Bupa Care Homes (GL) Limited

Cleveland House Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out this inspection on 4 and 11 May 2016. The inspection was unannounced.

The service provides accommodation and nursing care for up to 45 people. On the day of our visit there were 41 people living at the home. Accommodation at the home was provided in single bedrooms set over three floors.

There was a registered manager who was no longer managing the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had left the service in February 2016 and the home had been managed on a part time basis by a registered manager from another of the provider's homes. Subsequent to the inspection we were informed that the provider was reviewing management arrangements to the home in line with our concerns.

Concerns had been raised to us before the inspection about care in relation to people's pressure relief. Some work had begun to address the need to provide effective pressure care and to treat wounds, such as pressure ulcers and skin tears. However, preventative measures were not robust at the time of the inspection and the repositioning regime for some people was inconsistent.

Practice for moving and handling people was not appropriate at times to ensure people's safety and staff were not all familiar with the equipment and process needed to assist individual people to move and transfer.

Staff had a clear understanding of the safeguarding procedures to follow should they have concerns about a person's well being.

The provider did not have robust procedures in place to ensure the requirements of the Mental Capacity Act (2005) legislation was being met in support of people's rights. Staff knowledge of the mental capacity act was inconsistent.

People reported they enjoyed the food and drink in the home. There were concerns about weight management for some people as the recording and monitoring of this and of food and fluid intake was not consistent.

Staff interaction was kind, caring and patient and people were complimentary about the staff's approach to their work. Staff showed respect for people's privacy and dignity when supporting people with their care.

Many people remained in bed, with no clear rationale about the reasons. People did not all wish to remain in bed and expressed some frustration as having to depend upon staff to assist them to be out of bed. Some

people were at risk of being socially isolated due to their high dependency needs, although staff made efforts to chat with people when they carried out care tasks..

Care plans were not person-centred, lacked detail and were not up to date or accurate for all people.

People and relatives knew how to complain and the complaints process was managed appropriately.

The home was under new leadership and some improvements to the running of the home and the clinical oversight were being implemented. Staff reported morale was beginning to improve although said this had been poor in recent months, prior to the commencement of the new manager.

Relatives reported improved leadership in the home and they said their views were valued.

Regular audits were carried out by the organisation, although internal audits of quality and practice were not rigorous enough to identify and address the areas of concern highlighted at this inspection.

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"

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.

Individual risks to people were not assessed or mitigated.

Staffing levels did not enable people's needs to be met in a timely way or in keeping with their preferences.

Medicines were not managed safely.

Is the service effective?

Inadequate

The service was not effective.

Staff lacked knowledge and understanding of people's health care needs.

The provider was not working in line with the legislation to support people's mental capacity and decision making.

People's nutritional and health needs were not consistently met.

Is the service caring?

Requires Improvement

The service was not always caring.

Care was not planned to reflect people's wishes or preferences.

Staff were kind and caring and demonstrated a good understanding of the need to treat people with respect and dignity.

There was minimal information available about people's wishes for the end of their life.

Is the service responsive?

Inadequate

The service was not responsive.

Care was not person centred; many people remained in bed without good reason and often against their wishes.

Care documentation was poor, lacked accuracy and detail and was not person centred.

Complaints were appropriately managed.

Is the service well-led?

Inadequate

The service was not well led.

Although some steps had been taken to instigate improvements in the quality of care, there was a lack of strong and effective leadership.

Audits and checks of practice were not thorough enough to ensure people's needs were met.

Systems and processes were not rigorous to ensure regulations were met.

Cleveland House Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 4 and 11 May 2016 and was unannounced.

The inspection was carried out by two Adult Social Care inspectors on each day.
Before the inspection we reviewed the information we held about the service. This included looking at the concerns we had received about the service and any statutory notifications we had received from the service.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spoke with 17 people who were living in the home and four visiting relatives. We also spoke with a nurse, two members of care staff, the acting manager, the clinical lead, the housekeeper, the maintenance staff and a visiting dietitian.

