Nightingale Group Limited

Guardian Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 9 and 10 May 2016. This was an unannounced inspection. Our last inspection took place in August/September 2015 where we identified improvements were needed to ensure the service was; safe, effective, caring, responsive and well-led.

The service is registered to provide accommodation and personal care for up to 143 people. People who use the service have complex physical health and/or mental health needs, such as dementia, acquired brain injury and behaviours that challenge. At the time of our inspection 122 people were using the service.

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

At this inspection, we identified a number of Regulatory Breaches. You can see what action we told the provider to take at the back of the full version of the report.

Risks to people's health and wellbeing were not consistently identified, managed and reviewed and people did not always receive their planned care. Medicines were not managed safely and people were not always protected from the risk of abuse. This meant people's safety, health and wellbeing was not consistently promoted.

There were not enough suitably skilled staff available to meet people's individual care needs and preferences in a timely manner and people did not always receive the right care at the right time. Gaps in staff training meant people could not always be assured that they consistently received their care in a safe and effective manner.

Effective systems were not in place to consistently assess, monitor and improve the quality of care. This meant that improvements to the quality of care were not always made in a prompt manner and any improvements to the quality of care were not always sustained.

The legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) were not consistently met. This meant people could not be assured that decisions were made in their best interests when they were unable to do this for themselves.

People were not always treated with dignity and their privacy was not always promoted.

Safe recruitment systems were in place to ensure people employed by the provider were of suitable character. However, improvements were needed to ensure temporary agency staff employed by external providers were also of good character.

People were supported to access suitable amounts of food and drink of their choice and their health and wellbeing needs were monitored. Advice from health and social care professionals was sought and followed when required.

When people were able to make choices about their care, the choices they made were respected by the staff.

People and their relatives were involved in the planning of their care and their feedback about the quality of care was sought and acted upon to make improvements.

People knew how to make a complaint and complaints were managed in accordance with the provider's complaints policy.

The registered manger informed us of notifiable safety incidents in accordance with the requirements of their registration.

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. Medicines were not always managed safely and risks to people's health and wellbeing were not consistently identified, managed and reviewed.

There were not always enough staff to keep people safe and meet peoples agreed care needs and effective systems were not in place to ensure people were consistently protected from the risk of abuse and avoidable harm.

Safe recruitment systems were in place to ensure people employed by the provider were of suitable character. However, improvements were needed to ensure temporary agency staff employed by external providers were also of good character.

Is the service effective?

Requires Improvement

The service was not consistently effective. The legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) were not consistently met.

Staff had received some training to provide them with the knowledge and skills needed to meet people's basic care needs. However, improvements were needed to ensure training gaps were promptly addressed.

People's health and wellbeing needs were appropriately monitored and prompt action and advice was taken or sought in response to changes or concerns with people's health and wellbeing.

People were supported to eat and drink suitable amounts of food and drink that met their preferences.

Is the service caring?

Requires Improvement

The service was not consistently caring. People were not always supported to receive care and support in a dignified manner.

The provider was working to improve staffs' understanding of people's care preferences and needs so that positive relationships between staff and people could be consistently

maintained.

People were involved in making choices about their care. When people had the ability to make choices about their care, staff respected the choices people made.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. People did not always have their care preferences and needs met in a consistent or prompt manner.

People and their relatives were involved in the planning and review of their care and complaints about the care were managed effectively to drive improvement.

Is the service well-led?

Requires Improvement

The service was not consistently well-led. Effective systems were not in place to consistently assess, monitor and improve the quality of care.

Improvements were needed to ensure staff could approach the management team with any concerns about the quality of care.

A new registered manager and nominated individual were now in post and people spoke positively about the changes they had made.

Guardian Care Centre

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 was 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 9 and 10 May 2016 and was unannounced. Our inspection team consisted of seven inspectors.

We checked the information we held about the service and provider. This included the information that the provider had sent to us about the service and information we had received from the local authority and public. We used this information to formulate our inspection plan.

We spoke with 24 people who used the service, 12 relatives and a visiting health care professional. We also spoke with the registered manager, the provider's nominated individual, four unit managers and 18 members of staff which included nurses, care staff and the training coordinator. We did this to gain people's views about the care and to check that standards of care were being met.

