Buckland Care Limited

The Orchards Residential Home

Inspection report

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Date of inspection visit:
27 February 2018
05 March 2018

Date of publication:
18 July 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 27 February 2018 and 5 March 2018 and was unannounced. We carried out this inspection following concerns relating to incidents resulting in injuries to people.

The Orchards Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The Orchards Residential Home accommodates 44 people in one adapted building. At the time of our inspection there were 42 people using the service.

There was a registered manager in post. 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 service did not promote a person-centred culture that valued people as individuals. People were not always treated with dignity and respect. Some staff were task focused and did not always treat people in a kind and compassionate way.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service do not support best practice.

Systems to monitor and improve the service were not effective and the registered manager did not have a clear overview of the service and the quality of care being provided to people.

Accidents and incidents were poorly managed. There was no record of any action taken as result of accidents and incidents and no evidence of investigations being completed. There was no system in place to monitor accidents and incidents for trends and patterns.

Risks to people were not always identified and where risks were identified there were not always effective plans in place to manage those risks. Medicines were not managed safely to ensure people received their medicines as prescribed.

Systems in place to prevent the risk of infection were not effective. Areas of the home were malodorous. Some equipment was in a poor state of repair and not kept clean.

Staff were not deployed in a way that ensured people's needs were met in a timely manner. Staff did not always have the skills and knowledge to meet people's needs.

People did not always receive food and drink to meet their dietary needs and there was no effective system in place to monitor people's weights, when required. Where people had lost weight action had not been taken to address concern's relating to their weight loss.

Records were not accurate, up to date or fully completed. There were not always care plans in place and people's care records did not always reflect their current needs.

Records were not stored securely to ensure people's confidential information was protected in line with legislation.

People enjoyed a range of activities that were developed to meet their individual needs.

We identified six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risk to people were not always assessed. Where risks were identified there were not always plans in place to mitigate the risks.

Accidents and incidents were not effectively managed.

There were not effective infection control measures in place.

Medicines were not managed safely.

Is the service effective?

Inadequate

The service was not effective.

People were not always supported in line with the Mental Capacity Act 2005.

People did not always receive food and drink to meet their dietary needs.

Staff had not always completed training to ensure they had the skills and knowledge to meet people's needs.

Is the service caring?

Requires Improvement

The service was not always caring

People were not always treated with dignity and respect.

Staff were not always kind and compassionate with people.

People were not always referred to in a respectful manner.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care and support to meet their needs.

People and relatives were not always involved in decisions about their care.

Care plans were not always accurate and up to date.

There were a range of activities available for people to enjoy.

Is the service well-led?

Inadequate

The service was not well led.

The culture in the service did not promote person-centred care that valued people as individuals.

Systems to monitor and improve the service were not effective.

The registered manager did not notify the commission in line with their regulatory responsibilities.

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

The inspection was prompted in part by notifications received from the registered manager relating to incidents where one person had sustained a serious injury and one person had died. The information shared with CQC about the incidents indicated potential concerns about the management of risk of falls and those related to people exhibiting behaviour that may be seen as challenging.

During the inspection we found that risks to people were not being managed and this resulted in a breach of regulations.

This inspection took place on 27 February 2018 and 5 March 2018 and was unannounced.

The inspection was carried out by five inspectors, a specialist advisor in dementia care and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we looked at information we held about the service which included statutory notifications

We spoke with eight people and eight visitors . We also spoke with six social and health care professionals who support people in the service. We spoke with the registered manager, deputy manager, team leader, one senior care worker, four care workers, two activity staff, the chef and the maintenance person.

We looked at six people's care records, six staff files and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People were not supported by a service that provided safe care. We carried out this inspection following concerns relating to people experiencing injuries which indicated accidents and incidents were not being effectively managed.

We asked people if they felt safe living at the Orchards Residential Home. Whilst most people told us they felt safe, our observations and findings did not support that people were safe. Some relatives told us they felt people were safe. However, other relatives gave examples of incidents that indicated people were not safe. For example, one person had left the service unaccompanied when they were not safe to do so.

