Weston Park Care Limited

Weston Park Care Home

Inspection report

Moss Lane
Macclesfield
Cheshire
SK11 7XE

Date of inspection visit:
03 October 2017
04 October 2017
05 October 2017

Date of publication:
16 January 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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on the 3, 4 and 5 October 2017. Weston Park is registered to provide accommodation and nursing care for up to 118 people. At the time of our inspection, 79 people were using the service. People lived in four separate units, which ranged from general nursing support to specific units for people who were living with dementia.

There was no 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. Two managers had been running the home and were responsible for separate units; both had resigned from their posts. One had already left and the other was due to leave during the week of the inspection. Neither of these managers had registered with CQC. The registered provider had employed a new manager who had been in post for one day when we undertook the inspection. The manager told us that she intended to apply to register as soon as possible.

At this inspection we found that the provider had taken action to meet the requirement meeting people's nutritional needs and consent to care. However, we still had concerns relating to the safe care and treatment of people, how people were cared for, how people were protected from abuse and harm, staffing, consent to care and the governance of the service. The provider had not taken the necessary actions to meet the requirements. We also found further breaches during our most recent inspection. Following this inspection, we are taking further action against the provider for repeated and serious failures to meet the regulations. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

People could not be assured that appropriate action was taken when there was an allegation or concerns of abuse or avoidable harm. Risks associated to people's health and care needs had not always been appropriately assessed, monitored and reviewed. Staff did not always follow the guidance where risk assessments had been completed. This impacted on people's safety and welfare.

Recruitment procedures had not always been followed robustly and there was a risk that the systems in place did not ensure that suitable people were employed. We found that systems to ensure that there were sufficient staff on duty were not always effective, because there were occasions when staff absences could not be covered. There was a high usage of agency staff and some people said that agency staff weren't always as familiar with people's needs. The provider told us that recruitment was a priority.

People's medicines were not managed or administered in a safe way. People did not always receive their medicines as prescribed and thickener was not always administered correctly.

Staff had received some induction and training, but not all staff had received adequate training. Records could not evidence that staff received appropriate supervision and appraisal.

Previously, we found that people's nutritional needs were not being met effectively. At this inspection we found that some improvements had been made and we received some positive feedback from a visiting dietician. However further improvements were still required regarding the standard of the food provided.

Further improvements were required to ensure that The Mental Capacity Act (MCA) was always followed where necessary.

Whilst individual staff were mostly kind and caring to people, we saw instances where people's dignity and privacy was not respected.

Whilst some people spoken with were positive about their support and treatment this was inconsistent. We were concerned that people did not always receive care and support which was responsive to their individual needs and staff did not always follow the guidance identified within people's care plans. Work had been undertaken to review people's care plans however we found that the plans had not always been reviewed regularly and were not updated in response to people's changing needs.

People told us that the level of activity had recently reduced and we were advised this was due to staff holidays. There had been two new members of staff recruited to the activities team. There were some positive developments and ideas in progress, which involved the community.

The provider had a complaints procedure, however appropriate records of complaints had not been maintained.

The registered provider did not have effective auditing systems or processes, which assessed monitored and drove improvement in the quality and safety of the services provided for people. The service had not made sufficient improvement since the last inspection. Lack of effective governance or systems meant that patterns of risk were not always being identified or actioned.

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 than12 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.

People could not be assured appropriate and timely action was taken when there was an allegation or concerns of abuse or avoidable harm.

Risks associated with people's needs were not sufficiently assessed, monitored and managed.

Staff were not always employed appropriately with the necessary checks having been completed.

Improvements were required with the management of medicines

Is the service effective?

Inadequate

The service was not consistently effective.

People's ability to make decisions was not always assessed in accordance with the Mental Capacity Act.

Staff training was in progress and some staff had received supervision but this was inconsistent and did not follow the provider's policy.

People told us they got enough to eat and drink but feedback about the food was mainly negative.

Is the service caring?

Requires Improvement

The service was not always caring.

For the most part people's dignity and privacy were respected, but staff needed to be more mindful of this at times.

The majority of people said the staff were kind and treated them well.

Is the service responsive?

Inadequate

The service was not responsive.

People did not always receive care and treatment that met their needs.

There was a continued failure to maintain an accurate and complete record in respect of each service user.

The records did not evidence how verbal complaints had been dealt with to show that the provider's policy for dealing with complaints had been followed

Is the service well-led?

Inadequate

The service was not well-led.