We looked in detail at four people's care records and observed care in the communal areas of the home. We looked at four staff recruitment files and staff training records. We also looked at records relating to the management of the service including audits, maintenance checks, policies and procedures. We looked round the building and saw people's bedrooms with their permission, bathrooms and communal areas.

Inadequate

Is the service safe?

Our findings

We asked people if they felt safe in the home and they all said they did. One person said: "I'm safe here, this is home to me". Another person said: "I have no concerns about my safety, that I'm sure of". Another person said: "I used to be a professional so I'd know if the care was not safe. I feel safe in this home"

We spoke with three staff who told us they would be confident to recognise signs of possible abuse and report any concerns if they were worried about a person. Staff said they would immediately report any poor practice if they became aware of this, to make sure people in the home were safe. Staff clearly understood the safeguarding and whistleblowing procedures.

One person we spoke with told us how a member of staff had handled them in a rough manner. We discussed this with the manager who assured us this had been referred to safeguarding and the member of staff had been dismissed. The Care Quality Commission had received appropriate notifications from the manager where safeguarding referrals had been made. This demonstrated that policies and procedures were in place for reporting safeguarding issues.

We saw staff were not clear about individual risks to people when carrying out moving and handling tasks and care plans did not clearly identify the equipment which should be used or describe the process required to move each person safely. For example, we saw staff attempted to assist one person using a hoist, this manoeuvre was stopped by a senior staff member as not all staff were sure about the type of sling to be used. The person's care record showed no assessment had been carried out for the use of the hoist. Staff brought another piece of equipment for the person to use which was listed in their care plan, however there were no clear instructions for its use.

Where people were at high risk of developing pressure ulcers there was no adequate regime in place for repositioning them. Records of how often people needed to be repositioned and when this had happened were not clear or consistent and staff we spoke with did not always know the risks to individuals or how to provide safe pressure relief. The home had employed a clinical lead who was beginning to address this and establish consistent preventative measures. Although some improvements were beginning to be seen, adequate pressure care was not robustly in place at the time of the inspection.

Risk assessments for individuals were not always up to date in their care records or followed in practice. For example, monthly assessments for one person's bedrails had not been updated since February 2016. In one person's bedrails risk assessment it stated they were to be checked hourly, yet daily notes showed two-hourly checks had been made. Another person was identified as being in need of a pressure cushion when seated, yet we saw in practice this did not happen.

Accidents and incidents were appropriately recorded and analysis of falls data was completed. However, where injuries such as skin tears occurred, there was no clear evidence of further investigation into how these had been caused or discussion around future preventative measures.

Staff we spoke with told us what they would do in the event of an emergency, such as if a person fell or if there was a fire. We saw people each had a personal emergency evacuation plan (PEEP) section on one page of their file, although the information was not clearly highlighted for staff to be able to locate it quickly. We saw a file in the entrance with PEEPs in, but the manager told us this was out of date and not accurate for use.

We spoke with the maintenance staff who told us all equipment such as bedrails, wheelchairs and lifting equipment was regularly checked and we saw this was documented in the maintenance checklist. Some people with bedrails had refused to have protective bumpers in place and whilst it was documented they had refused, there was no corresponding risk assessment in the care plans or information to show the safe use of bedrails had been discussed and agreed. The manager told us the housekeeper was responsible for the safe upkeep of pressure relieving equipment, such as mattresses and pressure cushions. We spoke with the housekeeper who told us some of the basic signs they would look for when checking the integrity of such equipment. However, the housekeeper told us they relied on experience of doing this for a number of years, rather than instruction or training to know whether the equipment was suitable for use. We saw a list of mattress and cushion checks which the housekeeper signed when completed, although this did not show how thoroughly checks had been made. The housekeeper told us it was difficult to check some equipment, for example, mattresses for those people who remained in bed.