Risks to people were not always identified and where risks were known there were not always risk assessments or effective plans in place to manage the risks. For example, one person had experienced several falls. The person's risk assessment had not been updated following the person sustaining a fracture. We asked the deputy manager if the risk assessment had been updated. The deputy manager told us, "I don't know it should have been done". The person's risk assessment had been incorrectly completed and resulted in an inaccurate assessment of their risk. There was no clear up to date guidance for staff to follow when they supported this person to mobilise because there was no mobility care plan completed. We asked the deputy manager about the mobility care plan. They told us, "I don't know, it should be in there". This meant people were not always protected from the risk of falls.

Risks associated with pressure damage were not always managed. For example, one person's care plan stated, "Ensure [person] is on a pressure cushion at all times when sitting". During the inspection we saw the person was not sitting on a pressure cushion in their arm chair and when staff transferred the person to their wheelchair no pressure cushion was placed. This meant people were not always protected from the risk of pressure damage.

People were not always protected from the risk of choking. For example, one person was prescribed thickener for their drinks to prevent them from choking whilst drinking. The Speech and Language Therapist (SALT) guidance stated that all drinks should have, "Half a scoop of [thickener] in 200mls of fluid. The container of thickener stated "As directed". We spoke with staff about how they supported this person and they did not know the correct amount of thickener to use to keep the person safe. One member of staff told us, "I thought it was PRN [as required] to be honest". Another member of staff told us, "I want to say one scoop".

Where people were at risk of behaviours that may challenge themselves and others there were not always plans in place to manage the risks. For example, one person had been admitted to the service and was known to exhibit behaviours that could be seen as challenging, which could put themselves or others at risk. The person's care plan contained no details of the person's behaviour and any potential triggers to the person's behaviour. There was no guidance for staff in how to support the person when they displayed behaviour that may have put themselves or others at risk. Although staff told us about the person's behaviour and that the person could be 'Inappropriate' towards staff, they were not aware of the triggers for

the person's behaviour. One member of staff told us, "For some people who get distressed we do have trigger points. But not always in the care plans". This meant people were not always protected from the risk of behaviours that challenge.

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

Systems in place to identify, investigate and monitor accidents and incidents were not effective. Recording of accidents and incidents was not accurate or consistent. There were no effective systems in place to enable lessons to be learned and themes identified when incidents and accidents occurred. The service used both accident and incident forms. The incident template indicated that this form was used when an incident occurred and the person did not sustain an injury and the accident form used when a person did sustain an injury. However, we found that both recording processes had been used for events that both had and had not resulted in injury.

Accident and incident forms were not fully completed and there was no record of action being taken as a result of the incident. For example, we looked at 17 incident forms completed since the last inspection in May 2017. There was no evidence of any investigations or actions being completed. The area of the form that required "manager action/decision" had not been completed on any of the incident forms.

Where accidents and incidents occurred the registered manager did not always follow the provider's policy and did not ensure action was taken to keep people safe. For example, on the first day of the inspection we were informed that one person had left the building unaccompanied on 17 February 2018 placing themselves at risk and had been returned to the service by the Police. The service had not been aware the person had left the building until they were contacted by the Police. We asked to see the incident form and details of the subsequent investigation. The registered manager was not able to find the incident form and told us a senior care worker was completing the investigation. The senior care worker was not available. The provider's 'Missing person's policy' stated that investigations were "To be carried out by the home's registered owner who will be responsible for implementing any improvements that are indicated".

On the second day of the inspection the deputy manager provided an incident report they had completed. However, there was no evidence of any investigation being carried out. The deputy manager stated that the incident form had been completed, "Once everything had been done, like the DoLS [Deprivation of Liberty Safeguard]". The DoLS application had not been submitted until 3 March 2018.

Following the incident the person's care record was updated and stated, "Regular checks of whereabouts of the service user". However, there was no system in place to monitor the person. We spoke with the registered manager who told us they would put checks in place. On the second day of the inspection the deputy manager told us a form had been put in place from 28 February 2018 to record half hourly checks. However, there was no record available from 28 February 2018 to 1 March 2018. This meant we could not be sure the system in place would keep the person safe.