The service was rated requires improvement at our last inspection. We found effective action had not been taken to improve the service after this inspection.

The quality assurance systems in place were ineffective and failed to identify and mitigate risks to people's health, safety and welfare.

The provider had continued to fail to report significant events that had occurred in the service to us at CQC.

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

This inspection took place on 3, 4 and 5 October 2017 and was unannounced. The inspection was carried out by two adult social care inspectors and an expert by experience on the first day, one inspector on the second day and two adult social care inspectors on the third day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The service was aware of our visit to conclude the inspection on the second and third days.

We looked at any notifications received and reviewed any information that had been received from the public. A notification is information about important events, which the provider is required to tell us about by law. We contacted the local authority before the inspection and they shared their current knowledge about the home. We checked to see whether a Health Watch visit had taken place. Health Watch is an independent consumer champion created to gather and represent the views of the public. They have powers to enter registered services and comment on the quality of the care. A recent visit had not taken place but we read the latest report available.

We used a number of different methods to help us understand the experience of people who used the service. During the inspection we spoke with 15 people who lived at the home and two relatives/visitors, to seek their views. We spoke with 22 members of staff including the departing manager and new manager, regional manager, operations manager, five nurses supplied by an agency, unit lead, four carers, another four carers supplied by an agency, the activities manager, an activities coordinator and two maintenance staff. We also spoke with two visiting health professionals and a visiting social care professional.

We looked at the care records of six people who lived at the home and inspected other documentation related to the day to day management of the service. These records included, staff rotas, quality audits, training and induction records, supervision records and maintenance records. We toured the building, including bathrooms, store rooms and with permission spoke with some people in their bedrooms.

Throughout the inspection we made observations of care and support provided to people and observed lunch-time. As a number of people living within the dementia units at Weston Park were not able to tell us about their experiences, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

Inadequate

Is the service safe?

Our findings

We asked people and their relatives whether the support provided at Weston Park was safe. Comments included, "I feel safe, the staff are alright" and "It's very good, I'm quite comfortable here. It's quiet."

Following our last inspection In March and April 2017 we told the registered provider to take action to ensure that people received safe care and treatment. We had found that the service was not compliant with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because care and treatment was not always provided in a safe way.

At this inspection we found the provider had not taken responsive action in order to keep people safe. Individual risks to people were not always managed safely. We found there were widespread and serious shortfalls in this area and the registered provider remained in breach of this regulation.

People's risks associated with their care had not always been assessed or documented to help staff know how to mitigate the risks. For example we saw documentation about an incident that had occurred between two people living with dementia at the home. We saw that the incident had been referred by the provider as a safeguarding concern to the local authority. However, records did not demonstrate that a risk assessment had been completed to assess the potential for future risks and how to militate against these. In a further example we found that one person had experienced a high number of falls. Accidents records told us that the person had fallen on seven occasions since July 2017. They had a care plan in place for mobility and maintaining a safe environment but these had only been reviewed once since July 2017 and stated "no changes to input." The person had been seen by the GP due to falls and a falls diary had been put in place. However the diary was inaccurate and did not reflect the actual number of falls that had occurred. We found that the care plans and the moving and handling risk assessment did not record that any action had been taken following each fall to re-assess and ensure that further risks were being managed as safely as possible.

Where risk assessments identified actions to reduce the risk, staff did not always ensure these were followed. We reviewed one person's care plan, which recorded that the person had attempted to "escape" from Weston Park on three occasions in the previous two weeks. There was a risk assessment in place for the risk of absconding however this did not contain detailed information or sufficient guidance to staff. There was a "maintaining a safe environment" care plan written several months earlier, which documented that the risk of absconding was only minimal and did not reflect the increased risk or identify action to be taken in the event that the person left the building. The person's care plans also stated that they should be monitored using a behaviour chart and through hourly checks during the night. We checked to see whether there were additional monitoring charts in the person's bedroom and found there were no charts in place. Therefore actions identified to mitigate risks were not always being followed by staff.

Whilst we walked around the building we heard a service user shouting out from their bedroom for assistance. After a few minutes the inspector went to see the person, who told us that their leg was painful. The inspector saw that the person's call bell lead had been tucked into a chest of drawers and was

completely out of reach. We saw from his care plan that "(Name) requires staff to check he has his call bell to reach." Staff had not followed his plan to maintain a safe environment, which stated that he was at risk of falls. This exposed the person to the risk of harm and neglect of his care needs. This was raised as a safeguarding referral with the local authority.

