff we spoke with had a good understanding of how moving and handling risks should be managed. Where people displayed behaviours which may pose a risk, we saw that care plans were in place which identified the behaviours and the approach that staff should take to support them and minimise any risks.

At our last inspection the provider was not adhering to their own policy in relation to the reporting of safeguarding concerns to relevant other authorities. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponded to regulation 13 of the Health and Social care Act (Regulated Activities) Regulations 2014. We issued a requirement action.

Since our last inspection we had received information from the service that demonstrated they had reported concerns of a safeguarding nature to other appropriate professionals for investigation, including the local authority team and the police. Staff had a good knowledge of safeguarding and Whistle blowing. They knew their responsibilities for keeping people safe and identifying any concerns to the nurse on duty or a manager. One told us "[The general manager] would listen to us if we had a concern, I would not hesitate to report any concerns if one of the seniors or nurses did not listen to me and the owner is also around so there are loads of people to talk to. If they did not listen I would follow the Safeguarding Policy and refer the situation to the local Safeguarding Team, I would be nervous but I would still do it". The provider was now meeting the regulations with regard to safeguarding.

Requires improvement

Is the service effective?

Our findings

During our inspection on 24, 25 March and 2 April 2015 we found the provider had not ensured people's consent was gained and where required that staff understood and correctly applied the principles of the Mental Capacity Act 2005 (MCA). This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponded to Regulation 11 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice to the provider requiring them to be compliant with this regulation by 4 June 2015.

At this inspection we found improvements had been made. The provider had introduced consent forms for various aspects of the care including consent to care planning, the use of bed rails, photos for care purposes and photos for activities. People who had the capacity to provide this consent had been asked to do so and we found signed consent forms in their records.

People we spoke with and their relatives told us people were asked for their consent and staff ensured they did this before undertaking any care. Observations showed when staff approached people to undertake any aspect of care or support they asked for consent by saying, "Is it alright if we…". Staff then gave an appropriate explanation and waited for the person to respond.

We saw that people's capacity to make decisions had been assessed and best interests decisions had been recorded but this was not always consistent. For example, for one person their family member had signed a consent form regarding their care plans. No capacity assessment had been undertaken to determine the person's capacity to make this decision themselves and the family member did not hold the legal authority to provide consent to this particular area of need. A second person had been assessed as lacking the capacity to consent to the use of bed rails. Best interest decisions had been recorded. However, a family member had signed consent forms for the use of photos for one of these people but no assessment of the person's own capacity to make this decision had been undertaken.

For a further two people who had been assessed as lacking the capacity to consent to the use of bed rails, best interests' decisions had been recorded. Care plans had been developed for the use of their bed rails. For a fifth person, we saw they had been assessed as lacking the capacity to consent to their care plans and with the involvement of a family member a best interests decision had been taken that the care plans were appropriate to meet the person's needs.

Staff understanding of the Mental Capacity Act 2005 had improved and they were able to tell us what this meant and their responsibilities within this. They told us, and we saw, that training had been provided for staff to improve their understanding in this subject and further training was booked. In addition a staff member showed us pocket sized laminated copies of the Mental Capacity Act 2005. They told us that each member of staff was provided with one of these to keep on them at all times to refer to in case of any doubt.

Whilst improvements had been made and the provider was now meeting the legal requirements in relation to regulation 11 further embedding of the application of the MCA 2005 was required.

At our last inspection the provider was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponded to regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014. The use of restraint was not monitored. Some people were living in a locked area of the home and it was unclear why this was needed. We issued a requirement action.

The provider's action plan told us they had taken action to address this concern. We saw the keypad code to the door that locked this area had been disabled. This meant people were able to open the door and leave this area to enter the main house if they chose to do so. Access to the garden was previously prevented as one set of doors did not open and the other set of doors opened but led to a small area where access was blocked by trellis. At this inspection we saw that access to the garden was freely available to people should they choose to enter it. Staff understanding of what constituted restraint and a potential deprivation of liberty had improved. One said a Deprivation of Liberty Safeguard (DoLS) is "a way of making sure we do not restrict people by doing things like locking them in". The provider was now meeting the legal requirements in relation to regulation 13.

Requires improvement

Is the service effective?

During our inspection on 24, 25 March and 2 April 2015 the plans of care for meeting people's nutritional needs were not personalised and the monitoring of these were ineffective.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponded to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice to the provider requiring them to be compliant with this regulation by 4 June 2015.

