Care Quality Commission

Keiro Limited

Chase Park Neuro Centre

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This was an unannounced inspection carried out on 4 and 7 September 2015.

We last inspected Chase Park Neuro Centre in October 2014. At that inspection we found the service was meeting all the legal requirements in force at the time.

Chase Park Neuro Centre is registered to provide care to 60 people aged 18 years or over. The site is split into two locations, one which provides rehabilitation to people with a neurological condition and one which provides specialist nursing care to people with a neurological condition together with a service user group of older people.

A registered manager was 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.

Summary of findings

People said they felt safe. We had concerns however that there were not enough staff on duty to provide safe and individual care to people.

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

People did not always receive their medicines in a safe way.

Not all areas of the home were clean and well maintained for the comfort of people who used the service. Equipment was not always available to meet people's needs.

Staff undertook risk assessments where required and people were routinely assessed against a range of potential risks, such as falls, mobility, skin damage and nutrition. However, risks were not all regularly reviewed to reflect current risks to the person.

Staff were provided with training to give them some knowledge and insight into the specialist conditions of people in order to meet their care and support needs. People had access to health care professionals to make sure they received appropriate care and treatment.

Regular staff knew people's care and support needs. However care records we looked at were not all up to date. They lacked evidence of regular evaluation and review to keep people safe and to ensure all staff were aware of their current individual care and support needs.

People received a varied and balanced diet.

People said staff were kind and caring. However we saw staff did not always interact and talk with people when they had the opportunity. There was an emphasis on task centred care.

There was a programme of entertainment and activities provided by the activities person, however when they were not available, other staff did not provide activities for people to remain stimulated. People we spoke with and relatives said more activities and stimulation needed to be provided for people.

People and their relatives had the opportunity to give their views about the service. A complaints procedure was available.

The home had a quality assurance programme to check the quality of care provided. However, the systems used to assess the quality of the service had not identified all the issues that we found during the inspection to ensure people received individual care that met their needs.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
Not all aspects of the service were safe.

Requires improvement

People told us they felt safe however staffing levels were not sufficient to ensure people were looked after in a safe and timely way.

Staff were aware of different forms of abuse and they said they would report any concerns they may have to ensure people were protected.

Most people received their medicines in a safe manner.

Checks were carried out regularly to ensure the building was safe and fit for purpose.

Is the service effective?
The service was not always effective.

Requires improvement

Staff were supported to carry out their role and they received the training they needed.

Best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

People received a varied and balanced diet to meet their nutritional needs.

The environment was showing signs of wear and tear in several areas on the rehabilitation suite.

Is the service caring?
The service was not always caring.

Requires improvement

Staff were kind and caring but there was an emphasis on task centred care. Some staff did not spend time talking with people or engaging with them.

We found people on the rehabilitation suite were helped to make choices and to be involved in daily decision making. However, older persons who occupied the nursing suite were not involved in daily decision making.

There was a system for people to use if they wanted the support of an advocate.

Is the service responsive?
The service was not always responsive.

Requires improvement

Records did not always reflect the care and support provided by staff.

There were limited activities and entertainment available for people.

People had information to help them complain. Complaints and any action taken were recorded.

Summary of findings

Is the service well-led? Not all aspects of the service were well-led. A registered manager was in place. Staff and relatives told us the registered manager was supportive and could be approached at any time for advice and information. The systems used to assess the quality of the service had not identified the issues that we found during the inspection. Therefore the quality assurance processes were not effective as they had not ensured that people received safe care that met their needs.	**Requires improvement**

Care Quality Commission

Chase Park Neuro Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 4 and 7 September 2015 and was unannounced. The inspection team consisted of an inspector, two experts by experience and a specialist nursing advisor. One expert-by-experience was a person who had personal experience of using or caring for someone who uses this type of care service for older people and another expert by experience had experience of using a service for younger people with acquired brain injuries and associated conditions. The specialist advisor helped us to gather evidence about the quality of nursing care provided.

Before the inspection we reviewed the information we held about the service prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send the Care Quality Commission (CQC) within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care. We spoke with the local safeguarding teams. We also contacted health and social care professionals who worked with the service. We received information of concern from these agencies.

During this inspection we carried out observations using 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 communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with 22 people who lived at Chase Park, seven relatives, the registered manager, three registered nurses, ten support workers including one senior support worker, two visiting health professionals, a domestic person and three members of catering staff. We observed care and support in communal areas and looked in the kitchen, bathrooms, lavatories and some bedrooms after obtaining people's permission. We reviewed a range of records about people's care and how the home was managed. We looked at care records for 12 people, the recruitment, training and induction records for five staff, seven people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and their relatives, the maintenance book, maintenance contracts and the quality assurance audits that the manager had completed.

Is the service safe?

Our findings

People said they felt safe and they could speak to staff. However, they commented there were not enough staff. Comments from people on the rehabilitation suite included, "I have no worries, here I always feel safe," "I just call for staff. Sometimes you wait a while for them to come. They need a few more staff," "Staffing levels haven't improved," and, "There aren't enough staff here, they need some more. I need to be fed and there isn't always someone around to help me. My relative helps me." Some relatives' comments included, "I am concerned there are not enough staff on the unit, everyone talks about this. I do feel my relative is safe here and I'm not worried about this," "The lack of staff is a big problem. There are some good staff and some bad staff," "It's ridiculous, people are having to stay in their bedrooms due to lack of staffing, there's nothing for them to do," and, "I'm very worried about the poor standards of care." Comments from people on the nursing suite included, "I am safe and secure here, it will take a JCB to get me out of here," "Staff call regularly to check me, but they are always busy and don't have time to talk," and, "I've always felt safe here, but I do worry when there is only one support worker to help me in the shower." A relative commented, "They could do with more staff, especially at night." The registered manager told us there were currently eight staff vacancies.