We found shortfalls in the safe administration of medications. We were advised that there had been a deterioration in one person over the previous few weeks and they were increasingly agitated throughout the day and night. We checked the person's medication administration record (MAR) and saw that in the three weeks prior to the inspection, 19 doses out of 42 prescribed doses of Lorazepam medication had not been administered. The MAR records indicated that the medication was out of stock. The unit manager told us they had been on leave during this time and that staff had not contacted the GP to request further medication. Lorazepam is prescribed for anxiety and/or agitation type symptoms and guidance states that it should not be stopped suddenly. The medication had not been administered as prescribed and this potentially impacted on the person's well-being. The medication omissions had not been reported as an untoward incident or potential safeguarding concern due to the impact of the omissions. Action had been taken since to ensure that sufficient quantities were prescribed and available.

We found that guidelines were not always in place for 'as required' medicines. Some people using the service were not able to verbally communicate if they needed an 'as required' medicine such as pain relief or medication for anxiety or agitation. Guidelines for staff about how people would communicate non-verbally their need for an 'as required' medication were required. We discussed this with the unit manager who assured us that these would be implemented straight away.

Most medicines were stored securely in locked cupboards and fridges in the treatment room on each floor. We found Controlled drugs were stored safely in suitable locked cabinets and we checked a number of medicines and found the stock to be correct.

We were advised that one person's medicines were being administered covertly. This means medicines which are hidden in people's food or drink and given without their knowledge. The provider had a policy in place regarding the administration of covert medication. However we found that the person's care plan around medicines was blank and provided no information to staff about how to administer this medication safely and how often this should be reviewed.

A number of residents were prescribed a powder to thicken their drinks because they had difficulty swallowing. We saw on the Mulberry Unit that one tub of thickener was used for all of those service users who required thickened fluids. A previous complaint had been made about thickener not being added to a person's drink. The manager's response to the complaint was that the thickener had not been given as it should because the staff were using a common pot and processes would be put in place to ensure this didn't happen again. However, we observed staff giving thickener from one pot to people. A staff member told us that one person required five scoops of thickener, the handover sheet indicated they required "pudding consistency" and in their care plan required "syrup thick". The regional manager confirmed that five scoops of thickener in a drink would be too much and was incorrect. This presented a potential risk of inappropriate support and care. We saw from the person's care plan that they were at risk of choking and found the information to be unclear and contradictory. We concluded the management of medicines was not safe.

The above information meant that the provider continued to be in breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were concerned that people were not always effectively protected from harm and abuse. The provider had not ensued that all staff understood and followed local safeguarding processes.

Some staff spoken with were aware of safeguarding procedures and were able to tell us what to report and how they would report concerns of this nature. However the training records showed that only 69% of staff had completed safeguarding training. The provider told us they were introducing a new training system to address people's training needs.

Whilst some safeguarding concerns had been reported we found examples where procedures had not been followed which left people at risk. For example, we saw from an accident record that one person was reported to have extensive bruising. The record stated "unable to determine cause". We raised this with the new manager who was unaware of this issue but gathered further information. However, there were no other records available to confirm the cause of the bruising. Staff told the manager that the person had fallen over a fire extinguisher but this had not been recorded and it was unclear when this occurred. We also saw a further incident form related to the same person which recorded further bruising and swelling to his hand. There was no record of any explanation for this injury. We saw that the person had experienced a high number of falls. However there had been no safeguarding referrals or investigation to ascertain the possible cause of this bruising and/or evidence that appropriate action had been taken to manage any future risks. There was a risk that other causes of injury, including abuse, would not have been identified if they had occurred. We asked the manager to raise this as a safeguarding referral with the local authority and checked with the local authority that they had received this referral.

We found further examples where incidents had not been reported appropriately to the local authority under local safeguarding procedures. The new manager advised us that she had been unable to identify the number of active safeguarding referrals currently being dealt with or investigated within the service. We saw that there was a safeguarding folder for the Silk/ Tatton units only and were told that other records were stored in individual care folders. However, there was no written information about the outcomes of the safeguarding referrals and the system to manage these was ineffective.

This was a breach of Regulation 13 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new manager told us that the recruitment of staff was a priority. She had plans to ensure that each of the separate units had a clinical or unit lead appointed to take forward the leadership of each unit. We found that the organisation of staff within the Silk and Tatton units was more effective, a former agency nurse was due to commence as the unit lead and staff told us that the "med tech" role was being introduced which meant that staff were available to supervise people more effectively. The med tech role meant that staff who were not qualified in nursing were being trained to administer medication and undertake some clinical tasks, to help to support nursing colleagues. They were undergoing medication competency assessments.

