Larchwood Care Homes (South) Limited

Cams Ridge

Inspection report

7 Charlemont Drive
Cams Hill
Fareham
Hampshire
PO16 8RT

Tel: 01329238156

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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**

Summary of findings

Overall summary

This comprehensive inspection took place on 12 and 14 July 2016 and was unannounced. We bought this inspection forward as we had received some information which caused us concern, including information provided to us by the service. The last inspection took place in February 2015 when we rated this service as requires improvement.

Cams Ridge provides accommodation, support and nursing care for up to 46 people, however it is registered to provide support to 51 people. The people living at the home have complex nursing needs and some live with dementia or other cognitive impairments. There were 35 people living in the home on the first day of our visit and 33 on the second day. The home is built on two levels and there is a lift between the floors. There are four communal areas where people can socialise and eat their meals if they wish.

A registered manager was in place. 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.

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

Feedback from people living at the home was mixed, although they said they were happy living there. Some

were concerned that there were not always enough staff to meet their needs and some felt not all staff knew them well.

Staff lacked knowledge and understanding of people's complex health needs and the risks associated with these. Care records lacked information about risks associated with people's needs and health conditions. Some of these risks could have life threatening consequences so the lack of guidance and knowledge placed people at serious risk of harm. Where people were losing weight action had not been taken to identify the cause of this or plans developed to address this. We referred these concerns to the local authority safeguarding team.

Medicines were not always managed safely. Temperature checks were not consistently undertaken. As required medicines lacked clear guidance and gaps in recording could not be explained.

Staff awareness of safeguarding adults at risk was good and they said they were confident that the manager would respond appropriately to any concerns. However, we found records which indicated possible safeguarding concerns that had not been identified.

People's needs were assessed prior to the moving into the home however, this information was not used to inform care plans and people were not aware of their care plans. Care plans lacked personalised information so whilst staff knew people's preferences this was open to personal interpretation.

Staff lacked an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The MCA 2005 had not been correctly applied in practice. Staff lacked the support of formal supervisions and effective training to guide them in their roles.

Feedback from people and their relatives about the care staff provided was mixed. Whilst staff were described by some as kind and caring others did not always feel valued and listened to. We have made a recommendation about this. Some people told us of concerns they had but we could not find records of how these were managed. Other records showed complaints were investigated and responses provided. Whilst staff felt the registered manager was approachable and listened to them, the registered manager demonstrated a lack of understanding about what was happening in the home. System used to assess quality and drive improvements had not been effective and some records were not accurate, complete or up to date.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff lacked knowledge of the risks associated with people's needs and guidance was not always available to them. Medicines were not managed safely.

Whilst staff understood safeguarding, records which demonstrated concerns had not been investigated.

Staffing levels were sufficient to meet people's needs and recruitment practices were safe.

Is the service effective?

Inadequate

The service was not effective.

Staff lacked the support of formal supervisions and effective training to guide them in their roles.

Staff lacked an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The MCA 2005 had not been correctly applied in practice.

The service could not demonstrate that concerns regarding people's nutritional status were monitored and managed effectively.

People had access to other professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

People provided mixed feedback about the care they received, some describing this as kind and others described how they had felt undervalued and not listened to. We have made a recommendation about this.

People's privacy was respected but records were not held securely.

Is the service responsive?

Requires Improvement

The Service was not always responsive.

People were unaware of their care plans and care was not planned to meet peoples individualised needs. Activity provision was not well planned.

Some people told us of concerns they had but we could not find records of how these were managed. Other records showed complaints were investigated and responses provided.

Is the service well-led?

Inadequate

The service was not well led.

Whilst staff felt the manager was approachable they demonstrated a lack of awareness of what was happening in the home.

Systems and process to monitor the service and drive improvement were had not been effective, and not all records were accurate, complete or up to date.

Cams Ridge

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.

This inspection took place on 12 and 14 July 2016 and was unannounced.

The inspection team consisted of two inspectors, a specialist advisor in the nursing care of older people 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.

Prior to the inspection we reviewed previous inspection reports and information we held about the service including notifications. A notification is information about important events which the service is required to tell us about by law. This Information helped us to identify and address potential areas of concern.