We spent time observing care in communal areas and we observed how the staff interacted with people who used the service.

We looked at 26 people's care records to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included quality checks, staff rotas, recruitment records and training records.

Inadequate

Is the service safe?

Our findings

Although people told us they felt safe at Guardian Care Centre, we found effective systems were not in place to ensure people were consistently supported in a safe manner. At our last inspection, we told the provider that improvements were required to ensure medicines were managed safely and consistently. At this inspection we found the required improvements had not been made. We saw that medicines were not always handled in a safe manner. For example, a pharmacist had advised that staff needed to wear protective equipment when preparing one person's specific medicine. We observed a member of staff prepare this medicine without using the required protective equipment which meant the required safety procedures were not followed.

Accurate records of medicines administration were not always kept. For example, on two of the five units, we found that people's actual medicines stock did not always match the number of medicines that were recorded on their medicines administration records. This meant people could not be assured that they had received their medicines as prescribed. Some people who used the service were prescribed creams to help manage their risk of skin damage. We found multiple gaps in people's cream recording charts. This meant people could not be assured they were receiving their creams as prescribed, which meant there was a risk that people's skin condition could deteriorate.

Some people who used the service were prescribed, 'as required' medicines. Individualised plans were not in place to give the staff the information they needed to ensure these medicines were given in a consistent and safe manner. For example, 'as required' pain relief plans for people who could not communicate their needs did not record how these people displayed signs of pain, discomfort or distress. The permanent nursing staff we spoke with told us they knew people's needs and behaviours. They said they used this knowledge to identify if people needed pain relief. However, temporary nursing staff also worked at the service at times. These staff members would not always know people's needs and behaviours as well as the permanent staff. Therefore, individualised 'as required' medicines plans were needed to ensure all staff, including temporary agency staff gave people their 'as required' medicines in a consistent and safe manner.

Risks to people's safety were not always assessed and planned for. For example, one person who staff told us could not make important decisions about their health or care, required a specialist diet to reduce their risk of choking. Two members of staff told us this person sometimes ate, a 'normal' diet instead of their prescribed specialist diet. This had not been recorded in the person's care records and no plan was in place to protect the person from the risks associated with eating a 'normal' diet. These risks can include choking and chest infections. Another person had been identified as being at high risk of falling. Their care records showed they had recently fallen on at least two occasions over a two week period. Their care records showed assistive technology had been put in place to reduce their risk of falling in their bedroom, but this technology had not been planned for or utilised in other areas of the service, such as the lounge area. This person's care plan stated they needed to mobilise using a zimmer frame and assistance of staff to ensure their safety. However, we observed this person walking in an unsteady manner without staff support or a zimmer frame. We intervened and alerted staff who then provided assistance to the person. The use of assistive technology in the lounge area or another suitable risk management plan may have alerted staff

that this person needed assistance to keep them safe.

Where risks to people's safety had been recognised and planned for by the staff, we found that care was not always delivered in accordance with their agreed plan. This meant people's risks were not always being managed as planned. For example, we saw one person walking around their unit with no footwear on. Their mobility care plan stated staff needed to, 'ensure they wore well-fitting shoes'. Not wearing appropriate footwear may result in an increased risk of falling. Care records showed and staff confirmed that people were not always supported to change their position or have their personal care needs met as regularly as planned to manage their risk of skin damage. For example, one person's care records stated they needed to be supported to change their position every two to four hours. Staff told us they were unsure if they should support this person to move every two or four hours. The unit manager told us the person should be supported to change position every two hours during the day and four hourly at night to enable the person to sleep better. This person's care records showed they were not supported to change their position every two hours during the day and on three occasions over a three day period their records showed they had gaps of over five hours between receiving support to change their position. One of these gaps was for a time period of six hours and 55 minutes. This person's care records showed their skin had recently deteriorated and advice had needed to be sought from specialist NHS nurses.

People's risks were not always reviewed or updated following safety incidents. For example, one person had required intervention from the police during an incident where their behaviours became challenging for the staff. This incident had not triggered any changes to the person's care plan to help staff manage the person's risks associated with their behaviours that challenged, despite staff recording that during the incident they had to, 'Clear off as we could not manage their behaviours anymore". Another person who had fallen eight days before our inspection had not had a review of their risk of falling and no changes had been made to their care plan to reduce the risk of further falls.