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

Medicines were not managed safely. Medicine administration records (MAR) were not completed accurately or in line with national guidance relating to management of medicines in care homes. For example, one person was prescribed two separate doses of the same medicine. The medicine was recorded as one entry on the person's MAR. There was no record of the balance of the medicine. The National Institute for Health

and Care Excellence (NICE) guidelines state: Care home providers should ensure that a new, hand-written medicines administration record is produced only in exceptional circumstances and is created by a member of care home staff with the training and skills for managing medicines and designated responsibility for medicines in the care home. The new record should be checked for accuracy and signed by a second trained and skilled member of staff before it is first used. The entry was handwritten and only signed by one member of staff. This meant the provider could not assure themselves that the information on the MAR was accurate and the person would receive their medicine as prescribed.

Staff responsible for the administration of medicines were not always accurately completing MAR. For example, one member of staff signed to confirm people received their medicines at 8:00am. However, the member of staff did not commence the medicine administration until 9:00am. This meant people were at risk of not receiving their medicines as prescribed.

Where people were prescribed topical medicines there was not always information relating to the frequency of administration. For example, one person's topical medicine record stated their topical medicines were to be applied on an 'as required' (PRN) basis. The MAR for the person's topical medicines stated they were to be administered 'as directed'. We spoke to the team leader who told us, "Every time [person] is turned [person] is creamed". However, the records relating to the person's repositioning did not contain entries for the same times and dates as the MAR for the topical medicines. We could not be sure this person was receiving their topical medicines as prescribed.

NICE guidelines in respect of 'when required' (PRN) medicine states: Care home providers should ensure that a process for administering 'when required' medicines is included in the care home medicines policy. The following information should be included: the reasons for giving the 'when required' medicine, how much to give if a variable dose has been prescribed, what the medicine is expected to do, the minimum time between doses if the first dose has not worked, offering the medicine when needed and not just during 'medication rounds' and when to check with the prescriber any confusion about which medicines or doses are to be given recording 'when required' medicines in the resident's care plan. Where people were prescribed PRN medicines, the MAR were not always completed in line with NICE guidance and did not always contain details of the dose administered. For example, one person was prescribed PRN pain relief. The PRN protocol stated the dose was, "one or two soluble". The entries on the MAR did not state the quantity given. There was no entry stating why the medicine was administered. We could not be sure people were receiving PRN medicines to meet their needs.

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

Systems in place to ensure medicines were stored at the correct temperature were not effective. For example, the records relating to the medicine refrigerator temperature were not fully completed. Where the temperature had been recorded as outside the recommended temperature range there was no record of any action being taken. This meant people were at risk of receiving medicines that may not be effective because they had not been stored at the correct temperature.

Infection control procedures were not always effective. There were areas of the service that were malodorous. There were not always handwashing facilities available to staff when they had supported people with personal care. For example, one toilet contained no handwashing facilities. Staff were not able to wash their hands when they supported people to use this toilet. Staff did not always use PPE (personal protective equipment) such as disposable gloves and aprons, when supporting people with personal care.

Equipment was not always maintained to a good standard of repair and cleanliness. For example, one person had a tray table provided for them to eat their meals. The table was chipped and had dried food around the edges. Place mats were chipped and worn which meant they could not be cleaned effectively. Some were found to be dirty with dried food.

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

There were sufficient staff to meet people's needs. However, staff were not always deployed in a way that ensured people's needs were met. For example, one person told us, "I wouldn't say they were quick no, and I'm not sure if it's that they need more staff. I do have to wait and there seems to be plenty of them milling about".

On the first day of the inspection seven staff members were in the dining room at one time. There were no people in the room with them. We spoke with senior staff who told us three of the staff were taking their allocated break. However, no action was taken to address the remainder of the staff who were not attending to people's needs.

On the second day of the inspection several people were left in four communal areas of the service for more than 20 minutes. During that time some people became anxious. One person was walking around and causing others to become anxious. One person started shouting. No staff were present to reassure people. This meant staff were not deployed in an effective way to ensure people's needs were met.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have effective systems in place to ensure people were protected from abuse and improper treatment. For example, the incident forms contained two safeguarding incidents relating to verbal abuse and physical abuse of a person by another person in the service. There was no record of an investigation being completed and no record of a referral being made to the local authority safeguarding team.