On the first day of the inspection we found that the Mulberry Unit was short staffed because one carer had called in sick and an agency nurse had not arrived as arranged. The home manager told us that they had tried to arrange cover but this had not been possible at short notice. The registered provider remained very reliant on agency staff and we were told by the regional manager that recruitment of new staff had been difficult and remained a high priority. Staff spoken with said there had been a high staff turnover. One staff member commented "We still need regular staff, people just come and go (staff)."

Systems to deal with last minute staffing problems were not always effective as they mainly relied on the

availability of agency staff. We observed that the activities coordinator, who was undertaking one to one reminiscence work with someone in the lounge, was often interrupted because they needed to help to supervise another person. Staff told us that there weren't always enough staff to assist people to get up when they wanted. During the morning a member of staff said they were unable to support a colleague because they had to stay in the lounge to supervise people at high risk of falls.

There was a further example of staffing difficulties where an agency nurse had not arrived for a night shift during July 2017 and that only one nurse had covered both the Mulberry and Weaver Units, when the dependency levels indicated that there should have been two nurses. A safeguarding referral had been raised with the local authority following whistleblowing concerns reported to the Commission about this incident. Although the provider had planned for sufficient staff this was further evidence that systems in place to deal with staffing problems were not effective.

These issues were a breach of Regulation18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how staff were recruited and the processes followed to ensure staff were suitable to work with vulnerable people. We looked at three staff files and asked for copies of appropriate applications, references and necessary checks that had been carried out. We saw checks had been made but we could not always see evidence that recruitment procedures were robustly followed and that applicants were checked for their suitability, skills and experience.

Some staff had been employed at the location under the former registered provider. The current provider had undertaken an audit and identified where there were gaps in the recruitment checks. The regional manager confirmed that all staff had received a DBS, however there were still a number of staff members where appropriate references were not on file and these had not been requested or risk assessments been put in place because of this.

We saw that more recently a member of staff had not provided an employer reference, but had been employed based on two character references. We also saw a note relating to another member of staff which indicated that a risk assessment should have been completed prior to their employment to ensure that they were suitable. However, the regional manager and new manager were not aware of this and did not know whether a risk assessment had been completed. This meant that there was a risk that the systems in place did not ensure that suitable people were employed. The new manager had just introduced a new recruitment spread sheet to ensure that all recruitment checks were undertaken in future.

These findings were a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We carried out a tour of the premises and saw that the environment was generally clean and odour free. Staff were wearing appropriate gloves and aprons to reduce the risk and help the prevention of infections. Some refurbishment and redecoration of the environment had been undertaken and was on-going.

The provider employed to a maintenance team. We spoke with them and reviewed their records. These demonstrated that checks were conducted on the facilities and equipment, to ensure they were safe for the intended use. This included fire safety systems, call bells, water temperatures and electrical equipment. Gas, water and other appliances were also regularly serviced. We saw however that there were some gaps in the records for some of the necessary checks and that the fire risk assessments had identified a number of actions. Whilst there was no specific action plan the maintenance manager told us that they were

prioritising these actions. The maintenance person told us that another maintenance person had been recruited because it had been identified that further support was required to undertake all of the necessary maintenance jobs.

Inadequate

Is the service effective?

Our findings

We asked people and their relatives whether they found the care and support at Weston Park to be effective. People told us, "It's alright, normal food, nice room,"; "There are two shifts of staff, some are good. They are changing staff all the time," and "There are some really good staff.'

At the last inspection the registered provider had failed to ensure that staff had received effective induction and training. We were advised that they were working towards supporting the staff to increase their skills and knowledge.They told us that were addressing staff induction and training. At this inspection we reviewed training records. A training matrix was provided which evidenced gaps in staff training. Whilst some staff told us that they had undertaken training, according to the training matrix only 47% of staff had completed first aid training, 56 % had undertaken MCA training and there was 39 % compliance with training in person centred care. We saw that 69 % of staff on the matrix had received training in safeguarding and we found several examples during the inspection where staff had not followed safeguarding procedures and lacked understanding around the MCA. The registered provider planned to change the way that training was delivered to staff. The new manager told us that the induction of new staff was a priority and that all current staff would also be undertaking new induction training including competency assessments to refresh their knowledge.