The above evidence demonstrates that effective systems were not in place to ensure risks to people's safety and welfare were consistently assessed, monitored and managed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us how they would recognise and report abuse. However, we found that effective systems were not in place to ensure staff consistently identified and reported potential abuse when this was required. We identified one alleged assault that was not reported to the local authorities safeguarding team as required. The unit manager told us the incident was a, "safeguarding" incident, but confirmed no safeguarding referral had been made.

Some people who used the service required staff to physically restrict or restrain them when their behaviours presented as a risk to themselves or other people. National guidance should be followed to protect people from the risk of abuse or avoidable harm through the use of restrictive practice, such as restraint. The Department of Health's Positive and Proactive Care: reducing the need for restrictive interventions 2014 states that detailed and accurate records of restraint should be maintained. These records should include, 'The names of the staff and people involved, the reason for using the specific type of restrictive intervention (rather than an alternative less restrictive strategy), the type of intervention employed, the date and the duration of the intervention, whether the person or anyone else experienced injury or distress and what action was taken'. We found that accurate records of physical restraint were not being maintained. For example, one person's care records showed that staff had used a form of physical restraint on two occasions over a three week period, but there was no record of the full reason for restraint, the specific type of intervention used or the duration of the incidents. There was also no record of the person's response to this intervention in terms of if they were distressed or injured. This meant the provider

could not identify or monitor that staff were using physical restraint in a lawful manner that protected people from the risk of abuse or avoidable harm.

The above evidence demonstrates that people were not always protected from the risk of abuse or avoidable harm because effective systems were not in place to ensure appropriate action was taken in response to safeguarding concerns. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, relatives and staff told us and we saw that staff were not always available to meet people's care needs in a prompt manner or in accordance with their care plans. For example, one person told us they sometimes waited long periods to receive assistance from staff to access the toilet. They told us there were occasions where they waited up to an hour for staff assistance. They said, "I sometimes have to wait a long time, even though they know I have bowel issues and I've cried over it". Staff who worked with this person confirmed some people did have to wait lengthy periods before they received care and support. One staff member said, "It's impossible sometimes, there's not enough staff on the floor" and, "People get their care late, but the care does get done". Three people told us there were not enough staff available to enable them to access the community or the outside spaces at the service. We saw two of these people ask staff if they could go outside to get some, "fresh air". They were told by staff that they could not be assisted to go outdoors at that time, but they could go outside later. One of these people said, "They seriously need more staff". We returned to the unit two hours later and the two people told us they had still not been outside. The third person told us, "I'd love to go for a break, just in the garden or even in the car park, but there just aren't enough staff to take me". Staff on the two units where these three people resided confirmed there were not always enough staff available to enable people to spend time outdoors. Comments from staff included, "[Person who used the service] doesn't get the attention they should be getting" and, "No, there is not enough staff".

We found that staff were not always deployed effectively to ensure people's needs were met. On the afternoon of the second day of our inspection, two staff from one unit had needed to leave their shift. The remaining staff on the unit told us this had left their team short staffed and we saw and care records confirmed that some people's care needs were not being met as a result of this. For example, one person who required assistance from staff every two hours during the day to change their position had not received this assistance for a five hour period. We alerted the staff to this and they told us they hadn't had time to support this person. One staff member said, "I can't get round to people" and, "We do it as soon as we can". Another staff member said, "We are running behind on changing people and turning people". We fed back our concerns about staffing on this unit to the provider and registered manager. They told us the unit manager had asked the two nurses on the unit to support the staff to meet people's needs. However, people did not get the support they needed. After our inspection, the provider told us they were, 'Very disappointed' by the nurses conduct on the day of our inspection and they informed us the two nurses were no longer working for them.

The skill mix of the staff was not always considered in rota planning. We did see some good examples of the consideration of skill mix. For example, one staff member told us they were not allocated to provide one to one support to people with behaviours that challenged as they had not yet completed the training required to manage these behaviours safely. However, the skill mix of the staff was not consistently considered to ensure people's safety. For example, a unit manager confirmed there was not always a trained fire marshal on shift on one unit. Fire evacuation plans relied heavily on the presence of a fire marshal to ensure a safe and effective evacuation of the unit if required.