Although care staff understood their responsibilities to identify and report concerns relating to abuse, records showed that action was not always taken as a result of concerns being identified. For example, accident and incident forms showed that safeguarding concerns had been identified. However, action had been taken to raise concerns with the local authority safeguarding team. One member of staff told us, "I would report it to my senior, [deputy manager] or [registered manager]. I have the contact number for the area manager. I could go to CQC (Care Quality Commission). Another member of staff said, "I would report to [deputy manager] or [registered manager] and I know the number for safeguarding so I could call them".

The provider had effective recruitment processes in place to ensure staff employed were suitable to work in the service. The provider carried out recruitment checks which included employment references and DBS (Disclosure and Barring Service) checks.

Inadequate

Is the service effective?

Our findings

People were not always receiving food to meet their dietary needs. For example, one person had been assessed by the Speech and Language Therapist (SALT) as requiring a pureed diet. SALT guidance also stated that as the person ate quickly they should be offered several small portions of food. On the first day of the inspection the person was not given pureed food or small portions. On the second day of the inspection the person had been further reviewed by SALT. SALT recommendation stated that the person should be given "fork mashable" food. We observed the person was given food that did not meet the descriptors in NHS guidance for a fork mashable diet. The person was not given small portions of food. This meant the person was not receiving food to meet their dietary needs.

There was no information in the kitchen relating to people's individual dietary needs. We spoke to the chef who told us the information was 'In his head". The chef told us they were informed of people who were at risk of weight loss and they then provided a fortified diet. The chef was not able to tell us who was at risk of weight loss and was on a fortified diet. We asked the chef about people who were diagnosed with diabetes. The chef was not aware of one person who had diabetes. That person's care plan stated the person had diabetes that was controlled by diet and medicine. Therefore, people were at risk of being given food that did not meet their dietary and health needs.

Where people were at risk of malnutrition appropriate action had not been taken to address people's weight loss. For example, one relative told us, "[Person] has lost weight, maybe it's just poor appetite because of being inactive, but [person] eats like a bird. I'm not sure that staff can do anything. I know [person] has three meals a day but just eats tiny amounts". The person's care record showed they had lost weight and the risk assessment showed the person was at high risk of malnutrition. Actions to be taken included; weighing the person weekly, offering nourishing snacks between meals, fortifying food and recording the person's food and fluid intake. The records also identified the person should be referred to the community dietician for fortified drinks. However, staff were not following this care plan. We spoke to a member of staff who told us, "[Person] is not on fortified drinks. No one at the moment is being weighed weekly". Weight records showed the person was not being weighed weekly. The person had not been referred to the dietician for fortified drinks. Food and fluid charts for the person had not been fully completed and did not show the person was being offered nourishing snacks between meals. There was no information relating to the food that had been fortified for the person. This meant the person was not receiving food and drink to meet their needs.

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

Staff did not always have the skills and knowledge to meet people's needs. For example, we observed two members of staff supporting people to eat and drink. One member of staff was supporting a person with thickened fluids. We asked the member of staff if they had completed training in relation to supporting people with specific dietary requirements. The member of staff told us, "No, I just shadowed someone in another home, and if someone choked I'd just shout". Another member of staff who was supporting people to eat and drink told us, "I just help out at lunch, so if you see me doing anything that should not be

happening it's because I'm not a carer".

Staff did not always use safe practices when supporting people to move. For example, we saw one member of staff using an incorrect moving and handling technique when supporting a person to reposition in their chair. We spoke to the deputy manager who addressed this with the member of staff. We looked at the member of staff's training record, which showed the member of staff had not completed an update for their moving and handling training in line with the provider's policy. Staff training records showed that not all staff had completed moving and handling or fire training.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not supported in line with the principles of the Mental Capacity Act 2005 (MCA). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Where people were receiving care that included restrictive practice there was no evidence that a mental capacity assessment had been considered and no evidence that a best interest decision making process had been followed. For example, one person who was identified as having a cognitive impairment had a gate across their bedroom door. Staff told us the gate was to prevent people entering the person's room. However, the person's care plan did not include a capacity assessment in relation to the use of the gate and there was no evidence that the decision had been made in the person's best interest.

