Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Westbury Court

Station Road, Westbury, BA13 3JD

Tel: 01373825002

Date of Inspection: 10 July 2014

Date of Publication: August 2014

We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✖ Action needed
Management of medicines	✖ Action needed
Staffing	✖ Action needed
Supporting workers	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed

Details about this location

Registered Provider	Laudcare Limited
Registered Manager	Mrs Christine Bassett
Overview of the service	Westbury Court is a purpose built nursing home, registered to accommodate 60 people. The home provides care for people with varied needs. Some people may be living with varying types and degrees of dementia and some people may require nursing care. The home is close to the town centre of Westbury.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 10 July 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We talked with other authorities.

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 with us.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

Two inspectors and an expert by experience visited the home and answered our five questions, Is the service caring? Is the service responsive? Is the service safe? Is the service effective? Is the service well led?

Below is a summary of what we found. The summary is based on our observations during the inspection. We spoke with 18 people using the service, eight relatives or friends, 12 of the staff supporting them, the manager and the regional operations manager. We looked at eleven care plans in detail or partially. Additionally we used the Short Observational Framework for Inspection (SOFI) for a forty minute period.

Is the service safe?

Care plans instructed staff how to meet people's needs in a way which minimised risk for the individual. However there was no evidence to show that these were followed. We found that daily records had not been completed consistently and care plans were not always up-dated to reflect people's current needs. This put people at risk of not being cared for in the best and safest way.

Mental Capacity Act (2005) assessments were included in plans of care. Assessments had been completed by care staff who had not completed Mental Capacity Act training. We saw that a best interest decision, which could involve restraint, had been made by an

individual carer. This meant that the decision made may not be appropriate.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that the home liaised effectively with the local authority DoLS team and had, generally, made applications as appropriate. The home had made two DoLS referrals in 2014.

The home did not have any behavioural guidelines to support people with behaviours which could cause themselves or others distress. This put people at risk of not being supported safely during periods of difficult behaviour. We found that unexplained injuries or bruising were not investigated and it was not clear what action if any had been taken to minimise the risk of recurrence. People told us they felt they were: "very safe" living in the home. One person said: "there is no poor treatment, no abuse, it's not a bad place to live".

The home did not administer people's medication safely. We found that medication trolleys were left unlocked where people could access them. Medication was not always given at the prescribed times to allow safe timeframes between doses. This meant that people in the home may not be safe from harm caused by medication.

We found that there were not enough staff (or they were not effectively deployed) to meet people's needs. Call bells were not answered in a timely way which put people at risk of harm. The majority of people told us that there were not enough staff around but others told us: "There are always enough staff".

Health and safety was taken seriously by the home and all the appropriate safety checks had been completed. This reduced the risks to people and helped the service to continually improve.

Is the service effective?

Plans of care were not reviewed regularly and it was not clear if any necessary changes had been made to them. This meant that the care being given may have been out of date or inappropriate for the individual's current needs. It was unclear how people were identified as requiring 'nursing' or 'residential care'. People who were 'residential' care had their health care needs met by district nurses or community health professionals. This meant that people sometimes had to wait for paramedics to arrive for simple procedures such as the application of dressings.

People's individual well-being records were not completed accurately. They did not include 'targets' such as how much an individual should drink for staff to know if the individual was at risk of dehydration and of the action to take. The pressure setting of specialist mattresses used to promote individuals pressure care was not detailed for staff to monitor effectively. This meant that people may be at risk of harm because staff were not aware of how to ensure their well-being.

People told us they were happy with the care they received and felt their needs were met. One person told us they were going to an outpatient appointment they said: "the home has arranged a taxi and one of the nurses is going with me. It's lovely; I don't have to worry at all". However, some relatives told us they were concerned that their relatives care needs were not met in a timely manner.

Is the service caring?

People were supported by some staff who were mostly patient, kind and responsive. People who lived in the home told us staff were ""very nice, anything you want they do, they are not bad at all". Another told us how: "excellent" staff were when they helped them after a fall. However we observed that people were not always responded to in a timely manner when calling for assistance. Our observations found that some staff had not responded in a professional and caring manner. Examples included negative responses we overheard from staff when people had repeatedly asked for a drink, such as: "Oh dear everyone would think you were never fed and watered". Some people's requests during the lunch time meal had been ignored.