The above examples illustrate the provider was in breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
We looked at recruitment files for four members of staff. We saw evidence that suitability checks and induction had been completed prior to employment. For one staff member, a registered nurse, we saw there had been a documented concern about their competency to administer medicines and they had been suspended from doing so. We saw the nurse administering medicines, although information in their file suggested they should not be doing so. We discussed this with the manager who told us the nurse's competency had been recently assessed and confirmed at one of the provider's other homes, although confirmation of this was not yet recorded in their file.

The manager told us there had been recent changes to the staff team and some staff had left, although they had increased staffing levels since being in charge. There was no formal dependency tool in use to determine the staffing levels required, although the manager said there were plans to use one in the future. They said they had worked out the staffing required based on their own professional judgement and the home was overstaffed for carers, although the use of agency nurses was necessary at times.

People told us staffing levels had improved, although they felt there were still not enough staff to meet people's needs. We saw people in the home had a high level of dependency and staff told us 'most' people needed two staff to assist them with their care needs. We saw staffing levels at times were not sufficient to meet people's needs and people had to wait to be assisted or supported. Care staff were engaged in physical tasks with people and had little time to spend supporting people's social or emotional needs. For example, we had to locate staff to support one person who we heard calling out for more than 10 minutes that they felt lonely in their room. On another occasion we had to find staff to assist a person who was coughing and needed support to sit up. On a further occasion we located a member of staff who was assisting another person, to ask for their support on behalf of a person who was not comfortable in their seat. We saw one person asked to go to the toilet and they waited 10 minutes before staff were available to assist them. On all occasions the staff we alerted were busy attending to other people.

We spoke with people who remained in their rooms. Some people told us they preferred to be on their own. However, three people we spoke with said they had to wait 'long periods' for staff to assist them. One person

said: "It's 10 to 12, I can see the clock, every day is like this and I'm just stuck here until they get round to me. I can't do anything for myself so I just have to wait". The person told us: "If I had my way I'd have been up hours ago. I've been awake since 8 o'clock and the day's half over". Another person said: "I would like to get up if I can, but it's a long process with me. They don't have time".

At lunchtime we saw the housekeeper supported care staff in the dining room to serve meals and assist people. One member of staff took meals to individual people in their rooms. They told us they tried to ensure people had their meals as soon as possible but could only take one at a time so others had to wait.

The above examples illustrate the provider was in continued breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at recruitment files for four members of staff. We saw evidence that suitability checks and induction had been completed prior to employment. For one staff member, a registered nurse, we saw there had been a documented concern about their competency to administer medicines and they had been suspended from doing so. We saw the nurse administering medicines, although information in their file suggested they should not be doing so. We discussed this with the manager who told us the nurse's competency had been recently assessed and confirmed at one of the provider's other homes, although confirmation of this was not yet recorded in their file.

We looked at the systems that were in place for the receipt, storage and administration of medicines. We saw that the medicines room was cluttered and trolleys were not secured to the wall. There were discrepancies in recording of medicines; some were opened but not recorded. There were medicines for two people which were out of date but had not been discarded. Topical creams for people were not stored consistently, some were in the medicine cupboard and some were in people's rooms.

The above examples illustrate the provider was in breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed some people being given their medicine during our visit. Staff gave people their medicine in a calm, kindly manner, although we saw there was no conversation taking place with one person when the nurse assisted them with their eye drops. Staff responsible for giving medication told us they stayed with each person until they were sure the medicine had been taken.

We saw the Medication Administration Record (MAR) charts included details of the medicine, what it was for, the dosage and how the medicine should be taken. Where people needed PRN (as required) medicine for pain, staff knew when and how this should be given. Staff told us they were aware of clues in people's facial expression and body language that may suggest they were in pain. We saw one person who was nursed in bed had not had a recent assessment of their pain, despite a 24 hour syringe driver being in place to manage pain. This meant staff did not have current information about the person's needs. We discussed this with the nurse and later saw a review of this was scheduled in the diary.