Another person's care plan stated they required a lap belt when going outside in their wheelchair. There was no capacity assessment relating to the use of the lap belt and no evidence of a best interest process being followed.

Where consent forms were in place they were not in line with the principles of the MCA and referred to out of date legislation. Where people had appointed a legal representative to act on their behalf the provider had not recorded whether the authority contained any conditions in relation to the decisions that could be made.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had made several referrals for DoLS to the supervisory body but no authorisations had been made. There was no evidence that the applications had been reviewed or that peoples' care plans had been reviewed in relation to the DoLS application to ensure people were being supported in the least restrictive way.

People's records showed they some people were referred to health professionals. The service worked closely with the community matron and used an electronic system to enable regular monitoring of people in order to avoid unnecessary hospital admissions. However, we found that people were not always referred back to health professionals when requested or when people's conditions changed. For example, one

person had been referred to the dietician who had asked for a referral to SALT and for the person to be referred back to the dietician when they had been visited by SALT. There was no record of the person being referred back to the dietician. We spoke to the deputy manager who told us they would contact the dietician and arrange for the person to be reviewed.

Requires Improvement

Is the service caring?

Our findings

People were not always treated in a kind and caring manner. People and relatives told us that staff were friendly and approachable. However, our observations did not always support this opinion.

Staff did not take opportunities to interact with people. For example, staff placed people's meals in front of them without any interaction. One member of staff removed a person's clothing protector after their meal without speaking with them.

When people were calling out staff did not take time to reassure and comfort them. For example, one person was in a communal area of the service. They were distressed and called out saying, "I can't get up. Will someone help us". Two members of staff were present in the room. However, they did not acknowledge the person's distress or offer any reassurance. They both left the room without speaking with the person.

Staff did not offer reassurance to people when supporting them. For example, one person was being supported to transfer using a hoist. Two members of staff were supporting the person. Whilst the person was in the hoist they were calling out in distress. The staff did not offer any reassurance to the person.

People were not always treated with dignity and respect. Staff did not refer to people in a respectful manner. We heard staff refer to people who required support to eat and drink as "Feeds" and people who required regular repositioning as "Turns".

Staff were not always respectful of people when speaking. For example, one person was being supported to eat and drink. The member of staff spoke over the person to another member of staff saying, "[Person] eats well". The other member of staff replied, "Yes, [person] likes their food".

Staff did not always take care to protect people's dignity and privacy. For example, one person was being supported to transfer using a hoist in a communal area of the service. When the person was hoisted staff did not take steps to ensure the person was covered and the person was inappropriately exposed to other people in the room. .

People's possessions were not always treated with respect. For example, one relative told us, "There's a problem with the laundry, things are always getting lost. It doesn't matter how you label things. We bought all new things and then we come in and find [person] wearing something that isn't theirs or stuff in the wardrobe that isn't theirs, which isn't nice". During the inspection one person was observed becoming distressed as they were having to wear dirty clothes because they had no clean clothes available.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw some kind and caring interactions. For example, we saw a member of staff supporting someone to eat and drink in their room. The member of staff spoke gently with the person, checking they were ready for

their meal. The care worker used touch to reassure the person they were in the room and to encourage them to eat.

Requires Improvement

Is the service responsive?

Our findings

People were not always supported in a way that met their needs. One person told us, "They don't come quickly, but you can't blame them if they're [staff] busy. If they don't come I just have to put up with it". The person told us this resulted in them being incontinent. The person added, "But they [staff] don't mind, they just change me and don't say anything".

People were not supported in a person-centred way that valued them as individuals. Staff were task focused and did not take time to sit with people. For example, during lunch time staff did not engage with people in a meaningful way. Staff walked through the dining room, taking meals to people in their rooms, with no acknowledgement or interaction with people sat waiting in the dining room. People sat in the dining room for more than 20 minutes waiting for their lunch to be served while food was taken to people in other areas of the service. There was no explanation or reassurance offered to those people waiting. As people finished their main course staff removed people's plates without asking if they had finished their meal or whether they would like more food. The next course was served immediately, followed by hot drinks. Staff were focused on the task of serving the meal and not ensuring the dining experience was a social occasion. There was no attempt by staff to engage with people and create a pleasant dining experience.