We found that care and support had not always been provided in line with people's preferences and wishes. An example included a person who wanted to get up in the morning still being in bed at 2.30 pm. One person said, "you get fed up being in bed". They told us that they weren't sure if it was their choice to stay in bed but didn't think so because they hadn't been up much.

Is the service responsive?

Staff did not always respond to people's needs and requests in a timely way. We observed people calling out for help with little to no response. Care plans were not always amended as people's needs changed.

It was not always clear that the home had acted on the learning gained from accidents, incidents and complaints. They did not respond to advice from other professionals such as the pharmacist. We saw that pharmacist had visited in October 2014. They had made two recommendations which had not been actioned.

The home had various ways of listening to the ideas and opinions of the people who lived in the home and their relatives and friends. They had made some changes and improvements as a result of ideas and discussions with people who live in the home and their relatives.

Is the service well-led?

The regional manager told us that the registered manager had left her post in May 2014. We had not received a registration cancellation application from them. An interim manager was in post until the permanent manager was appointed on 2 July 2014. Staff told us it: "feels like months since a manager was in place". Some told us: "Things have gone down-hill since the manager left" (referring to the last registered manager).

Staff told us they were clear about their roles and responsibilities. Most of the staff we spoke with told us there were not enough staff to meet the needs of the people who lived in the home. They told us they felt unsupported, staff morale was low and that they did not always work well as a team. Some staff told us that they had no confidence in the management of the home. There were high levels of staff sickness in the home.

The service had a comprehensive quality assurance system. However, the system had not identified shortfalls in important areas of the quality of the care being given. As a result the quality of the service was not being maintained or improved.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 21 August 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We found that people's needs were assessed prior to or when people were admitted to the home. However, care and treatment was not planned and delivered in line with their individual care plan. We looked at four full care plans and seven daily care plans (kept in people's bedrooms). The information in the full care plans and the daily care plans was not always accurate. An example included a person's mobility not being noted as an issue on a care plan when the individual had recently sustained a fracture as the result of a fall.

We saw that the full care plans were detailed and clearly identified people's needs and the actions that needed to be taken to meet those needs. However, daily notes did not show that the individuals' needs were met in the way described. For the four people whose care we tracked in detail we found daily entries had not been made consistently. An example was a gap of 10 days in one person's daily record called 'my journal'. The provider may find it useful to note that the complex system of daily recording made it difficult to 'track' the care that had been provided.

The four plans of care we looked at had not been regularly reviewed during 2014 and it was not clear if any necessary changes had been made. Examples included assessments for mobility that were not up-dated when people returned from hospital. Nutritional assessments were not up-dated when people lost large amounts of weight in a short time frame.

We found that care and treatment was not planned and delivered in a way that ensured people's health, safety and welfare. There was a 'whiteboard' in the nurse's station on the ground floor which noted which charts needed to be completed in which rooms. This information was not dated but did not reflect the current situation. The manager told us they were not aware of this and corrected it during the course of the day. We saw that

daily plans of care, which included health and well-being charts, were not completed accurately. Examples included food and drinks charts which did not cross reference accurately with fluid charts and turning charts that should have been completed three hourly but which contained six hour gaps. Fluid and food charts did not contain 'targets'. Staff could not see how much people needed to eat and drink and what action to take if they did not have the required sustenance. We saw that during a 10 day period one person's food and drink chart had been completed from three to eight times a day. Staff told us that there should be at least six entries a day. A carer told us that one person, whose fluid intake records had not been completed accurately, had been diagnosed as dehydrated by the emergency services who were transporting them to hospital. we were unable to confirm this at the time of the inspection. However, the deputy informed us after the inspection that the hospital admission was due to loose stools caused by medication, which had resulted in dehydration.

Health care records were kept and included referrals to external professionals such as GPs, district nurses and tissue viability nurses. District nurses looked after the health care needs of people who were not identified as requiring 'nursing' care. A paramedic was called to apply a dressing to a person's leg because they were 'residential'. As it was out of hours a district nurse was not available. The criteria used to identify those people who required 'residential' and those who required 'nursing' care was not clear. The manager and area manager told us it depended on people's needs and staff told us it depended on the complexity of people's medication. There was confusion about carers and nurses responsibilities and there was no clear path for residential people requiring nursing intervention. This meant that we could not be sure that their needs were met as quickly and effectively as they should be.