There was a high usage of agency staff and some people said that agency staff weren't always as familiar with people's needs. One person told us that they were always having to explain their particular wishes and felt this was something the management should tell new staff. A handover sheet had been introduced to help staff, including agency staff being provided with information about people's health and care needs. The handover sheet contained information including people's health diagnosis, specific risks, mobility needs and any other comments. However we found that some of the information contained within the handover document was inaccurate. For example it was recorded on the handover sheet that one person required normal food and fluid, however the person actually required a soft diet as confirmed by staff and the person's care plan. We saw another example where the information was contradictory and inaccurate on the handover sheet. This meant that staff referring to the sheet may obtain incorrect information which exposed service users to the potential risk of harm.

Discussions with agency staff indicated that they had received basic information for their induction to the home. This included a tour of the unit and handover from another staff member to provide basic details about people before they supported them. A handover sheet was provided to staff which gave an overview of people's needs, however as noted above this was not totally accurate on the day of inspection. One member of agency staff told us that their induction had been basic because it had been received from another agency member of staff. We reviewed records where agency staff were asked to sign to agree that they had received an initial induction, this was a checklist of topics that had been discussed. However we found that induction checklists for agency staff had not been completed since February 2017. Whist some agency staff told us that they had received an induction the records did not evidence that all agency staff had received this induction.

The registered provider could not demonstrate that they were appropriately supervising all staff because records were not available to evidence this. Following the inspection we asked the new home manager to forward an overview or matrix of all supervisions sessions undertaken in the last 12 months and were advised that there wasn't one available. Staff spoken with told us that supervision was inconsistent across the different units of the home. The registered provider's policy on staff supervision stated "All staff must attend formal supervision sessions at least six times per year." This policy was not being adhered to.

The above issues were a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was also a further breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Previously, we found that people's nutritional needs were not being met effectively. At this inspection we found that some improvements had been made and we received some positive feedback from a visiting dietician. However further improvements were still required regarding the standard of the food.

Feedback from several people indicated dissatisfaction with the food. Two people said that the chef had been brought to discuss this with some of them and there was a slight improvement for a while but there was still negative feedback. Comments included, "Breakfast is OK. Food is awful at lunchtime. Tea is not bad," '"The food is cold and not cooked properly. I've never had a hot meal whilst I've been here,"; "Once or twice a week it's not too bad" and "The cooking is no good. Vegetables are never cooked. Plates are cold. Potatoes are not always cooked."

The regional manager told us that this had been an area which they had been addressing and the chef had been asked to speak with people about their preferences. One person told us that they were vegetarian and that the choices had recently improved. However overall, people made a number of complaints about the standard and temperature of the food being served.

We saw that some improvements had been made to the dining experience. We observed lunch time on the Weaver Unit and saw that hot trolleys had been purchased, from which the food was served. There were tables set with napkins, glasses and flowers. Five members of staff were in the dining room and were supporting people in a sensitive manner. There were two sittings and we were advised that those people who required assistance with their meals were supported to have their meals first, so that the staff could spend focused time with them. One carer was carefully explaining to a visually impaired person where their spoon, fork and cup were located and enabled them to eat independently. We saw that one person did not have much of their meal, a carer noticed this and encouraged them to try an alternative option.

Throughout the inspection we saw that drinks were readily available and people told us that they were offered plenty to eat and drink. We saw from the records that peoples' nutritional and hydration needs were recorded. There was some evidence that staff monitored those people who were at risk of losing weight and action taken where concerns had been noted. We spoke with a visiting dietician who told us that they had noticed some improvements. They told us that changes to staff had made it more difficult to implement some of the necessary changes, however there had been an improvement in the completion of food and fluid charts and overall people's weights were more stable. They told us that ongoing improvement was required to ensure that all staff implemented their recommendations such as when someone required milky drinks or to encourage milkshake drinks. We saw for example that one person's care plan stated that they should be monitored through weekly weights but that these had not been recorded.

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.

At the last inspection we found the provider was not consistently working within the principles of the MCA. The regional manager told us that they had focused on ensuring that where necessary applications were made to the supervisory body (local authority) where it was deemed that people were being deprived of their liberty. At the last inspection we were unable to ascertain from the records which people were subject to a DoLS authorisation. We saw that a new matrix had been implemented which provided clearer information about DoLS applications made and authorisations in place.