People and their relatives were not always involved in the development of people's care or in care reviews. One relative told us, "We've never been sat down to talk about care or anything that might have changed". Another relative told us, "We were asked recently to look at a DNAR (do not attempt resuscitation) form. It wasn't recorded correctly, so that got changed, but that's the only time and it wasn't really a care review".

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

People's records were not always accurate, up to date or fully completed. For example, we saw that food and fluid charts, repositioning charts and night check forms were not fully completed. Records were not always dated and signed.

Care plans did not always contain information relating to guidance given by health professionals. For example, one person had been seen by a health professional. A letter in the person's care file from the health professional noted that the person's tongue had been coated and asked that the person be supported with mouth care in the future. There was no assessment of the person's mouth care needs and no care plan guiding staff in how to meet those needs. This was contrary to NICE guidance on oral health for adults in care homes.

People's care records contained information that referred to the incorrect person. For example, two people's names were written on the same page in one person's care plan. It was not clear which information was relevant to the person whose file the information was in.

Care plans did not always contain up to date information. For example, one person's risk assessment stated that staff must "Ensure [person] has Zimmer frame". However, this person was unable to mobilise independently and used a wheelchair at all times. This meant staff did not have access to accurate information to ensure they were able to meet people's needs.

Care plans did not always contain sufficient information to guide staff in how to support people. For example, where people required the support of staff and a hoist to transfer care plans did not contain information in relation to the type and size of sling the person required to transfer them safely.

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

People enjoyed a range of activities that were developed in relation to people's individual interests. Relatives were positive about the activities and the team that arranged them. One relative said, "The activities are just wonderful, [person] goes to the WI and joins in everything happily". Another relative told us, "[Person] has made this [showed a clay pot] the other week, which is amazing thinking how they were before they came here".

We saw people enjoying a chair based exercise class. One person told us in a cheerful manner, "I've done my physical jerks today. It keeps you going". People gave examples of activity staff providing activities that interested people. One person said, "I've got these DVD's [in my room] which he's [activity coordinator] given me because I love my old films and shows".

The two activity staff we spoke with were enthusiastic about their role and ensuring people were engaged in activities they enjoyed. The activity coordinator told us, "I designed a quiz which includes things I know individuals will know the answer to or will start a discussion as there's often no suitable quizzes. They're all about general knowledge or facts people can't remember because they have dementia".

There was an activity programme displayed which included: musical entertainment, exercises, games, quizzes and craft activities. People also had the opportunity to take trips out which included attending the local WI group, visiting local garden centres, going out for a pub lunch and shopping.

Where people did not enjoy group activities they were offered one to one support. One member of the activity team told us, "Some people aren't able to take part in the activities, but I sit with them, perhaps while they are having their tea and we have a lovely chat or look at a book together and they enjoy that time, which the care staff haven't got time to spend".

The provider had a complaints policy and procedure in place, which was displayed in the entrance to the service. Relatives felt confident to raise concerns. One relative told us, "We haven't had to make a complaint, but communication is quite good generally and we haven't had any big concerns".

Records contained one complaint since the last inspection. The registered manager had responded to the complainant. However, there was no evidence of an investigation being carried out and no evidence of concerns raised being addressed with the member of staff in question.

Inadequate

Is the service well-led?

Our findings

We carried out this inspection following concerns relating to people experiencing injuries which indicated accidents and incidents were not being effectively managed.

During the inspection we found the registered manager did not have a clear overview of the service. Throughout the first day of the inspection the registered manager was not always able to provide evidence requested and provided inaccurate answers to inspectors' questions. For example, a record of an incident involving a person's behaviour could not be found. The registered manager told us the incident form may have been removed by a visiting health professional. We spoke with the health professional who did not have the incident form. The registered manager was unable to give any explanation as to why the incident form was not available.

Systems for monitoring and improving the service were not effective. There were a range of audits in place; however they had not identified the issues we found during the inspection. For example, a medicines audit had been completed on 23 January 2018. The audit identified that the medicine refrigerator temperatures had been recorded daily. However, during our inspection we identified there were ten gaps on the record from 1 January 2018 to the 12 January 2018.