The clinical lead for the home identified there were no homely remedies supplies and was taking action to clarify the organisation's policy regarding this and to contact the pharmacy.

Staff used personal protective equipment (PPE) appropriately to help prevent the spread of infection. On the first day of the inspection we were told two people had been asked to stay in their rooms because they had been vomiting. Staff explained to people the reason for this. We saw there were cleaning staff on duty and the home was free from unpleasant odours.

However, we saw the home had two cats whose food and bedding were in one of the lounge areas. The cats wandered freely through the home and we saw one cat attempted to get on a person's bed which may have posed a risk of infection. The housekeeper was unable to provide evidence in support of the frequency of mattress cleaning and said this was particularly difficult to do when so many people were nursed in bed.

In February 2016, the home had been visited by the infection, prevention and control team and the audit carried out revealed poor practice had been identified throughout the home. The manager told us they were aware of the actions required, had taken steps to raise standards and were confident things were improving to ensure people's safety from the risk of infection.

Inadequate

Is the service effective?

Our findings

People we spoke with gave their views about the staff's abilities to do their job. Two people said staff skills had improved in relation to the care of their wounds. One person said: "Oh my legs were really bad and I had horrible itchy bandages on before [staff name] came here. Now, I feel they are much better and I don't need the bandages, just this smaller dressing". Another person said: "They [staff] have improved, they've got a better idea of what will help me heal. They said if I drink lots of water that will help a lot and I'm sure they're right". One person told us staff were 'good at their job' and another said: "I think I'm in good hands. I used to be a nurse and I think from what I've observed they do things as they're supposed to. I know they are always doing training". Another person said: "It's not that the staff don't have the right skills, it's that there's not enough of them and it's not easy work".

Relatives told us they were confident in the capability of the staff. One relative said: "They know my [family member] so well and they know just the right way to manage their care". Another relative said: "This is the best place for [my family member], they are so happy here. There's been a change in staffing and they seem better at what they do".

Staff we spoke with said they were supported to undertake mandatory training for their role. We saw the training matrix showed staff had received relevant training, although we found from speaking with staff they lacked knowledge of key aspects of people's care, such as pressure care, dementia care and the legislation around people's mental capacity and rights. The manager told us training needs had been identified and we saw evidence of training that had been arranged for some staff. The nurse we spoke with told us they had been booked on to training for managing pressure care and the clinical lead said they were offering in house training to all staff to ensure they knew how to prevent and manage people's pressure care in a clear and robust way.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We found staff did not understand the legislation regarding MCA and DoLS and how this impacted upon their role in supporting people's rights. It was clear from people's care records their mental capacity had not been assessed or due consideration given to any deprivation of liberty issues. The manager told us 'very little' had been done since they came into role to address this; although they acknowledged this was a significant area to improve and planned to take action.

We found there were restrictions on people's liberty and choices, particularly with regard to people remaining in bed when they said they would prefer to get up, and the use of bed rails. One person had stated they did not want bedrails to be used, but staff made the decision to use these against the person's wishes. Daily notes for the person stated 'demanded bedrails be removed. Explained for own safety'. The person's care plan recorded they did not require an assessment of their capacity and 'is able to make simple

day to day decisions'. We discussed this with the manager who agreed to review this.

This meant that staff were not working in line with the requirements of the MCA and DoLS and the provider was in breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff supervisions had taken place and staff confirmed they felt supported by this process. Staff told us there had been an improvement in this aspect of their support since the previous manager left. Staff meetings had taken place although it was not clear from the records which staff had attended. Staff we spoke with told us communication had improved in the home and they felt better supported to undertake their roles.

We saw people enjoyed the food in the home. One person said: "I do enjoy the meals, you can ask my [relative]. I look forward to them". Another person said: "I am such an old body and I like the food here. If I don't fancy what's for dinner they make me something else, I never go hungry".
We saw staff regularly took the drinks trolley to people and offered drinks and snacks. One person said: "I look forward to a nice cup of tea when they come round. If I wanted a drink any time I could ask and I would get one".