We used the Short Observational Framework for Inspection (SOFI) tool for forty minutes during the lunchtime period. We specifically observed five people in the dining room on the first floor. We saw some staff responding appropriately to people's needs. Three staff did not respond in a timely manner to people who needed but did not ask for assistance. We noted that it was thirty minutes before one person was offered help to cut their food up. Some staff were positive and encouraging but some did not listen or respond to people's requests. For example people who requested gravy at the beginning of the meal, repeated the request for twenty minutes. Staff did not respond and as a consequence some people left most of their food. Staff removed almost full plates without asking why people had not eaten or offering them alternative food. We saw that some staff talked among themselves and did not include people in conversations.

In addition to using SOFI we observed meals being given to four people on the first floor. We saw that two people were encouraged to eat by an ancillary staff member, who was cleaning rooms. A third person was assisted by a member of care staff, we noted there was very little spoken interaction between a the staff member and the person they were feeding. We noted that another person's meal was taken away uneaten after approximately five minutes when they had not had any help or encouragement to eat it. Additionally we observed meals being given to four people on the ground floor. Carers were positive and encouraging during the meal service.

17 of the 18 people we spoke with told us that generally they were happy living in the home and with the standard of care they received. One person told us: "the home has arranged a taxi and one of the nurses is going with me. It's lovely; I don't have to worry at all" (for an outpatient appointment). Another person said sometimes, one of the senior carers will ask if there is anything extra they need help with during the day. One person

described how: "excellent" staff were when they helped them after a fall. Relatives and friends of people told us that they were generally happy with the standard of care people received. Some friends or relatives gave us examples of how people's physical appearance had improved since admission to the home. However, two relatives told us they had to take steps to ensure their relatives personal care needs were met. They said: "We were very upset a few weeks ago and had to step in to help my relative with personal care" and "Once or twice (referring to their relative) their hygiene needs were not met."

People who used the service would only be deprived of their liberty when this had been authorised by the Court of Protection or by a supervisory body under the deprivation of liberty safeguards (DoLS). The home had made two DoLS referrals in 2014.

Safeguarding people who use services from abuse ✖ Action needed

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was not meeting this standard.

People who used the service were not protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

There were comprehensive safeguarding policies and procedures, including whistle blowing, available in the home. We saw that training records showed that 46 of the 58 staff had received safeguarding training. Staff told us that safeguarding training was not part of the induction process. This meant that some staff may not have been able to recognise or appropriately report possible abuse.Safeguarding training was repeated via e-learning every year, to ensure all staff were kept up-to-date with policies and procedures. We noted that some of the up-dates had not been completed. This meant that staff may not be aware of the latest information regarding safeguarding procedures. The four staff we spoke with about safeguarding had a clear understanding of their responsibilities with regard to protecting the people in their care. They described how they would deal with a safeguarding issue, including reporting issues outside of the organisation, if necessary. People told us they felt they were: "very safe" living in the home. One person said: "there is no poor treatment, no abuse, it's not a bad place to live".

People who used the service were not protected from the risk of abuse because the provider had not taken reasonable steps to identify the possibility of abuse and prevent it from happening. We looked at four plans of care, two noted unexplained injuries such as severe bruising to an eye and deep skin flaps. Photographs were taken of any injuries and falls and accidents were recorded. However, body maps were not always completed and records did not include an investigation of how the injury had occurred. There were no records to show that anyone had looked into how the bruising or lacerations could have occurred or taken any steps to minimise the risk of recurrence. We saw that some unexplained bruising was noted on the computer system. These records did not include any information with regard to investigations.

Specialist mattresses to minimise the risk of pressures sores were provided. The pressure setting of the mattresses was checked daily. However, there was no guide of what level the mattress should be inflated to for the individual using it. Staff therefore noted the air pressure but it was not clear if it was at the correct setting to promote the individual's

pressure care.

Mental Capacity Act assessments were included in all plans of care. They were an integral part of each specific care plan such as emotional well-being and communication. The assessments were completed by care staff. Training records showed that care staff had not completed Mental Capacity Act training. Staff spoken with confirmed that they had not received this training. We saw a best interests decision that had been made for an individual. This decision involved the potential use of restraint to assist the individual with personal care. This had been made by an individual carer, there was no reference to a multi-disciplinary meeting or discussion with the individual or advocates.

The home did not, generally, offer a service to people whose behaviour may cause themselves or others harm or distress. However, if people did develop long or short term behaviours that were distressing, the home referred them to a community psychiatric nurse. There were no behaviour plans for staff to follow to support people to control difficult behaviours, in those incidences.