During the inspection we spoke with 8 people and 4 relatives. To help us understand the experience of people who could not talk with us we spent time observing interactions between staff and people who lived in the home. We spoke to the registered manager, deputy manager and the regional manager. We spoke to 12 staff including nurses, care staff, domestic, activity and administration staff. We also spoke with a visiting professional.

We looked in depth at the care records for six people and sampled the records for a further 11 people. We looked at medicines administration records for 15 people. We looked at seven staff members' recruitment records. We looked at the staff supervisions file, training records for 15 members of staff, a home training matrix and the staff duty rota for four weeks. We also looked at a range of records relating to the management of the service such as accidents, complaints, quality audits and policies and procedures.

Prior to the inspection we gained feedback from a social care professional. Following the inspection we asked the registered manager to send us further information regarding training, policies and quality assurance. We received this.

Inadequate

Is the service safe?

Our findings

People told us they were happy living in the home and that they felt safe. Relatives said they felt their family members were safe.

Risks associated with people's health needs had not always been identified, assessed and plans developed to reduce the risk to ensure people's safety and welfare. Staff knowledge of the risks associated with people's care varied greatly.

For example, a risk assessment had been developed for one person living with a specific complex health condition. However, staff lacked an awareness of this risk assessment and knowledge of this potentially life threatening condition. As staff were not aware of this they did not know what to monitor for. One member of staff when asked what this condition was described this incorrectly before looking this up on the internet.

A second person's pre admission assessment identified they were at risk of falls. No assessment had been undertaken around the risk and no plan had been implemented to reduce the risks. Staff spoken to were not aware of the risk of falls for this person. This person also suffered with a health condition which impacted on their ability to breathe and on their sleep. However, their breathing and sleeping care plan did not identify this condition or any risks associated with it. Subsequent information sent to us by the provider showed a falls risk assessment had been completed and information about the health condition had been included in their care plans. However we also noted that this person had diabetes and while a care plan had been developed this did not identify all the risks associated with this condition and the actions staff should take to prevent these risks or address them if they presented.

A third person's care records identified that they required fluids to be thickened and food to be pureed due to a risk of choking and a risk of aspiration. Their care records detailed how they must be positioned in an upright position and supported by staff when eating and drinking. One member of staff told us their fluids and diet varied dependent on their position, they said if they were sat upright they could have a soft diet. This was not in line with the specialist advice. We saw on two occasions this person left alone with fluids that had not been thickened. On one occasion they were laying almost flat in bed. This placed the person at risk of choking and aspiration.

Where bed rails were in use the assessment of the risks associated with the use of these had not always been undertaken.
Information contained within one person's care records regarding their wishes around resuscitation were inconsistent. A do not resuscitate document was in the care file which stated that nurses had discussed this with the person and their relatives. However, their end of life care plan stated they wished to be resuscitated and did not want to talk about their end of life. No records were available to show that nurses had discussed this with the person, only with their relatives. The registered manager needed to seek clarification from the person on the day of our visit.

Medicines were not always managed safely. One person living at the home required the administration of

oxygen for a health condition, via a concentrator. The care plan did not indicate the flow the oxygen should be set on. A nurse told us what flow this was set at and added this to the care plan. However, the nurse and registered manager were unable to confirm this was the prescription. In addition should this piece of equipment fail and staff be required to use the oxygen cylinder to provide this, no written information was available to inform staff as to the flow of oxygen required. Too much or too little oxygen for a service user with this health condition could be harmful and therefore having a record of what the prescription directed would provide staff with the information they would need to care for the person safely. . We saw a second person's room contained an oxygen cylinder. The registered manager told us the person had previously used oxygen for breathing problems as they suffered recurrent chest infections. However they stated they had not used this for at least 6 months. There was no reference to the possible need for oxygen in this person's breathing care plan dated 20 May 2014 and no risk assessment on file to tell staff when and if this could be used.

This oxygen cylinder was wedged in a corner of the person's room but not held securely. This was contrary to the Safe Storage of Oxygen Guidelines which state that cylinders should always be secured to avoid the risk of them falling and damaging the flow metre causing a discharge of oxygen, especially in a confined place (MHRA, 2016).