Further improvements were required to ensure that the MCA was always followed where necessary. We found in some cases that mental capacity assessments along with best interest decisions had been made appropriately where people lacked the capacity to make the decision themselves. For example we saw a record of a best interest decision made around the use of bedrails and a laser sensor beam in their bedroom to alert staff to any movement. However this was inconsistent across the service and further work was needed to develop this. There were MCA assessments and best interest forms in the people's care files, however these were often left blank and had not yet been completed. We also found that where a person's medication was being administered covertly, the MCA had not been robustly followed. A best interest decision had been made with the GP to administer the medication covertly, however there was no information about whether there had been consultation with the person's relatives or pharmacist.

These issues were a continued breach of Regulation 11 of the Health and Social Care Act (2008) Regulated Activities (2014) Regulations.

There was access to health and social care professionals and this was recorded in people's care records with regard to GP visits, optician and dental appointments. We saw that referrals were also made to other health professionals such as dieticians and speech and language therapists. A visiting GP told us that changes to staffing sometimes affected communication and the use of agency staff meant that they weren't always familiar with people's needs. The local surgery visited the home at least weekly and asked the home to advise them where possible regarding who needed to be seen. In some cases advice had not always been followed and information had not been passed on to other members of staff. However the GP had found an improvement with the more stable staff team on the Silk and Tatton units.

Requires Improvement

Is the service caring?

Our findings

We asked people and their relatives whether the service was caring, they told us, "There are some really good staff" and "I like it here, people are nice with you and I've got friends". One relative said that their relative "Appeared to be well looked after and seems quite happy. He's alright."

At our last inspection we found the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not always treated with dignity and respect.

During this inspection we found staff were not always mindful of people's dignity. For example during lunchtime we observed that a person was left seated at the table. The person was living with dementia and was slightly agitated, they attempted to remove their clothing. The person was not wearing any underwear and therefore exposed themselves to other people in the dining room. When staff noticed, a carer did offer appropriate support. However we found the person's dignity had been compromised as they had not been supported to dress in a manner that supported their dementia needs.

We observed that staff were talking to each other across the dining room and discussed who they had supported and who required further support. We found that staff needed to be more mindful of the language used, to ensure that people were respected as individuals. For example one carer said "(Name's) been done." We saw that a member of staff supported a person with a drink, however they stood over them and did not sit down beside them to offer support. We noted that the manager did identify this and spoke with the carer, providing guidance around the most appropriate way to support the person.

One theme of discontent amongst relatives was clothing being misplaced. The new manager was aware of complaints with regards to the laundry service and told us that they were addressing this.

These issues were a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff spoken with were able to demonstrate ways in which they would maintain people's dignity and privacy. We also saw that some care plan documentation made reference to the importance of respecting people's privacy and dignity.

In some cases people were supported to be involved in making decision about their care. We spoke with one person who told us that they now had an electric wheelchair which had made a big difference and meant that they were much more independent around the building and no longer had to wait for assistance from staff when wishing to move around the home.

During the inspection we saw examples where staff treated people in a kind and caring manner, but this was inconsistent. We saw an example where a member of staff approached a person in an uncaring manner. We sought support for a person by pressing their call bell. The inspector advised the carer that the person was

feeling uncomfortable. The carer responded by telling the inspector that the person was "Like this all the time" and appeared unconcerned. We observed that they did not communicate with the person in a caring manner. They simply lowered the person's bed without speaking to the person.

However we also observed some positive interactions. For example we observed a carer sitting with a person in the lounge. The person was quite agitated and sought constant reassurance. We observed the carer attempting to distract the person by sharing a magazine, the carer was very patient and kind in their approach. In another example we saw that a person had become upset and a member of staff went across to comfort them and offered appropriate reassurance. We spoke with some people who told us that they were happy with the way they were treated. One person said that the staff did, "A marvellous job."

Inadequate

Is the service responsive?

Our findings

We asked people about the care and support they received at Weston Park, they told us "It is very nice, the accommodation is extremely good" and "I like it here, people are nice with you and I've got friends."

At the last inspection in March and April 2017 we asked the registered provider to make improvements to the care and treatment of people and to ensure that their needs and preferences were met in a safe and effective way. The provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the provider remained in breach of this regulation.

Whilst some people spoken with were positive about their support and treatment this was inconsistent. We were concerned that people did not always receive care and support which was responsive to their individual needs and staff did not always follow the guidance identified within people's care plans.