The registered manager and provider told us they regularly assessed people's dependency levels to ensure

there were enough staff on shift to keep people safe and meet people's needs. Examples were given to show how staffing numbers had recently increased in response to these assessments which staff were able to confirm. Despite these assurances from the management team, our evidence above shows staff were not always available to keep people safe and meet people's individual care needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After our inspection, the provider told us they had increased staff numbers on two of the five units in response to inspection feedback. We will check if staffing levels have been improved and maintained at our next inspection.

People told us they felt safe around the staff. Comments included, "The staff are nice" and, "The staff are quite good, friendly and helpful". We saw that effective systems were in place to ensure staff employed by the service were of suitable character to work with people who used the service. However, the registered manager and provider could not evidence they were consistently and regularly checking the effectiveness of the recruitment and quality monitoring systems of the external provider's they used to source temporary agency staff from. This meant people could not always be assured that temporary agency staff were of suitable character to support people who used the service. The service regularly used temporary agency staff to fill staffing gaps.

Requires Improvement

Is the service effective?

Our findings

We found that when people were unable to make important decisions about their health and wellbeing, the provider did not always act in accordance with the law. 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We saw some good examples of the application of the Act. However, we found the requirements of the Act were not consistently followed. For example, staff told us and care records showed they had recently physically restrained a person so they could receive a prescribed medicine. Staff confirmed this person did not have the ability to make decisions about their health care. Staff confirmed that no best interest decision had been made with the prescriber of the medicine to show that receiving their medicine under these circumstances was in their best interests. The staff member who administered this medicine to the person in this manner told us, "It didn't feel right, but I was told to do it by [another staff member]".

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). We saw that staff had requested DoLS authorisations for the majority of people who required them. However, we found that these requests were not always made in a timely manner. For example, we saw and staff confirmed that one person was being restricted by staff on a daily basis. We heard this person ask staff if they could go outside for a cigarette on a regular basis and on some occasions the staff responded by telling them they could not go out. Staff told us this was because the person didn't have the resources to smoke throughout the day. Staff confirmed no DoLS application had been made. We alerted the registered manager and provider to this and they immediately completed all their outstanding DoLS referrals.

Some people who had DoLS authorisations in place had associated conditions attached that needed to be legally met. We found that people's DoLS conditions were not being consistently met as required. For example, one person's DoLS condition was to ensure the person regularly accessed their unit's garden area. Their care records did not show they had accessed the garden for the four weeks prior to our inspection and staff told us they were unaware that this person had a condition placed on their DoLS authorisation. This meant the condition the person's DoLS was subject to was not being consistently met. Following our inspection, the provider told us they were going to request additional training in the MCA and DoLS to improve the staffs' understanding of the requirements of the act.

The above evidence shows that effective systems were not in place to ensure staff acted in accordance the MCA and DoLS to protect people from improper treatment. This was an additional breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that effective systems were not in place to ensure staff had the knowledge and skills required to deliver safe and effective care. Staff told us they had received some training to enable them to meet people's

basic care needs. However, some staff told us they didn't feel they could always access additional training to enable them to meet people's specialist needs in a timely manner. For example, one staff member told us, "[A person who used the service] came in with a feeding tube and we didn't have training on it (the feeding tube) until they had been here for a while". This meant that the staff member did not have the knowledge and skills required to meet this person's needs when they started to use the service and there were occasions where this staff member was responsible for this person's care during this time. Training records showed there were some gaps in training. For example, records showed only 48 percent of the care staff were up to date with the training required to assist people to move and change position safely. Our observations confirmed that some staff had not got the knowledge and skills required to move people safely as we observed three people being supported to move in an unsafe manner. This was an additional breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, we told the provider that improvements were required to ensure people received the support they needed at mealtimes and to ensure mealtimes were a pleasant experience. At this inspection, we found that further improvements were still required. On one of the five units, we saw that people were not always supported to dine at a suitable table. For example, we saw staff place one person's meal on a low table at the side of their comfy chair. This person shouted, "Help" as they couldn't eat their lunch in that position. Staff then assisted the person to move to the dining table to eat their meal. However, this meant staff didn't consider the person's dining needs before they served them their meal.