The service could not demonstrate that medicines were stored safely. Temperature records of the medicines rooms and fridges were inconsistently completed and did not reflect these occurred daily or in line with the provider policy. Four people's medicine records (MAR) showed they had medicines prescribed 'as required' (PRN) for behaviour/anxiety. No protocol was available for one person and the other three people's records contained PRN protocols with insufficient guidance. Topical medicine administration records were in place and provided staff with some guidance however, the registered manager confirmed they did not use signature sheets to demonstrate when creams or lotions had been applied by care staff. The coding used on medicine administration records was not always clear and it could not be identified when medicines had not been administered. One person's MAR contained no signatures for two medicines on one day. This had not been investigated and it was therefore unclear if it had been administered or not. Discrepancies in medicines stock had been identified during a medicines audit. The registered manager told us they were not aware of this matter, despite this audit being held in a file in their office. As a result this matter had not been investigated to determine the cause of this discrepancy.

Two emergency resuscitation bags were held in the home. The registered manager told us these should be checked monthly. The last check undertaken of the stock of these bags was in March 2016. The registered manager was unaware of this. This meant in an emergency situation the staff may not have access to life saving equipment they need. On the second day of our visit, the registered manager told us they were removing these bags as they did not contain any more than a first aid box.

There were two Defibrillators in the home. A defibrillator is a piece of equipment used in a medical emergency to support with resuscitation. A service of this equipment on 8 July 2016 stated "Please check the dates on your pads and battery every 6 months. Also run a self-test every month." On the second day of our inspection the registered manager confirmed they had not yet put a system in place to support the checking of this equipment

We found in the rooms of three people tins of 'Thick and Easy'. In addition there was a tin on the sideboard in the dining room. Thick and Easy is a substance used to thicken fluids. A patient safety alert issued in February 2015 provided guidance about the safe storage of thickening powders due to risk of aspiration/choking. This had not been actioned. There was a risk that this substance was in reach of people as it was not held securely. We spoke to the registered manager about this and on the second day of our

inspection these were not left around the home.

The failure to undertake effective risk assessments and develop plans to mitigate any risks for people, and the failure to ensure the safe management of medicines and equipment was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Suitable procedures and policies were in place for staff to refer to, including a whistle blowing policy. Training was in place to maintain staff's knowledge about safeguarding, however 19 of 44 direct care staff either had not completed this or their training was out of date. This was a breach of Regulation 18 of the Health and Social Care Act 2008.

Staff were aware of the types of abuse, what to look for and how to report them if they had any concerns. Staff said they were confident any concerns would be reported by the registered manager to the appropriate external authorities but were confident to do this themselves if needed.

The registered manager held records of any safeguarding matters they had in the service. These showed they worked with external agencies where required. However, we were concerned about the accuracy of their investigation reports at times. We had been made aware by the local authority of an injury a person had sustained in the home. The registered manager had been required to provide a report to the local authority. We found this reported stated that no injury was present on the day the incident occurred, however the person's daily records stated that the injury was present.
We found a record in one person's file that stated that it appeared a bandage had been used to stop a person from clenching their hand. The use of a bandage in this manner could be seen as a form of restraint. The use of this could not be explained by the registered manager. No risk assessment was in place and no plan of care detailing that this was required. The use of this bandage subsequently caused a minor injury to the person. No investigation had been done to determine why this was used and this had not been reported to the local authority. We referred this matter to the local authority safeguarding team.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's views on whether there were enough staff to meet their needs varied. One person and a relative felt there were enough staff while another person told us they felt some staff "rushed" them and a third said staff were "too busy to stop and chat".

At the time of our inspection the registered manager told us there were nine care staff on duty during the day with two registered nurses. In addition an activity co-ordinator worked five days a week as well as kitchen and domestic staff. An administrator was also available five days a week.

On the first day of our inspection the registered manager provided us with a document which they stated outlined the staffing requirements in the home. The registered manager and regional manager agreed this was not based on people's needs but rather the number of people living in the home. At the end of the first day the regional manager told us they had found a staffing dependency tool and they would be completing this the following day. The following day the registered manager emailed us a further dependency tool which appeared to be based on service user care needs. This recorded that the staffing levels provided according to the duty rotas was sufficient to meet people's needs.

Most people chose to spend the days in their rooms rather than communal areas. They had access to call alarms should they need staff and these were heard to be alarming regularly. Whilst the call alarms were

heard regularly they were responded to within reasonable timescales. The alarm system allowed print outs of the times taken to respond to call alarms to be monitored. However, the registered manager told us they only looked at these if there was a concern.