During the inspection, we observed that one person who was seated in the lounge, was distressed and anxious. An agency member of staff went to the person on a number of occasions but was unable to reassure them and appeared to increase their agitation. We saw that another service user was offering support to the person and gave advice to the member of staff. When we reviewed the person's care plan and we saw that there was no care plan in place with regards to the person's psychological needs and insufficient information available for staff about how best to support the person's needs.

We identified concerns about the availability of continence products. One person told us that the home would often run out of continence products and they had to use products which were ineffective and caused them to be uncomfortable at times. The current manager and staff confirmed that there were some issues with continence supplies and told us that she believed that agency staff did not always use the prescribed continence products for people as they used larger products for everyone. This approach did not meet people's individual needs and meant that certain products would run out more quickly. Therefore people's individual requirements were not always met and dignity could be compromised.

Some people spoken with told us that their preferences and wishes were respected. For example one person said that they could spend time in their room as they chose and went to bed at their preferred time. One person said they had a shower and their hair washed once a week. A member of staff nearby said that people could ask for more frequent showers if they wished. However, we were concerned that people were not always provided with choices about when they would like to receive personal care. Previously we raised concerns that people were supported with personal care at 6am when this was not necessarily their preference. At this inspection we were concerned that this practice continued. One member of staff told us that when they began their shift in the morning on the Weaver Unit, most people would usually have been supported with a wash by the night staff and day staff would "Just need to reposition people ready for breakfast." We raised this with the management team who advised us that staff had been reminded of the importance of respecting people's choices and that this was being monitored.

These issues were a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, we identified a number of issues with people's records and how they were maintained. At this inspection we found that there was a continued failure to maintain an accurate and complete record in respect of each service user. We reviewed people's care records and found they did not always contain the information needed to support people safely and appropriately. Care plans had not always been reviewed regularly and were not updated in response to people's changing needs. Previously, we were told that all care plans and risk assessments were being reviewed and re-written. However, the care plans reviewed still did not provide staff with accurate information about how to meet people's needs. Care plans were being re-written but we found that there were gaps in the records and there were a number of blank care plans in people's files awaiting completion. For example we reviewed the care plan of a person who had experienced a high number of falls. The care plans did not include information about the action taken to re-assess and respond to the person's changing needs. Discussion with staff indicated that the person's sleeping arrangements, pressure relief and reasons for a soft diet were all in need of review. We also saw that another care plan for maintaining a safe environment had not been reviewed for over six months and did not reflect the increased risk of the person absconding from the home.

In one case we saw that a care plan had been written around the support a person required with a health condition, however the hand writing within the care plan was illegible and both inspectors were unable to read the guidance. There were also other care plans in the care folder which were illegible, including communication and breathing. This meant that staff may not be able to read and understand how to support this person safely and effectively.

We found that daily charts had not always been completed in accordance with people's care plans. One person had pressure ulcer monitoring charts in place which had been completed inconsistently. Towards the end of the first day of the inspection we checked the pressure ulcer chart and saw there were no entries. The last recorded check was on the night chart at 6am. We reviewed the person's care plan for skin integrity and found there was no guidance about the frequency of the monitoring or pressure relieving equipment required.

These issues were a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team advised us that they planned to introduce a "resident of the day" system, whereby one day each month the person's needs and care plans would be reviewed in consultation with them and their relatives where appropriate.

We spoke with the activities manager, who informed us that two new activities coordinators had been recruited and were due to start at the end of October. People had commented that there had been a decline in the activities available over recent weeks and staff confirmed that during September staff holidays had impacted on the activities programme. One person told us that they had started to enjoy monthly trips out to a local café but that they were "struggling" with activities at the moment and had not been out for a while. The activities manager was optimistic that the new recruitment would make a significant difference.

We saw that a folder had been created which contained photographs and enabled people and their relatives to see they type of activities that had taken place. The local football club visited the home and other activities such as music moments, bingo, a garden project and crafts were undertaken. The activities manager told us that she had been exploring ways in which to involve the community within the homes

activities and we saw that some local students were visiting to undertake work experience. There were plans to enable them to spend time with people to create life histories and support people with the use of electronic devices. There were some positive developments and ideas in progress.

The provider had a complaints procedure in place, which was on display in the reception at the home. People said that they felt able to raise any concerns with staff. One person told us that they occasionally complained to "Whoever was available." There was a complaints folder which contained some information about complaints that had been received and the response from the manager. However, there were no records to demonstrate how complaints had been dealt with since April 2017. The regional manager confirmed that there had been some complaints but suggested that these had been received verbally. The records therefore did not evidence how these verbal complaints had been dealt with or demonstrate that the provider's policy for dealing with complaints had been followed.