We saw people's lunchtime experience in the dining room was sociable and relaxed. People were shown a visual choice of meal so they could decide what they would like. Where one person seemed to struggle with their soup in a bowl, staff offered to put some in a cup to make it easier for them to manage. People were offered second helpings where they wished to have more. Some people enjoyed a glass of sherry with their meal. One person told us they enjoyed that part of the meal. We spoke with one person's relative at lunchtime and they said whenever they visited the meals seemed appetising and were nicely presented. Staff were attentive to people's needs and requests, although on occasion there were no care staff in the dining room and the housekeeper offered support.

We spoke with a visiting dietitian who told us staff in the home were receptive to their advice about people's nutrition and how best to support their dietary needs. They told us snacks had improved in quality and frequency to supplement people's diets. We found from looking at people's care records, there was variable input or referral to the dietitian. Although people told us the meals were good and they enjoyed the food, we found there was lack of consistency in people's weight management and no close monitoring to identify concerns. We reviewed a sample of records of people's weight and saw some people had gained weight but others had shown a steady decrease and there was little evidence of action taken. For example, on one person's weight record it was noted 'speak to dietitian' where they had lost weight, yet where other people had lost weight there was nothing recorded. One person's care record stated they were to be weighed weekly, yet there was no recorded weight since 6 April 2016, despite known weight loss.

On people's care records we found incomplete and inaccurate risk assessment scores for the malnutrition universal screening tool (MUST) used to identify if a person was nutritionally at risk. For example, one person had no score against the 'weight loss' section in spite of having lost weight. For some people, there was no height recorded, yet there was a body mass index (BMI) score, which takes height into account when determining the individual risk.

We found conflicting information in some people's care records about their dietary needs. For example, one person's record stated 'normal diet' in one section and 'fortified diet' in another section. Where people's food and fluid intake was recorded, this was not totalled or action evidenced where people refused food or drink and therefore monitoring of this was not carried out. The clinical lead told us they were reviewing each person's dietary and hydration needs as part of their role and this would be a priority.

The above examples demonstrate a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had received information prior to the inspection that a significant number of people had some form of skin damage, such as pressure ulcers, wounds or skin tears and a lack of involvement of the tissue viability nurse (TVN) team for specialist care. On the first day of the inspection we were told there were six people with high risk pressure sores at category three or above. Staff lacked knowledge of when intervention may be needed or the signs that may suggest a problem.

However, we found the newly appointed clinical lead had taken prompt action upon being appointed in their role, to prioritise this and ensure the involvement of the TVN so that people's skin care needs were being addressed. We saw evidence by day two of the inspection of recorded improvements to people's skin integrity, which showed the action being taken by the clinical lead was effective. However, there was no still clear regime established and understood by staff for managing people's pressure care. For example, repositioning support for people was not clearly documented and there appeared to be no consistency in the frequency this was done, with ad hoc times recorded.

The above examples illustrate the provider was in breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us if they needed to see a doctor the staff arranged this quickly for them. We saw from people's care records there were other professionals involved in support of people's health care needs when required, such as GPs, dieticians, chiropodists and optometrists.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us staff were caring in their role. One person said: "I cannot fault the staff, they are so kind and thoughtful". Another person said: "They care about me, they just don't have a lot of spare time which I understand". Another person said: "There's no comparison to the last place I was in. I know the difference when staff care and when they don't. This lot really care, they do". One relative said: "From the moment we came here, this felt like home. My [family member] is really happy here. The staff know [my family member]'s needs so well. They really care for them". Another relative told us their family member enjoyed having their hair and nails done and staff ensured this aspect of their care took place. They said: "It is important for their dignity to look and feel nice and staff understand this".