Recruitment records for staff contained all of the required information including references and Disclosure and Barring Service (DBS) checks. These checks help employers make safer recruitment decisions and help prevent unsuitable people from working with people who use care and support services. People could be confident that they were being supported by staff who were safe to work with adults at risk.

Inadequate

Is the service effective?

Our findings

People said they felt supported by staff who knew enough to help them with what they needed.

Staff told us they did not receive support in the form of supervisions. We saw records of 'group supervisions' however the registered manager explained the process of these which did not reflect supervision for staff. They told us the records were typed up, given to staff to read and if they had any questions or concerns they could then ask. They confirmed this did not involve individual sessions with staff where open discussion about their role, progress or concerns could take place. By the second day of our inspection the registered manager had changed the format of supervisions. They had planned to hold individual meetings with staff. Appraisals had not taken place.

The provider used a combination of face to face and eLearning training, although staff told us this was mostly eLearning. Most staff felt the training was sufficient although one told us how they did not benefit from eLearning. The system used to track training was held centrally on a computer and did not allow the registered manager to print a whole staff training matrix, only the training considered as mandatory. As a result we viewed this matrix and sampled the training records for 15 staff. Training undertaken was not always effective in providing staff with the knowledge they required. For example, 37 of 45 direct care staff, including the registered manager and nurses had completed training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, staff spoken to did not always understand what this was and records confirmed this was not applied in practice correctly. One said "It is where residents are able to do things, talk etc." A second member of staff told us they thought they needed a refresh on this. Care staff were unable to tell us about specific health conditions, what these meant and the risks they posed to people. They told us they had not received training in areas such as diabetes, Parkinson's, epilepsy and other specific health conditions and the training records confirmed this. Staff supported people with complex health conditions such that any complications arising from them could be life threatening. Only three of 33 care staff had received training in basic life support and 10 of 11 nurses had completed this. We were concerned about the assessment and management of risks for people. Risk assessments and plans to mitigate risks had not always been developed leaving staff with a lack of clear guidance bout people's needs. No staff had received training on risk management and only two of 15 staff had completed training on care planning. The registered manager told us they pulled reports from the central system about the training staff had or had not completed, which they then organised. We saw this covered areas such as dignity and safeguarding but no training around people's specific health conditions was planned. The lack of training in addition to a lack of clear guidance for staff about people's needs placed people at risk of receiving inappropriate and unsafe care and support.

The lack of effective training and supervision of staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission monitors the operation of Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At this inspection we checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

For one person their pre admission assessment stated that they would need their mental capacity assessing on admission to the home. This had not been undertaken. Bed rails were in use and consent had been provided by a relative who confirmed to us they did not hold the legal authority to provide such consent. No assessment of the person's capacity to make this decision had been completed and no best interest's discussion recorded around any least restrictive options before the use of bed rails was implemented.

A second person's care records indicated they had capacity to make their own decisions. However, on the first day of our inspection, consent for the use of photographs, family involvement and access of personal records by professionals had been given by a family member who the registered manager confirmed had no legal authority to provide this consent. By the second day of our inspection this consent form had been removed and the person had provided written consent. However, a further consent form for the use of bed rails was in their records signed only by a member of staff. Bed rails were in place for this person. A third and fourth person's capacity to decide about the use of bedrails was assessed in 2015. Whilst the assessment determined these people lacked the capacity to make this decision, no best interest decision making process had been followed with people relevant to this person's life. In addition their capacity to provide consent to care and treatment had also been assessed in 2015 and it was determined they lacked capacity to make this decision. However, consent to care and treatment can cover a wide variety of areas and the Mental Capacity Act 2005 makes it clear that assessments should be decision and time specific, and these assessments were out of date.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager understood their responsibilities in Deprivation of Liberty Safeguards (DoLS) Applications had been made to the supervisory body for some people and records of these were held in the back of people's care files. One person's application had been approved. The care files for people contained care plans titled 'maintaining safety', however no reference to the DoLS were included in these, what this meant for people and the actions staff should take.
Care staff knowledge of this was limited. For example, two members of staff told us they did not know what DoLs was. The lack of effective training in DoLS to ensure staff understanding was a breach of Regulation 18 of the Health and Social Care Act 2008.