Inadequate

Is the service well-led?

Our findings

At the last inspection in March and April 2017, we identified breaches of regulation in relation to the well-led domain and this domain was rated as, 'Requires improvement.' Following the last inspection, the provider sent us an action plan which outlined what they intended to do to make improvements within the service to ensure it met the regulations.

During this inspection we found the provider had not addressed all of the concerns identified at the last inspection and continued to be in breach of regulations, we also found further breaches. We concluded the service was not well-led.

There was no registered manager in post at the time of the inspection. There had been two managers at the home, one had been responsible for managing the Tatton and Silk Units, whist the other managed the Weaver and Mulberry Units. Neither had registered with the CQC and had both recently resigned from the service. One manager had already left and the other was due to leave shortly after the inspection. We found that the leadership and management responsibilities within the units had been unclear and ineffective. The culture had been reactive rather than proactive in ensuring that a good standard of care and accommodation was provided for the people living in the home. The provider had employed a new manager, who had started their first week of employment at the time of the inspection.

There were ineffective systems in place to identify the failings found by the CQC inspectors at this inspection. The registered provider did not have effective auditing systems or processes, which assessed monitored and drove improvement in the quality and safety of the services provided for service users. The service had not made sufficient improvement since the last inspection. Lack of effective governance or systems meant that patterns of risk were not always being identified or actioned. For example, where one person had experienced at least seven falls in the previous three months, their care plans around mobility and maintaining a safe environment had not been reviewed effectively following the falls to assess the ongoing risk and to ensure that all action had been taken to mitigate against further risk of falls. Although accidents and incidents were recorded, the analysis of these needed to be more robust to identify themes and trends more effectively.

There had been ineffective leadership within each of the units, with gaps in staff supervision, training and induction evidenced. Medication audits undertaken had not been sufficiently robust enough to identify the failings found of the day of the inspection regarding out of stock medication and use of thickeners.

We found that whilst some staff knew how to provide care to people, accurate records were not maintained to show this. These did not demonstrate how changes to people's needs were being managed. There was a risk that any new staff, including the high volume of agency staff working at the service could provide ineffective and inappropriate care, by following inadequate care plans. They were in the process of reviewing files and meeting with the families in order to update the care plans but this had not been completed. There was also evidence of poor communication between staff and information was recorded in different places which led to potential confusion and possibility that issues were not identified

appropriately.

Systems for managing safeguarding incidents, accidents and complaints were disorganised and ineffective. Safeguarding concerns had not always been identified and reported appropriately. We could not be sure that all service users were adequately protected from harm and abuse. Where safeguarding referrals had been made, records did not detail any investigations undertaken or the outcomes of these. We discussed this with the current manager who acknowledged that information about the action taken or outcomes relating to the safeguarding first account forms were not fully recorded. This was concerning because she was shortly due to leave the service. In the case of two examples where safeguarding referrals had been made, systems were inadequate as they had not identified that risk management strategies had been appropriately considered or recorded following these incidents.

These issues were a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the new manager and management team were motivated to make improvements and took immediate action to start to address some of the issues identified during the inspection. The new manager told us that staff recruitment and the management of risk would be a priority. The operations director told us that they were committed to making the necessary improvements and believed that with the new strengthened management team they were now in a much better position to reach compliance in a short timeframe.

Providers have a duty to notify The Care Quality Commission about any allegations or suspicions of abuse and we found that whilst we had been informed of the majority of incidents safeguarding referrals, we had not been notified about all safeguarding incidents. This meant we did not have accurate information on the number of incidents which occurred in the service.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We have written to the provider about this and are dealing with this as a separate matter.

Staff told us that some staff meetings had been held. We saw on the day of the inspection that a full staff meeting with the new manager and regional manager had been arranged. Whilst some staff told us that they felt supported by the management team others told us that morale was low. However some staff told us that they were optimistic that the situation would improve with the changes in management.

Residents' and relatives' meetings had occasionally taken place, but the management team told us that these would be reinstated on a more regular basis, in order to seek people's feedback about the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not ensured that people who used the service received person centred care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had not ensured that people were treated with dignity and respect at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that staff acted in accordance with the requirements of the MCA.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured that recruitment processes were effectively operated.