People's rooms were personalised with their own belongings, such as photographs. We saw staff respected people's privacy by knocking on doors before entering.

We saw care staff had very limited time to spend engaging with people in a social way because they were busy carrying out physical care. However, when supporting people staff interaction was positive and provided information and explanations about the care being given. Staff were kind and caring in their approach to people's care needs and they spoke with them respectfully. Staff took time to speak with people at an appropriate pace and used friendly faces and tones of voice when interacting with them. Staff respected people's privacy and we saw they were discreet when offering assistance with personal care. We saw staff greeted people by name and asked about how they were feeling. Staff listened when people spoke with them and they made good eye contact, used appropriate gestures such as smiles and nods.

We saw all staff in whatever role they held, were friendly and chatted with people as they went about their work. For example, cleaning staff talked to people about the weather as they went into people's rooms and they alerted care staff if people needed support.

Staff we spoke with were positive about their role and had an understanding of diversity and equality. One member of staff told us: "Each person is different, you can't treat them all the same, they have individual needs". Staff were aware of people's different preferences, personalities and family circumstances. One member of staff told us they had given extra time to support a person's emotional well-being as the person had experienced a recent bereavement.

Where people were nursed or cared for in bed staff had no clear understanding of why this was. On one person's care plan it stated 'nursed in bed due to ill health'. Staff we spoke with did not know which people in the home needed nursing care. One member of staff told us people were in bed 'because of dementia'. This showed staff lacked understanding of people's needs.

We spoke with the activities co-ordinator who was temporarily in post. They told us they had begun to spend time getting to know individuals and how they liked to be cared for. As part of their work they said they had been encouraging care staff to enhance the quality of people's care by understanding why some people were in bed all the time and what could be done to ensure people were not socially isolated.

It was not always clear from people's care plans whether they had expressed any end of life care wishes. One person was receiving palliative care, yet there was no evidence of their wishes being discussed with them.

Inadequate

Is the service responsive?

Our findings

We gathered mixed views from people about whether their care was responsive to their needs. One person said: "I am fully mobile, I can get myself to wherever I need to be. I entertain myself and I do not need anyone to find me things to do". Another person said: "There's always enough for me to do, I'm happy as I am. I get my visitors and that's enough for me". Another person said: "There isn't enough to stimulate people here. I'm lucky because I can walk around so I don't need any help in that way. But others have to rely of staff for everything and there's not enough for people to do here". Another person said: "There's nothing for me to do. I would like to get out of my room, but unless they [staff] help me, I'm stuck fast". One person said: "I really would like to do more, you know, be where people are instead of in here [own room] all the time". We heard one person who was in bed called out for staff attention. They repeatedly called: "Please, please someone come and talk to me, just to talk to me, I'm so lonely". We went into the person's room and they told us: "I'm so lonely in here, I'd love someone just to talk to me for a while".

We found care was not person centred and people were at risk of being socially isolated due to spending continuous time in their own rooms with limited interaction. Staff were unable to give an explanation of why individual people remained in bed. The manager told us people were 'stuck in their ways' and did not wish to come out of their rooms. We asked people in their rooms if it was their choice to be in there. Whilst some people told us they preferred to stay in their rooms, many other people we spoke with, particularly those in bed, said this was not through their own choice. For one person in particular, we saw their care record contained advice from other health professionals for them to be regularly out of bed and for specialist seating to be sought. We saw this advice had not been acted upon and we asked the manager to review the needs of all people. The manager told us they were considering ways in which people could be encouraged to spend time out of bed, such as by making changes to the purpose of communal areas.

This is a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the temporary activities staff member had begun to spend time with some people individually to identify their social needs and to plan activities that were meaningful to each person. This member of staff told us although they were temporary, they had many ideas for ensuring people had purposeful activity in their day and they were working with the manager to consider ways in which people could be encouraged or supported to get up and be out of bed where possible. These ideas had not been implemented at the time of the inspection and there was a proposed new activities co-ordinator being appointed to work alongside the temporary one until they were confident in their role.