Management of medicines ✖ Action needed

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider was not ensuring that the appropriate arrangements to manage medicines safely were being followed by staff.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We found that there were appropriate arrangements for obtaining and recording medicines. The home used a monitored dosage system (MDS). This meant that each dose of medication had been prepared by the pharmacy and sealed into packs. People's medicines were prescribed by their GP and dispensed by the supplying pharmacist. Topical, liquid and controlled drugs were not dispensed within the MDS packs. These were recorded on the Medication Administration Record (MAR) for each person. One of the registered nurses showed us the schedule for reviewing and ordering the 28 day cycle of medicines. We saw that all prescribed medicine was ordered and were available for people to have as intended by their GP. Medicines that included medicines in boxes were counted as part of the homes quality monitoring process.

Arrangements were in place in relation to the recording of medicine. However, not all records were accurate or up-to-date.We looked at the Medicines Administration Records (MAR) for four people and found their medicine had been signed as administered. Prescribed creams (topical medicine) were not signed for. The MAR referred these to a Topical Medicines Application Record (TMAR). The TMAR was kept in individual's room for staff to sign once they had applied the person's prescribed cream. People's topical medication records were not complete. The TMAR of two people indicated they were not being administered topical medication as prescribed. One person's TMAR 26 June to 9 July 2014 indicated topical cream was administered once daily. This was as opposed to twice daily. Records showed that the person's topical medication had been reviewed by their GP and community nurse within this timeframe and were prescribed as twice daily. There were no written records to explain why the cream had not been applied. We observed there were several days between 26 June 2014 and 9 July 2014 where no recordings had been made. This meant that people's topical medicines may not have been administered as prescribed to promote the person's wellbeing.

When the medicine trolleys were not in use, medicines were kept safely. All medicines that included stock medicines were stored in locked cupboards or mobile medicine cabinets

within a secure room. The temperature of the medicine refrigerator was being recorded daily and was within the required temperature range. The medicine storage area had an air conditioning unit and records showed that the room was kept at a safe temperature. However, we observed the medication trolley was left open and unattended when staff were administering people's medication on the morning round. Some people who lived in the home lived with dementia. There was a risk that people could have taken medication from the unattended medicine trolley. This had placed people's welfare needs at risk of taking medicines that were not prescribed for them. We informed senior staff of our observation. Staff immediately took action to ensure medicine trolleys were not left unattended and that they were secure when left unattended. We have not been able to test that this compliance has been sustained.

The home had appropriate Controlled Drugs (CD) safes. CD storage is more secure than general medicines storage due to the increased risks. We checked the balance of the Controlled Drugs held in the CD safe against the register and these were in agreement.

Medicines were not safely administered. We observed people on the ground floor had received their medication within a reasonable timescale as prescribed. However, the administration of the morning medication to people on the second floor had taken three and half hours from 8:45 to 12:35. There were specific circumstances as to why the round had taken so long. However, this meant that some people may not have received their medication at the time they needed it. The time that medications were administered was not recorded on the MAR sheet. This meant that people were at risk of receiving unsafe dosages of medication. Additionally if a health problem arose staff would be unable to confirm at what time people had taken their medication.

At 14:00 we observed a member of staff administering people's medication, on the first floor. We established from our discussion with the staff member that they had started the afternoon medication round at 13:10. They told us they had administered medication to 13 people. This was approximately 35 minutes after the morning medication round had ended. This meant people were placed at risk of there not being enough time between medications or potential interactions between medicines being taken too close together. The member of staff told us that they had not received a handover at commencement of their shift due to covering staff absence. There were no records for the staff member to see to advise them that some people had received their medication late.The staff member immediately stopped administering people's medication and made safe the medication trolley. We spoke with the manager and informed them of our concern. We were later informed that the manager had contacted the prescribing GP to make sure people were safe due to the short time between the morning and afternoon administration of their medication.

The pharmacist visited the home to conduct and advisory inspection in October 2013 and made two recommendations. The home had not taken any action with regard to the recommendations. The regional manager told us via e-mail that the manager would now be completing an action plan to address all the recommendations.