Most of the people we spoke with told us they enjoyed the food. One person said, "The food used to be awful, but it's improved loads". Another person said, "The food is lovely". We saw that people were offered meal choices and people confirmed they could choose the foods they ate. We also saw that staff assisted people to eat and drink when this was required and people were supported to consume dietary supplements if these were prescribed.

People told us and we saw they were supported to stay as healthy and well as they could be. This included prompt referrals to a variety of health and social care professionals if required. One person told us how staff quickly supported them when they became acutely unwell due to a long term respiratory condition. They also told us how staff supported them on a daily basis to help manage this condition. Care records showed that people's health was regularly monitored and prompt action was taken to respond to any changes in health needs. For example, when one person's weight had dropped, advice was immediately sought from a GP. A GP who visited the service twice a week told us that on the whole the staff worked effectively with them to ensure people's health needs were assessed, monitored and met. They said, "They are usually responsive in telling us about issues".

Requires Improvement

Is the service caring?

Our findings

At our last inspection, we told the provider that improvements were required to ensure people were consistently treated with dignity. At this inspection, we found the required improvements had not been made.

Some people told us and we saw that their dignity needs were not consistently promoted or met. One person said, "The staff keep opening my door when I'm using the commode. They just don't seem to realise it's an issue". Although we did see some positive examples where staff treated people with dignity, we saw multiple examples where this was not the case. For example, we saw a member of staff lift a person's top up to access their feeding tube in front of other people in a communal area. We observed another person who used the service sitting in a communal area who smelled strongly of urine. This person was supported by staff after a period of 60 minutes and when they were supported to move we saw urine on their chair which showed they were not supported in a prompt or dignified manner.

Staff did not always address people in a dignified manner. For example, one person who repeatedly stated, "I want to go home" was frequently ignored by staff. We informed staff that this person required assistance as we found them walking in a corridor in an unsteady and unsafe manner. A staff member said to the person, "You can't stay here" and asked, "Why did you get up?". The person's response to this question was, "I wanted help". The staff member did not try to identify the cause of this person's distress by asking them why they felt unsettled and why they wanted to go home. We also heard staff describing people who needed assistance to eat as, "Feeders" which is an undignified way of describing people's needs.

Some people had signs above their chairs highlighting the fact they were, 'Nil by mouth'. Staff told us these signs were used to remind staff about people's needs. However, labelling people in this way in communal areas did not promote or respect their right to privacy. A person who required one to one support from staff during the day had a staff member right next to them all day. We asked staff why they were so physically close to the person at all times. Staff told us they stayed close to the person to protect them from other people's behaviours. However, we saw staff follow the person very closely when they moved, even when other people were not present in the room. This was an intrusive approach to one to one care that did not respect the person's right to their own personal space.

The above evidence shows that people were not consistently treated with dignity and respect. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above evidence, most people told us they were very happy with the way the staff cared for them. Comments included, "The staff are quite good, friendly and helpful" and, "I'm really happy here, the staff are helpful". Alongside the undignified care we observed, we also saw positive interactions between people and staff. For example, we saw one staff member who assisted a person to receive their medicines say, "Here's your medication sir". We also saw staff chatting and laughing with a person they were supporting to move. The person responded positively to the staff member's interactions by chatting and laughing back.

Most people told us that the permanent staff at the home knew their care preferences and needs well. One person said, "The staff know me and know what I like". Another person said, "They [the staff] know me well and treat me well". This enabled staff to develop positive relationships with people. However, some people told us that staff who were moved to cover shifts on other units and temporary agency staff did not know people's needs well. One relative said, "The staff change quite frequently and when they change, they don't know [person who used the service]". Our observations and conversations with staff also confirmed this. For example, we asked a member of staff to tell us about the care preferences and needs of a person they were responsible for providing care and support to. They replied, "I don't know a lot about them, they are new. I know they are at risk of falling". This meant that sometimes staff could not develop positive relationships with people as they did not know people's interests or communication needs to enable them to spend quality time with them. Following our inspection, the provider sent us a new profile sheet they had designed to record people's care needs and preferences. The purpose of this was to enable staff to gain a snapshot of people's care needs and preferences. The provider told us they planned to roll this new initiative out immediately to ensure staff had the information they needed to develop positive relationships with people and meet people's care preferences and needs. We will check the effectiveness of this at our next inspection.