At this inspection we found care plans in place to meet people's nutritional needs provided information about their likes, dislikes and preferences. They gave guidance about the person's abilities to manage their own nutritional needs and any support they needed.

Staff knew they were required to report any concerns about people's nutritional intake to the nurse on duty and said the nurse would take the necessary action to address any concerns about people's intake or weight.

People's food and fluid intake was monitored if required however, care plans and monitoring charts did not contain specific information about the person's ideal food intake. The records of the amount of food people had consumed which had been recorded was not clear and this made it difficult to establish a person's actual intake. People's weight was monitored regularly and we saw times when staff took action if they were concerned. For one person we saw staff had written to the GP requesting a referral to the dietician due to weight loss. They had been prescribed nutritional supplements and staff were monitoring their food and fluid intake. The food and fluid intake monitoring for this person was poorly recorded. No target food or fluid intake was recorded on either the monitoring chart or the care plan and it was not clear they were receiving the supplements as prescribed, however their weight was checked regularly and showed this had increased.

However, for a second person we noted that their care plans stated staff would refer to the GP or dietician if they lost a significant amount of weight. No guidance had been provided about what would be considered a significant weight loss and the weight record for the month of June 2015 showed they had lost weight. We found no record to indicate that contact with the person's GP had been made since this weight record had been taken. A food chart was in place but the records did not support effective monitoring as they did not provide a clear indication as to what and how much had been consumed.

We recommend the provider seek advice from a reputable source about the effective planning and monitoring of people's nutritional needs.

Requires improvement

Is the service caring?

Our findings

During our inspection on 24, 25 March and 2 April 2015 we found people were not always treated with dignity and respect. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponded to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice to the provider requiring them to be compliant with this regulation by 4 June 2015.

At this inspection people said they were treated with dignity and respect by staff who were kind, caring and listened to them, and people's relatives also said this. However whilst our observations of how people were treated showed some improvements since the last inspection, this was not consistent and people were not always treated with dignity and respect. We continued to have concerns and our findings did not reflect the service was always caring. The provider remained in breach of the regulation.

We saw examples where staff treated people with dignity, respect and supported their independence. When one person required support to mobilise, staff spoke clearly to them, in a kind and caring manner. They provided good explanations about what was happening and offered reassurance throughout. On another occasion we saw a staff member supporting people into their wheelchairs. The people we observed did not appear to have a great deal of strength in their legs or their arms. The staff member offered the Stand Aid to the person (A stand aid is a piece of equipment that helps a person to stand and mobilise safely) but each time this was refused. The people moved themselves safely but it took a great deal of time. We spoke to the staff about this who told us "they both have full capacity and are both independent, they want to do as much as they can for as long as they can so although it takes ages, I can just support and advise them the best way to move that is also the safest. I think it's important to help people stay as independent as possible". Staff provided clear explanations to people about the food they were eating and offered choices about drinks and the use of clothes protectors. We observed staff knocking on doors before entering, introducing themselves and engaging in conversation with people while checking they were ok.

However, our observations reflected that the support given was not consistent and staff did not always talk to people in a dignified manner. For example, on one occasion we observed a member of staff supporting a person to eat their meal. As the staff member was placing the spoon to the person's mouth they said "num num num" as if they were talking to a child. Throughout the lunch period we observed a member of staff approach a person who was being supported to eat their meal. The member of staff said to them, "Isn't she sweet, what a lovely smile". Whilst the person responded to these comments by smiling, it can be undignified and disrespectful to talk and refer to a person by their gender when talking to them instead of using their name as it risks patronising the person.

On another occasion we heard a discussion between a member of staff and a person. The person asked if they were going to have a bath and the member of staff stood in front of them swaying their arms and body, saying "I'm not giving you a bath, I'm not giving you a bath". The tone of voice used and the body language of the staff member was patronising and disrespectful. We spoke to the general manager about this who told us it would have been 'banter'. Banter is the playful and friendly exchange of teasing remarks. However, the person's facial expressions and body language did not indicate they saw this as 'banter'. The person was not smiling or laughing and they appeared uncomfortable. On another occasion we observed this staff member support a person who was using the toilet. When they approached this person whilst they were using the toilet they opened the door leading to the hall where the bathroom was and then the bathroom door, meaning this person using the toilet was on view to people seated in the dining room initially. This risked compromising the person's privacy and dignity. The second time they approached this person they closed the door leading to the hall before opening the door to the bathroom.