People had care plans in place regarding their nutritional needs. These did not contain information about people's preferences and were not always accurate, up to date or being followed. For example, one person's detailed how they required a pureed meal but staff told us they had a soft meal if they were seated upright and alert.

Monthly assessments of people's nutritional status were undertaken using the Malnutrition Universal Screening Tool (MUST). 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk

of malnutrition, or obese. We found concerns that for three people, weight loss had not been identified by staff in the home. Whilst people's weight was monitored, where this was reducing, the cause had not been explored and no action had been planned or taken. Nutrition care plans did not always mention weight loss, its causes or any plans to address this. For example one person's weight records demonstrated they had lost 6kg in 2 months. Their nutrition care plan did not identify if this weight loss was planned or recognised it had occurred.

For a second person who had lost a significant amount of weight, a care plan had been implemented in April 2016 however, the registered manager and deputy manager could not demonstrate the actions that had been carried out. For example, no records were held to show this had been discussed with other professionals, an increase in their weight monitoring was not taking place and although their intake was recorded by care staff, the manner in which this was recorded made it extremely difficult, if not impossible, to monitor and evaluate. No evaluation of their food intake had taken place. We referred this to the local authority safeguarding team.

The lack of recognition of the weight loss, evaluation of people's food intake and action planned or taken to address any concerns meant people were placed at risk of not receiving the safe and appropriate care and support they needed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All except one person we spoke with told us the food was good and they had a choice. People were asked in the morning which of the choices they wanted for lunch. Two choices for both the main course and dessert were available and several options were available at teatime. The menu was based on a two week rotation and all food was cooked from fresh ingredients. The kitchen staff were provided with information regarding people's nutrition needs by the care or nursing staff on a daily basis. The kitchen held a list of people's preferences and needs. The kitchen staff were able to explain how they catered for specific diets.

We observed people having meals at lunchtime. The breakfast meal was particularly unhurried and people had a choice about the time they ate, whether it was in the dining area or their room and they also could choose the time. During the lunchtime people had the same choices. We saw the meals were presented attractively and the staff took care to offer people choices about what they wanted to eat. This applied even when people chose to eat in their lounge chairs. Staff offered people a range of cold drinks and hot beverages during and after the meals and throughout the day. We noted that the people who were supported to eat were helped in a respectful manner with staff sitting next to them and taking sufficient time for people to eat their meals at a pace that seemed to meet their needs. There appeared to be plentiful amounts of food available.

People and their relatives confirmed they had access of other health professionals if needed. We saw records confirming physiotherapy, speech and language, chiropody and GP input for people.

Requires Improvement

Is the service caring?

Our findings

People's view about the care they received was mixed and people did not consistently feel they were treated with kindness, compassion and respect. One told us "they're (staff) very good people, principally because they care". A second told us how they felt staff spoke to them as though they were "simple". They said they found this upsetting as they understood everything staff said. A third said the staff were "mostly kind" but they described how they preferred staff at night who they felt knew them better and had more time to spend with them. They told us they preferred the night staff to support them as some of the day staff didn't seem as willing to help with personal care.

We observed one occasion when a person was clearly distressed. One member of staff approached them in a gentle manner and supported them to have a drink. They stayed with them offering reassurance, for several minutes but after they left the person became distressed once again. A second member of staff responded to the person saying "Why are you crying, there is no need to cry". They did not seek first to comfort the person or demonstrate empathy with them. They did not approach the person in such a manner that they were able to explain their distress and other issues such as pain were not explored.

No one we spoke with knew of any residents meetings and all said they had not been asked for their opinion of the home. A relative told us how they had attended a meeting and said "we can air any grievance". They told us they had raised concerns regarding oral care being carried out. They said this remained "hit and miss" and that they had been told by the Manager that "you're quite at liberty to do it".

Staff understood the need to respect people's confidentiality and understood not to discuss issues in public or disclose information to people who did not need to know. Any information that needed to be passed on about people was placed in the handover records and discussed at staff handovers which were conducted in private. However, the room and cupboard where people's records were held, were unlocked throughout our inspection meaning these could be easily accessed by people who may not have the right to see these.