People told us they were given choices about their care. For example, people told us they could choose their drinks, meals and clothing. We saw that where people could make choices about their care, staff respected the choices people made. For example, we saw a member of staff respect one person's choice to change their mind about when they wanted to receive their medicines. The person initially chose to receive them whilst they were eating their breakfast, but later changed their mind. The staff member respected the person's decision and waited for the person to finish their meal before administering their prescribed medicines. One person who used the service told us they had helped to choose the colour for new curtains in the lounge. They said, "They've finally agreed to replace those curtains there. We've chosen a gold colour which will be lovely". Minutes of a meeting with the residents on this unit confirmed people's involvement in the plans to replace the curtains. Staff confirmed they offered people choices about their care. Comments from staff included, "Staff must always let people make their own choices, like asking if they want to get up and giving them a choice of clothing" and, "I enjoy caring for the residents and I like to see them happy. I help them and treat them individually by giving them choices as it's their home".

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, we told the provider that improvements were required to ensure people received care that met their individual preferences and needs in a timely and consistent manner. At this inspection, we found the required improvements had not been made.

Some people's care records did not contain the information staff needed to meet all their individual care needs in a consistent manner. For example, one person who used the service was displaying signs of agitation and distress by frequently asking to go home. We found that staff managed this person's requests to go home in different ways. One staff member responded by saying, "I can't take you home" and, "I told you yesterday, it's out of my hands". This did not ease the person's distress. However, another staff member responded by saying, "You live here with us now" which the person responded more positively to. This person's care plan contained no information to guide staff on how to manage their agitation and distress caused by wanting to go home. This meant staff used inconsistent approaches to manage this person's behaviours that challenged.

We saw that staff were not always responsive to people's individual needs and people did not always get the right care at the right time. For example, one person told us they were, "Fed up" of waiting for assistance from staff to help them access their bedroom for an afternoon nap. They said, "I told them I wanted to go to bed at 3.45pm. I usually go for a lie down every afternoon, but it hasn't happened today". We observed this person ask staff on four occasions for assistance to go to bed over a 30 minute period. One staff member responded by saying, "I'll be back in a second", but they did not come back to offer assistance during the 30 minutes we spent in the room. The person's other requests for assistance received no response from the staff who were present at the time. This meant the person's care preferences had not been met that day. We saw there was no record of this person's preference to go to bed in an afternoon in their care records, but a member of staff we spoke with confirmed that this was the person's current preference. They said, "[Person who used the service] has started to like going for a lie down in an afternoon". This meant the person was at risk of consistently not having their care preference met, particularly at times when temporary agency staff were responsible for meeting this person's needs, as they would not have access to the information they would require to support this person in accordance with their care preferences.

Some people told us and we saw that care and support was sometimes provided to meet the needs of the staff rather than the people who used the service. One person told us, "I sometimes think they do things for quickness, when I can do things for myself sometimes". We observed two people being supported to move from their chair to a wheelchair using a sling that was designed for accessing toilet facilities. We asked a member of staff why they were using this sling for these people and they said, "We use that sling so we can move them more easily". This meant staff were using the sling to make the transfer easier for them, rather than using equipment to suit people's individual needs.

Changes in people's needs were not always communicated effectively by staff. For example, one staff member told us a person was rubbing their gums and cheek because they had toothache. The person's medicines records showed they had not received any pain relief for their pain at that time. We asked a nurse

why the person had received no pain relief and they told us they had not been informed that the person was experiencing pain. This meant the person had not received pain relief in response to their pain.

People told us they were not always supported to participate in social and leisure based activities that met their individual preferences. Comments from people included, "I love doing the craft sessions and bingo, but there just aren't enough staff to do it as often as I'd like", "The staff are good, but they haven't always got the time to do many things with us" and "There's nothing to do, it gets boring sitting here all day". Due to a recent change in staffing, there was one activities coordinator who was employed to work with all 122 people who used the service. We observed the activities coordinator spending short periods of time engaging some people in meaningful activities and we saw that people responded positively to this. However, these positive interactions were short lived before they moved on to spend time with other people. This meant people were not consistently and regularly supported to participate in meaningful leisure and social based activities. Staff told us they were too busy meeting people's basic care needs to provide additional support to help people to participate in their preferred leisure activities. One staff member said, "It would be nice to have more time to spend with people". Following our inspection, the provider told us they were reviewing the way that activities were promoted at the service, to improve the quality of care.