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled ,experienced or effectively deployed staff to meet people's needs.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

There were not enough, effectively deployed, qualified, skilled and experienced staff to meet people's needs. The manager told us that minimum staffing ratios were eight (including one registered nurse) between 8am and 8pm. Minimum staffing during night time hours 8pm until 8am was one qualified nurse and five carers. The care staff were supported by an ancillary staff team which included a chef, domestics and maintenance personnel. We looked at rotas from 2 June to 6 July 2014. Rotas showed that the minimum staffing ratios were generally achieved although there were occasions when less than eight staff were on duty. However, rotas did not clearly show who was on duty and managers were not included on the rotas. On one occasion five staff were off sick and agency cover could not be provided. We noted that on 25 October 2013 the home advised us via E-mail that staffing levels were eight care staff which included two registered nurses for 22 people using the service. The current staffing complement of eight staff included one registered nurse to meet the needs of the 45 people currently using the service. A carer told us that at least 10 people had nursing needs, which was the same number as reported in October 2013. However, the number of nurses had been reduced by one.

We saw that the deployment of staff, on the day of the inspection, was three care staff on the ground floor (Willow Brook) to support nineteen people, four staff on the first floor (Cotton Meadow) to support twenty four people and one staff member on the second floor (Bluebell) to support two people. During our visit there was one person in Bluebell, they were being supported by one staff. The criteria for assessing who required nursing care and who required residential care was not clear. It was not clear why the people on the second floor of the home required higher staffing ratios than those living in the other areas.

One person told us: "my one complaint is that there are never, never enough carers". They described all the staff as "very kind and helpful' and said: "I can't praise the carers enough". However, she said that carers had no time to chat at all and sometimes she felt lonely as a result. Another person who had lived at the home for nearly a year and was unable to mobilise said it was: "hectic, I have to wait a long time for some things, like getting up for the toilet". They said: "the home doesn't seem to have enough staff to help".

One person described what happened when they were taken for a shower. They said: "they undress me and then say 'oh, I've just got to go and do something' and leave me. I sometimes get cold and put the towel around my shoulders". One person told us that there were: "plenty of staff, they don't take long to answer the bells and they always come if you need help".

At approximately 12.30 we noted that five of the 19 people who lived on the first floor were still in nightclothes. One person was still in bed at 2.30 pm. The person, still in bed, told us that they wanted to get up in the morning and their care plan noted that it was important to them to get up and dressed between 7.45 and 8.45. When staff were asked why the person had not been helped to get up they said: "no one has got her up". A carer told us later that there was not enough time to get everyone ready in the mornings. Relatives of someone who lived in the home told us that sometimes their family member was still in bed and unwashed at 11.00 or 11.30, when they visited. They said that on those occasions their uneaten breakfast things were still in the room. Others told us that they felt staff had too much to do but were: "always kind and considerate of their relatives needs". Some relatives told us they were concerned that their family members personal care needs were not met in a timely manner. We observed people calling out for a drink and assistance between 11.30 and 12.05. Staff did not respond to people's requests for help or assistance during the 35 minute time period. We heard people calling but did not hear any staff in the vicinity.

We noted that a call bell was sounding for 30 minutes before it was answered. A visiting professional told us that they had pressed the emergency bell and it had taken 20 minutes for a carer to arrive to help. Staff told us that there were enough staff if everybody 'turned up' but it was rare for people not to call in sick and they were always 'short'. Some staff felt people's safety and comfort was compromised on occasions. Rotas showed that there were numerous incidence of sickness.

The majority of staff we spoke with told us that they felt staffing levels sometimes put people at risk. They confirmed that it could take much longer than five minutes to answer the call bells. Other staff members told us that while they thought people were safe they did not receive the standard of care they should. They said that people frequently had to stay in bed because there were not enough staff to get them up. Staff and other professionals reported poor organisation and low staff morale.

Staffing shortfalls were covered by staff working extra hours or agency staff. However, staff often called in sick at very short notice and the agency was consequently unable to provide cover. The manager told us that any agency cover had to be sanctioned by a senior manager of the organisation. The regional operations manager told us that this did not cause any delays in obtaining agency staff. The manager told us that they were trying to recruit permanent staff. They confirmed that sickness was an issue in the home and it did leave staff shortages. The manager told us that they were trying to recruit more permanent staff and to the 'bank'.

Supporting workers ✖ Action needed

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was not meeting this standard.

People were cared for by staff who were not supported to deliver care and treatment safely and to an appropriate standard.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Staff did not receive appropriate professional development. Some staff we spoke with told us that they had not received a comprehensive induction. They described their first week as: "being thrown in the deep end". They told us they did not feel confident that they had been properly prepared to offer safe care to the people who lived in the home. We were unable to review any induction records, on the day of the inspection as the management team were unable to locate them. They told us that they existed but we were unable to verify this.