During the inspection the registered manager was unable to provide any up to date audits relating to their overview of the quality of the service. A manager monitoring checklist had last been completed on 9 May 2017 and had identified no issues. Following the inspection the provider sent copies of monthly home audits for November 2017 and January 2018 that had been completed by the quality assurance manager. The audits had identified many of the issues found during the inspection and included the action required by the registered manager. However, the audits did not give dates by which actions needed to be completed and no evidence of any follow up action taken when registered manager had not completed the actions identified.

Systems for gaining feedback about the service were not effective. A quality assurance survey had been completed by people in December 2017. However there was no system in place to address areas of concern. For example, 17% of respondents were dissatisfied with staff availability and attentiveness and 12% of respondents were dissatisfied with the way staff addressed people and spoke with them. These issues had not been addressed. Relatives told they were not aware of any formal methods of seeking their feedback about the service in the form of meetings or surveys.

Systems in place did not promote a person-centred culture that centred on people's needs and valued them as individuals. For example, records from a team meeting on 9 January 2018 stated, "Care staff to check bath list every morning and ensure six baths are shared daily". The daily handover report included the allocation of staff duties. The report referred to people requiring support to eat and drink as "Feeds" and people who required the support of two members of staff as "Doubles".

Although staff told us they felt supported there was no system to monitor staff training and staff supervision

to ensure staff had the skills and knowledge to meet people's needs. For example, the records we looked at for three staff had no file relating to supervisions or appraisals.

People's records were not stored securely to ensure confidential personal information was protected. Care plans were stored in an unlocked cupboard in the main entrance to the service. People's names and room numbers were displayed on a notice board in the main entrance of the service.

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

The registered manager did not submit statutory notifications in relation to events notifiable under their registration. For example, the registered person had not notified the commission of a person leaving the building unattended.

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

People were not always clear of who the registered manager was. One person told us, "I don't know who she is".

Throughout the inspection there was a lack of leadership and guidance for staff. On the first day of the inspection seven staff members were in the dining room at one time. There were no people in the room with them. We spoke with senior staff who told us three of the staff were taking their allocated break. However, no action was taken to address the remainder of the staff who were not attending to people's needs.

Staff were confident they provided person-centred care. One member of staff said, "We have a culture of well-being. There is a person-centred approach". However, this was not always observed during the inspection.

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider did not notify the commission without delay of incidents specified in the regulation.

The enforcement action we took:

A Notice of Decision imposed on the provider to send monthly reports to the commission to reflect the actions being taken to address the concerns identified.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure the service users received support that met their needs and reflected their preferences.

The enforcement action we took:

A Notice of Decision imposed on the provider to send monthly reports to the commission to reflect the actions being taken to address the concerns identified.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider did not ensure service users were being treated with dignity and respect.

The enforcement action we took:

A Notice of Decision imposed on the provider to send monthly reports to the commission to reflect the actions being taken to address the concerns identified.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not ensure service users were supported in line with Mental Capacity Act 2005.

The enforcement action we took:

A Notice of Decision imposed on the provider to send monthly reports to the commission to reflect the actions being taken to address the concerns identified.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Service users did not receive care that was safe. Risks were not assessed and plans were not in place to mitigate risks. Medicines were not managed safely. Risks relating to the spread of infection were not assessed and managed.

The enforcement action we took:

A Warning notice was issued requiring the provider to meet the requirements of the regulation by 31 May 2018.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor and improve the service were not effective. Systems to monitor and improve the quality and safety of the service were not effective and systems in place to mitigate risks relating to the health, safety and welfare of service users were not effective. There were not accurate and complete records for each service user and records were not stored securely.

The enforcement action we took:

A Notice of Decision imposed on the provider to send monthly reports to the commission to reflect the actions being taken to address the concerns identified.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably competent, skilled and experienced staff deployed to meet people's needs.

The enforcement action we took:

A Notice of Decision imposed on the provider to send monthly reports to the commission to reflect the actions being taken to address the concerns identified.