Some people who used the service required constant one to one support from staff during the day. We saw that some staff did not engage with the people they were providing this support to. We found that this was because staff didn't have the knowledge they needed to provide effective and person centred one to one care and support. For example, we asked a member of staff who had been allocated to support a person on a one to one basis how the person communicated. The staff member replied, "With not working on this unit I don't know the clients very well, it's very awkward". They then asked another staff member, "Are they verbal? I don't know him". This person's care records contained information about how they communicated their needs, but staff told us they often did not have time to read people's care plans. Comments from staff included, "I don't get chance to read the care plans, I'm too busy" and, "It's very rare that I get time to read a care plan".

The above evidence shows that people's individual care preferences and needs were not consistently met. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us they were sometimes involved in the planning and review of their care. One relative told us how they had told staff about their relation's life history and care preferences. Another relative showed us their relation's room and said, "They let me decorate the room how we wanted it, [person who used the service] really likes it". Another relative told us how they were kept updated when their relation's needs changed. They said, "They always tell me if [person who used the service] is poorly, or if they need a change to their care plan". Care records showed relatives were invited to attend care reviews and we saw that flexible times outside of standard working hours were offered to them to work around relatives' needs and availability.

People and their relatives knew how to complain and they told us they would inform the staff or managers if they were unhappy with their care. One person said, "If I had any issues, I would go to the manager". People and their relatives also told us that when they had complained, improvements to care had been made. A relative said, "I've had a couple of issues to bring up with the manager, little things really that I felt needed dealing with, so I wrote a letter to the area manager about it. They sorted it and the manager checks with me every now and again to see if everything is okay".

Meetings with people and relatives were held on a regular basis that gave people the opportunity to raise concerns or complaints in a less formal manner. We saw this was an effective forum for discussing concerns and changes. One relative told us, "I raised something at a family meeting which was acted upon by the manager". The complaints process was clearly displayed in the reception area and on all the units of the home and we saw that complaints had been managed in accordance with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, we told the provider that improvements were required to ensure that effective systems were in place to regularly assess, monitor and improve the quality of care. At this inspection, we found the required improvements had not been made.

The systems the provider used to assess, monitor and improve the quality of care were not always effective. For example, although we saw care plan audits had identified areas for improvement which had been acted upon, these audits did not always identify the same concerns we found. An audit of one person's care records had not identified that their plans were not accurate as another person's name was referred to in their mobility care plan. We found multiple examples that showed people's care plans were copied and pasted from one plan to another as other people's names were frequently seen in the wrong people's care records. This meant there was a risk that people might receive delays in receiving safe care and support. This was because temporary staff or staff, who did not know people's needs would have to seek advice from permanent staff members to identify which person the information in people's care plans related to. We also saw that medicines audits were not always effective in sustaining improvement. For example, some of the concerns we had identified with medicines management had previously been identified and acted upon through medicines audits, but these improvements were not always sustained to ensure medicines were consistently managed safely. Following our inspection, the provider told us they would review their audit tools, to improve their effectiveness.

Safety incidents were reviewed by the management team and recommendations were made and recorded to reduce the risk of further incidents. These records were then returned to the relevant unit managers so the recommendations could be actioned. However, we found the management team did not always ensure these recommendations were incorporated into people's care plans. For example, one person's incident form that had been reviewed by the management team after the person had fallen contained detailed information about how staff should be managing the person's risk of falling. These recommendations had not triggered a review of the person's care plan which meant the information about how to keep this person safe was not recorded in the correct place for staff to refer to. This meant there was a risk this person's risk of falling was not being managed effectively.

We found the registered manager and provider were not consistently or effectively monitoring the use of physical restriction or restraint. This was because incidents of physical restraint were not always recorded or reported effectively. We found that some incidents of physical restraint were not recorded on the correct forms in accordance with the provider's restrictive practice policy. Some staff told us they were not sure where this information needed to be recorded. One staff member said, "I'm unsure which paperwork to fill in". This meant the registered manager and provider could not follow the recommendations of The Department of Health's Positive and Proactive Care: reducing the need for restrictive interventions 2014 guidance which states, 'Service providers must ensure that where appropriate lessons are learned when incidents occur where restrictive interventions have had to be used'. Following our inspection, the provider sent us an action plan detailing how they were going to make improvements in this area. This included the plan to provide additional staff training and the plan to design a protocol for the use of restraint to ensure

staff were consistent with its use. We will check the effectiveness of this plan at our next inspection.