We recommend the provider and registered manager review the available support, training and observation of staff approaches for ensuring all people are treated with dignity and respect at all times.

Staff used people's preferred form of address. When speaking to people staff got down to the same level as people and maintained eye contact. Staff spoke clearly and repeated things so people understood what was being said to them.

Our observations saw staff demonstrating respect for people's privacy. People said they preferred to have their doors open as they liked to know that staff could see them as they went past, they all felt their privacy was respected and that staff would call out to them before entering their rooms. People told us they were given choices and these were respected. For example, we were concerned that very few people were in communal areas and when they were they returned to their rooms very early. Staff told us this was people's choice and people confirmed this. Staff were observed asking permission from people before undertaking any tasks such as cleaning or providing any care or support.

Requires Improvement

Is the service responsive?

Our findings

People told us staff knew them well enough to help them. One relative told us "I know that I can rest without worrying what's going on'. Another relative told me she felt her mother "was being looked after OK". A visiting professional told us "this is a fantastic home; it must be one of the best around. The staff are responsive and kind."

Pre admission assessments were carried out prior to people moving into the home. The registered manager told us that care plans were then developed from these, based on people's individual needs. However, we could not see that the pre admission assessment information was used when registered nurses developed care plans and undertook risk assessments. For example, for one person recently admitted to the home, the pre admission assessment contained information about specific health conditions they had, however no plans of care or risk assessments had been undertaken for these. The care plans that had been developed appeared to be based on the contents list contained within the provider's care planning system.

People did not know they had a care plan. Care plans were not consistently individualised and did not always describe people's preferences and choices about how they wished to be supported. For example, one person's communication care plan detailed the difficulties they had but contained no information about how staff could support this need, other than to anticipate their needs. For another person a maintaining safety care plan did not provide information about the persons needs in relation to this. It stated how they needed their room to be kept clean and what to do in the event of a fire. However, this person experienced physical and mental health conditions that placed them at risk. No reference to these was included within this plan.

Staff were knowledgeable of people's preferences, likes and dislikes. Their knowledge of people's preferences enabled them to promote care that was delivered in a way that people wanted . However, the lack of personalised care planning left this open to individual staff member's personal interpretation.

The provider employed an activities co-ordinator (AC) and the registered manager told us they would be recruiting a further person for this role. No activity plan was available for people to see what would be taking place. The AC told us they had been unable to do this since working alone and were flexible to what people wanted to do day to day. We observed them supporting people with arts and crafts and quizzes. They also offered people a choice of old films or documentaries to watch. Very few people engaged in activities in the communal area as very few people accessed this. Records held were tick lists and did not record people's level of engagement and participation in activities. These mostly reflected that people remained in their rooms, watched TV or listened to music.

A lack of personalised care planning and delivery was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a complaints procedure. Only one person knew the registered manager by name but others knew them by sight. People knew who to talk to if they had a complaint and said they felt comfortable to do

so. Staff knew how to support people to make a complaint and said they felt confident the registered manager would listen and act on these. Some people and relatives told us of concerns they had raised and the response to these varied. For example, one person told us how several personal items had been "lost" and although they had asked about it several times there had been no resolution. One relative described an issue of difficulty between their family member and one care staff member. They said the matter had been resolved by talking to the registered manager and they were happy with the care. No record of either of these complaints was found in the complaints folder. However, we did find records which showed how the service had investigated and responded to complaints.

Inadequate

Is the service well-led?

Our findings

A registered manager was in place at the time of our inspection. Staff described the registered manager positively and said she was approachable. One said "they are brilliant and really listen, nothing is too much trouble and you feel really part of the team here".

The registered manager confirmed that they did not hold staff meetings with care staff but said they could raise concerns or ask question at any time and were always involved in shift handovers. Staff stated they were involved in handovers which discussed service users' needs and any changes to these. The registered manager told us meetings took place three days a week between them, the nurses on duty and heads of department for catering, housekeeping and maintenance. These discussed any updates and issues. Actions were set and although these were marked when completed, the outcome was not recorded. For example, one record showed three people had made concerning comments about the service. The action plan recorded for the registered manager to discuss this with them and was marked as completed. However, no outcome of this was detailed or recorded as discussed and no update was provided at the next meeting.