We saw training records which showed that staff had completed training in core areas including safeguarding, moving and handling and end of life care. However, records showed that some care staff had either not started the mandatory courses or their training needed up-dating. An example was safeguarding vulnerable adults training which had not been started by 12 of the 58 staff.

Supervision records showed 51 care staff, of these 13 had not received any recorded supervision in 2014. The manager was unable to provide us with any supervision records which were not held in the staff files we reviewed. Care staff we spoke with confirmed that they did not receive regular supervision. Appraisal records were not available and staff told us they had not received appraisals.

The service held a staff meeting in July 2014 but meetings had not been held regularly prior to this. It was not clear when the last staff meeting had been held. Staff told us that there had not been a staff meeting for: "many, many months".

Staff were able, from time to time, to obtain further relevant qualifications. The manager told us that 23 of the 58 staff had been awarded the National Vocational Qualification (NVQ) 2 or above and seven staff were completing a qualification course.

Staff members told us that they did not have good opportunities for training and felt 'unsupported'. Some staff members told us they had no confidence in the new manager

and said: "I don't think she'll listen to us". The manager had been in post for eight days. Most staff did not feel they worked well as a team.

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider had a system to regularly assess and monitor the quality of service that people receive. However, it was not effective as it had not identified shortfalls in important aspects of the care provided.

The provider had a system in place to identify, assess and manage risks to the health, safety and welfare of people who used the service and others. However it was not always effective as it had failed to identify that individual risk assessments were not always reviewed and up-dated.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We found that the provider did not have a system to effectively assess and monitor the quality of service that people receive. The home had a quality assurance team based at head office and a senior manager completed a monthly quality monitoring visit. The last visit was recorded on 11 and 18 June when a temporary manager was in post. The home manager completed a variety of weekly, monthly and three monthly audits. Audit records were not readily available on the day of the inspection. The quality assurance system had not identified the shortfalls such as inaccurate care plans, incomplete daily recording and staff shortage and/or deployment issues.

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted upon. The home held relatives and residents' meetings approximately every three months. The last meeting was held on the 29th May 2014. 13 people who used the service and four relatives attended. A quality of care questionnaire was sent every six months to people who used the service and other interested parties. These were sent back to head office who analysed them and sent a summary to the regional operations manager. The regional operations manager discussed the results with the manager and developed an action plan, as necessary. The manager gave us two examples of changes made as a result of listening to people who used the service. These were changing the menu and improving activities.

We saw that the provider had health and safety policies and procedures. The home had developed generic health and safety risk assessments along with risk assessments for individuals. However, risk assessments for individuals were not always reviewed or up-

dated in a timely manner. Examples of safe working practice risk assessments included expectant mothers and grass cutting/mowing. We saw that maintenance records were up to date. They included bedside electrical appliance testing, water quality and wheelchairs. The home had a generic evacuation plan and contingency response guidelines to tell staff how to respond in any likely emergency.

The provider took account of complaints and comments to improve the service. We saw that the provider had a comprehensive computer system to record and 'track' complaints. However, we were unable to see the content of the complaint and what investigation and action had been taken as a result of the complaint. The manager told us that it clearly showed on the system but did not provide us with this information. We were therefore unable to fully 'test' compliance in this area.

Most of the people we spoke with told us that they had never made any complaints but they would do so, if necessary.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The registered person was not taking the appropriate steps to ensure each service user is protected against the risk of receiving care or treatment that is inappropriate or safe. Regulation 9. (1) (b)(i) and (ii).
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: The registered person had not made suitable arrangements to ensure service users are safeguarded against the risk of abuse. Regulation 11. (1) (a), (2) (a) and (b).

This section is primarily information for the provider

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: The registered manager was not protecting service users against the risk associated with the unsafe use and management of medicines. Regulation 13.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: The provider had not taken appropriate steps to ensure that at all times there are sufficient numbers of suitably qualified, skilled and experienced staff employed for the purpose of carrying on the regulated activity. Regulation 22.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: The registered person did not have suitable arrangements in

This section is primarily information for the provider

procedures Treatment of disease, disorder or injury	place in order to ensure the persons employed for the purposes of carrying on the regulated activities are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard. Regulation 13 (1) (a)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision** **How the regulation was not being met:** The registered person did not protect service users and others who may be at risk, against the risk of inappropriate or unsafe care and treatment , by means of the effective operation of quality monitoring systems. Regulation 10.(1) (a)

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 21 August 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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