We heard a member of staff shouting a comment. When we approached the member of staff they told us they had shouted at another member of staff for making an inappropriate comment about a third staff member. This took place in front of people who were living with dementia and the staff members showed a lack of consideration and respect to the people living in the home during this apparent confrontation.

The lack of respect shown by staff to people was a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service responsive?

Our findings

During our inspection on 24, 25 March and 2 April 2015 we found people had not been involved in the planning of their care. Care plans contained very little information about people's likes, dislikes and preferences. There were identified areas of need but no plans of care developed to ensure staff could monitor and meet these needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponded to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a warning notice to the provider requiring them to be compliant with this regulation by 4 June 2015.

At this inspection, the provider was now compliant with the regulation. However, whilst improvements had been made to the planning of individualised care and in ensuring people were involved in their care planning, further embedding of this was needed to ensure consistency and sustainability.

People said they felt supported by staff who understood their needs and knew how to provide their support. However, they did indicate that the support provided by agency staff was not as good. One said "Some agency staff are a bit rough". Another said they felt agency staff could benefit from more training. Staff's knowledge of people had improved and they told us they had access to up to date care plans if they needed these. The provider had changed the system used for staff shift handovers. They had introduced a document which contained information about people's diagnosis and needs. Care staff told us handovers happened at every shift change over and this provided them with up to date information about people's needs. When we spoke to staff about specific needs for people they were able to describe these and the action they would take to meet such needs, which we saw was outlined in people's care plans.

At the last inspection nurses were responsible for compiling care plans but had not received the training to support them to do this. The provider's action plan supplied to us following the last inspection told us that nurses and senior staff had received training in care planning and the general manager confirmed this had taken place and guidance sheets were provided. The general manager said they had sat with nurses to review and update all care plans in the home since our last inspection. We found care plans had improved. They were more personalised, detailed and included the correct information about people's names and gender. They included information about people's preferences and how to support them to make day to day choices.

At the last inspection we found that areas of need identified during a pre-admission assessment had not been planned for. No further admissions to the home had taken place since our last inspection so we could not establish if any improvements had been made to the pre admission assessment process. However, we did not find any gaps in the plans of care for people. Where a need was identified a plan was in place.

People had not always been involved in their care planning previously. Since our last inspection the provider had introduced a document titled "This is me". This is a document which is used to gather information from people and their relatives about people's needs, preferences, likes, dislikes and interests. The general manager told us people who were able to complete this with the support of staff were encouraged to do so and those who were not able to contribute to these had been passed to family for their input. Not all of these had been returned by family members at the time of our inspection. The general manager told us these were used to support the development of plans of care and gather information about people's preferences.

Care staff told us how they provided information to nurses to help inform the review of care plans. They said nurses would review care plans monthly and hold 6 monthly reviews with people. People and their relatives told us they were involved in discussing and reviewing care plans. One person told us staff had recently been discussing with them what they liked and wanted from staff at the home. One relative told us they reviewed their relative's care plan regularly, another told us they had been involved in discussions about their relative's medicines and end of life care choices.

Inadequate

Is the service well-led?

Our findings

During our inspection on 24, 25 March and 2 April 2015 the provider was not meeting the legal requirements in relation to notifying CQC of incidents that occurred within the home. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We issued the provider with a requirement action.

Following our inspection in March/April 2015 we had received notifications of incidents including issues of a safeguarding nature and of serious injury. The provider was now meeting the regulations with regard to notifications.

We did not plan to assess any other evidence with regard to well-led as a part of this inspection and did not look at any other areas that related to the question “Is the service well-led?”. As such the rating is unchanged.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Service users were not treated with dignity and respect at all times.** Regulation 10(1)(2)(a)

The enforcement action we took:
A Warning Notice was served on the Provider requiring them to be compliant with this Regulation by 14 August 2015. A further
inspection will be carried out in due course to ensure the provider has met the requirements of this notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered provider had not ensured the proper and safe management of medicines. Care was not always provided in a safe way because staff did not adhere to plans which reduced risks to people.** Regulation 12 (1)(2)(b)(g)

The enforcement action we took:
A Warning Notice was served on the Provider requiring them to be compliant with this Regulation by 14 August 2015. A further
inspection will be carried out in due course to ensure the provider has met the requirements of this notice.