Only one meeting involving the registered manager and registered nurses had taken place since January 2016. We saw this discussed improvements that were needed following safeguarding issues. This related to wound care plans and documentation. Whilst it was made clear these required improvement, we did not see clear and effective wound care plans or documentation at the time of our inspection. For example, one person's records dated 18 June 2016 stated "wound is healing" but nothing had been recorded since this date. It was therefore not clear if this wound had been looked at since this date. Measurements of wounds were not always provided. Where records showed "healing well" there were no objective measurements to monitor against. No follow up meeting had taken place and no record of progress discussed was made. Whilst meetings that did take place shared actions to be taken, there was a lack of involvement of all staff, not just nursing staff, and a lack of follow up meant required improvements could not be tracked and evaluated.

We asked the registered manager if they undertook any care plan audits and they told us they had not done these for a long time. They did not show us any records of previous audits completed. We identified a number of concerns regarding care plans that an effective audit would have identified.

The regional manager told us they had carried out care plan audits as part of an impact assessment. They provided us with copies of these on the second day of our visit as they said these were not in the service but stored at their home address. We saw these audits had been completed for three people living in the home in March 2016. We saw that these identified concerns regarding care plans but no action was recorded as being required.

The regional manager and registered manager told us these care plans audits formed the impact assessment of the service, held centrally on a computer and that this then informed the home's development plan. Whilst we saw some actions recorded on the home's development plan regarding care planning, these related to daily record entries being a true reflection of time and date and transferring

records to a new format. However, the audits identified that care plans were not specific and measurable, that a summary of people's food and fluid intake was not recorded, and that people's weight was not completed as a minimum monthly. These care plans audits had been ineffective in informing the home's development plan and as they were not stored in the service, the registered manager was unable to access these readily to look at any further areas that may require improvement.

Medicine audits were carried out monthly by nursing staff, however these had been ineffective in identifying issues of concerns and in ensuring further action was taken where required. These audits had identified that there were no concerns regarding the policy and procedure and no concerns regarding the checking of room and fridge temperatures. However, the policy we saw available to staff in the medicine room was for a different company and we found temperature checks were not consistently completed. The most recent audit also highlighted a stock discrepancy which had not been investigated further and the registered manager was unable to explain this.

The registered manager demonstrated a lack of understanding about what was happening in the home. For example, they were unaware of the medicines discrepancy that had been discovered in the audit. Although this audit was held in a file in their office, they told us they had not read this. They were unaware that the emergency resuscitation bags had not been checked since March 2016. We asked the registered manager if they were supporting any person with a pressure sore and they told us they were not, however we found one person in the home did have a pressure sore that staff were treating. The registered manager was unaware of entries in daily records that indicated concerns despite having written reports for external authorities that would have required them to look at these records. For example, one person had suffered an injury that the registered manager's report stated was not present until the day after the incident occurred. However the person's daily records stated this was present on the day of the injury. The daily records also reported t how a member of staff applied an inappropriate cream to this injury the day after the incident. The registered manager told us they were unaware of this, however the records clearly stated this.

Records were not always accurate and available. Care plans were incomplete, and risk assessments had not always been completed where needed. One person's mobility care plan did not reflect their current needs as described to us by staff.

The lack of available and accurate, complete records and effective systems to assess quality and drive improvement was a breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person had failed to ensure personalised care planning and delivery. Regulation 9(1)(a)(b)(c)(3)(b)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person had failed to ensure an understanding and appropriate application of the MCA 2005. Regulation 11(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person had failed to ensure people were protected from the risk of abuse. Regulation 13(3)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had failed to ensure effective risk assessments and plans to mitigate any risks for people, and failed to ensure the safe management of medicines and equipment. Regulation 12(1)(2)(a)(b)(e)(g)

The enforcement action we took:

We served a warning notice requiring the provider and registered manager to be compliant by 12 September 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had failed to ensure available and accurate records and effective systems to assess quality and drive improvement. Regulation 17(1)(2)(a)(b)(c)(e)

The enforcement action we took:

We served a warning notice requiring the provider and registered manager to be compliant by 12 September 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had failed to ensure effective training and supervision of staff. Regulation 18(2)(a)

The enforcement action we took:

We served a warning notice requiring the provider and registered manager to be compliant by 12 September 2016.