Systems were in place to monitor the staffs' development needs. However, this system required improvement to ensure development needs were met in a prompt and effective manner. For example, training records showed 44% of staff required training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Improvements were also needed to ensure staffs' understanding of training was effective. For example, the poor moving and positioning practice we observed had not been identified or addressed by the management team. Following our inspection, the provider shared a new tool they had designed to assess and monitor the staffs' understanding and competency to ensure people were supported to move around the service safely. We will check the effectiveness of this tool at our next inspection.

The provider's service improvement plan showed they had identified and planned to address many of the concerns we identified during our inspection. However, we found the plan had not been effective in bringing about timely improvements to address all the concerns with the quality of care. For example, the provider had planned to ensure a minimum of 75% of staff had completed safeguarding training by the end of April 2016. However, training records showed only 50% of staff had completed this training. The plan also stated that by the end of April 2016, auditors of care plans needed to check actions required as a result of their audits had been completed, but we found this was not always happening. For example, one care plan audit stated the person needed an end of life care plan completing, but this had not been completed by staff or followed up by the auditor. This showed the registered manager and provider were not always making the required improvements in a timely manner in line with their action plan.

The above evidence shows that effective systems were not in place to ensure the quality of care was consistently assessed, monitored and managed to improve the quality of care people received. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff gave us mixed views about the new management team. Positive comments included, "The manager is good, I can talk to them easily" and, "They are approachable". However, some staff did not feel as positive towards the new management team. Comments from these staff members included, "I don't feel happy going into the managers' office" and, "I feel I can't raise concerns with the management team, when I've raised concerns before, they have been brushed under the carpet and no action has been taken". We fed this back to the management team and they told us they would look at improving the way they supported and engaged with staff.

People spoke positively about the changes the new registered manager and nominated individual had made at the service. One person said, "Things have been improving since the new management team came in". Another person said, "It's on the up, it feels like my second home now". People also spoke positively about the staff and the staff told us they took pride in working at the service. One staff member said, "I like my job, helping people makes me feel good". Another staff member said, "I love my job because I like to look after people and make them feel cared for".

People told us regular meetings took place where they were asked to give feedback about the quality of their care. Minutes of these meetings showed that people's feedback was sought and acted upon. For example, minutes showed people had previously shared concerns about the quality of the food. We saw that changes to the kitchen staff had been made and people now spoke positively about the quality of the food at the service. A satisfaction survey had also recently been sent out to people and their relatives to gain additional feedback about the quality of care. The registered manager and provider told us they planned to analyse people's feedback and show people how their feedback was acted upon by posting this on a, 'You

said, We did' board. This showed the management team had planned to use people's feedback to make further improvements to the quality of care.

Following this inspection, the provider immediately formulated and sent us an action plan outlining how they were going to make the required improvements. This action plan addressed all the areas of concern we had identified and realistic and prompt timescales had been set to make these improvements. This showed the registered manager and provider had responded proactively to our feedback. We will check the effectiveness of this action plan at our next inspection.

The registered manager understood the responsibilities of their registration with us. They reported significant events to us, such as safety incidents, in accordance with the requirements of their registration.

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 People's individual care preferences and needs were not consistently met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not consistently treated with dignity and respect.

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 People were not always protected from the risk of abuse or avoidable harm because effective systems were not in place to ensure appropriate action was taken in response to safeguarding concerns. Effective systems were not in place to ensure staff acted in accordance the MCA and DoLS to protect people from improper treatment.

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 Suitably trained staff were not always available to keep people safe and meet people's individual care needs.

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 Effective systems were not in place to ensure risks to people's safety and welfare were consistently assessed, monitored and managed. Medicines were not managed safely.

The enforcement action we took:

We warned the provider and registered manager that immediate improvements were required by 1 July 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 Effective systems were not in place to ensure the quality of care was consistently assessed, monitored and managed to improve the quality of care people received.

The enforcement action we took:

We warned the provider and registered manager that immediate improvements were required by 31 August 2016.