Care records we looked at did not centre round people's individual needs, they lacked detail and information was not up to date or accurate. At times information was conflicting. For example, one person's care record stated 'is able to use all five senses' yet another section stated the person was blind and partially deaf. Another person's care record stated they needed a wheelchair and standing hoist for assistance with mobilising, yet in another section it stated they were always hoisted. There was no further information about the use of the hoist within the care plan. For one person who was a recent admission to the home there was blank information in the care record in relation to consent, moving and handling, safety and skin care. This

meant staff did not have knowledge of the care needs or risks for people.

This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The complaints procedure was accessible to people and we spoke with the manager about how complaints were managed. We saw the complaints record and the manager assured us the procedure would be followed in line with corporate procedures. People we spoke with said if they were unhappy they would speak with staff and let them know. Relatives were confident that staff and management would deal with any concerns and said everyone who worked in the home was approachable.

Relatives reported a change in their confidence in management during recent months. One relative said: "There's been a shift in management, it's much better now than it was before so if I had any complaints I'd know exactly who to speak to". Another relative told us: "Things seem to be better than before, though I'm not sure why that is. I'm happy any complaints would be looked into, but I don't have any".

Inadequate

Is the service well-led?

Our findings

People, staff and relatives we spoke with told us the home was improving in the way it was being managed although said the manager was not always visible in the home. One person said: "There's a new boss, I like [them]". Another person said: "There's another person steering the ship and you can tell, it's a better place". One relative said: "We feel more involved than before in the care of [family member]. I think it's running well and I have no concerns about that". Staff told us they thought things were improving and said morale had recently been low but was better now than before. One staff member said things were 'picking back up' under new leadership and reported a more open culture.

There was a registered manager but they were no longer in post at the time of the inspection. We found that the home was not well led or managed at the time of the inspection. The home was being managed on a part time basis by another registered manager from one of the organisation's other homes. Support for this manager was provided by the regional manager and by a newly appointed clinical lead. The manager told us they were aware there had been issues to address when they took over the running of the home and they had begun to implement systems and processes for clearer leadership.

We saw there were regular audits carried out in the home by managers within the organisation with overall responsibility for managing quality. However, there were no robust systems and processes in place that enabled the manager to identify and assess risks to the health, safety and welfare of people who used the service. For example, although we saw some internal checks were recorded as complete, such as maintenance of mattresses, these were not rigorous enough to ensure quality of service provision. Other internal audits, such as care plan audits, did not identify where errors and inconsistencies in people's care occurred or where there were risks to people's health that we had observed.

Although the clinical lead had been appointed and was supernumerary, they were initially focused on improving the skin care regime of people in the home. This involved spending time assessing people's skin integrity, developing staff's knowledge and competence in managing people's care needs and devising individual plans of care. This meant there were other aspects of people's care that required addressing as identified through the inspection process and there was limited management oversight of these.

We saw the weekly clinical risk review highlighted actions to undertake in relation to people's health care needs and an extensive action plan was drawn up. This picked up some of the themes identified at the inspection. Some of the actions required the clinical lead to carry out assessments and reviews for the ongoing management of people's care moving forward, but at the time of the inspection there was no evidence to show this was carried out or sustained.

This above examples illustrate a breach of Regulation 17 Health and Social Care Act 2008 (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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent to care was not sought or their rights respected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's dietary and nutritional needs were not closely monitored.

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 There were insufficient staff deployed to meet people's needs in a timely manner.

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 9 HSCA RA Regulations 2014 Person-centred care Care was not person centred and many people were nursed or cared for in bed without known reason.

The enforcement action we took:

Warning notice

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 Risks were not properly assessed or mitigated. Medicines were not managed safely.

The enforcement action we took:

Warning notice

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 Systems for assessing and monitoring the quality of the provision were not robustly in place.

The enforcement action we took:

Warning notice