Although people said they felt safe we had concerns there were not enough staff to meet people's needs safely and to ensure they received the care they required.

Our observations and staffing rosters showed there were not enough staff to meet people's needs. Staff were particularly busy because of the needs of the people. We saw most staff did not have time to engage with people apart from when they carried out tasks. The registered manager told us staffing levels were determined by the number of people using the service and their needs. Our findings did not support that people's dependency levels had been taken into account to ensure sufficient staff over the 24 hour period. A number of complaints and safeguardings had been received since May 2015 for both sites about the care of some people who used the service.

At the time of our inspection there were 16 people who lived on the rehabilitation suite, this included one person who was away. People were supported by two nurses and four support staff, we were told there were usually five support staff because of one to one support some people received. Staffing rosters showed staffing levels were not consistently maintained and we considered due to people's complex needs and physical care requirements four support workers were not sufficient to provide person centred care to people in a timely way and at the same time provide the required one to one support to some people. Staff told us eight people required two staff for their moving and assisting needs, some people were confined to bed and required regular positional turns from two staff every two hours to prevent pressure damage to their skin. We were told some people received some 1:1 hours from separate workers for their therapeutic or social care needs. However, some staff who provided rehabilitative therapy and support told us they did not have time to carry out therapeutic or social care activities as they were involved in providing direct personal care which was not their role. Another staff member commented, "The staffing issues prevent activities from taking place. The activities team are often asked to cover care work which means activities cannot go ahead."

The nursing suite accommodated 25 older people and people with a physical condition and this included one person who was in hospital. Staffing numbers included two nurses and six or seven support workers to work from 8:00am until 2:00pm. The number of support workers then reduced to six staff at 2:00pm until 8:00pm. Staffing rosters showed the majority of days in the last three months only six support workers were available to provide care and support to people all day, including people with some complex physical needs. We saw on the ground floor of the nursing suite three support workers were available to provide support to 14 people. Staff told us 14 people on the ground floor required two staff for their moving and assisting needs, five people required total assistance with all their care needs and some people were also nursed in bed. This meant when two support workers were busy attending to one person there was only one member of staff available to provide direct care to the other 13 people. A staff member commented, "We have no time to spend with people."

11 people on the top floor of the nursing suite were supported by one nurse and three support workers. Staff told us 11 people required two staff to assist with their moving and assisting needs, 11 people required total assistance with their care and support needs and three people were nursed in bed. This meant people required

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more staff assistance due to their level of need and only one member of staff was available to attend to other people when staff were busy. We observed a person waited over ten minutes to be assisted to the lavatory as two support workers were assisting someone else and the third worker was on their break. The nurse was unavailable to provide direct care as they dealt with other duties such as medicines, clinical interventions and liaising with professionals involved in the person's care. This meant when staff were busy attending to people others had to wait for assistance and they were at risk as they were not supervised. Staff members comments included, "We could do with more staff," "Staffing levels haven't improved," "We don't get time to spend with people as we're so busy," and, "We're very short staffed at the moment, I had to come over from the other site today to help out." Staffing rosters showed staffing levels were not consistently maintained and staffing levels fluctuated between six to seven support workers.

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

The provider had a system in place to log and investigate safeguarding concerns. We viewed the log and found concerns had been raised by staff where necessary and logged appropriately.14 safeguarding alerts had been raised. They had been investigated and resolved and one was still being investigated by outside agencies at the time of inspection.

Staff had an understanding of safeguarding and knew how to report any concerns. They were able to describe various types of abuse and tell us how they would respond to any allegations or incidents of abuse and knew the lines of reporting within the organisation. They told us they would report any concerns to the manager. Staff members' comments included, "I'd report any concerns immediately to the person in charge," and, "I would speak to management if I was worried or concerned."

We saw care plans for distressed behaviour were in place and they provided guidance for staff about the actions that should be taken when the person became agitated and distressed. Written information was available that included what might trigger the distressed behaviour and the staff interventions required. For example, "(Name) wants instant gratification from food and can be verbally aggressive if not given food instantly. Staff to use diversional techniques and give reassurance during these times." Advice and guidance was provided by the behavioural team to help staff understand the triggers for the behaviours and why the person may show the distress. However, we were told not all staff had received training to understand the reasons for distressed behaviour and why it might occur to support the written information in people's care plans. The staff training matrix showed this staff training was planned to take place in January 2016.

Medicines were given as prescribed. We observed a medicines round. Medicines were administered by the nurses. We saw they checked people's medicines on the medicine administration records (MAR) and medicine labels to ensure people were receiving the correct medicine. We observed the administration of medicines to people was not consistent. Staff who administered the medicines did not all explain to people what medicine they were taking and why. People were given their medicine and they were not all offered a drink to take with their tablets and the nurse on the rehabilitation suite did not remain with the person to ensure they had swallowed their medicines. The nurse in charge told us this would be addressed.

Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

Staff members who administered medicines told us they would be given outside of the normal medicines round time if the medicine was required. We saw written guidance was not in place for the use of some "when required" medicines, and when and how these should be administered to people. For example, for pain relief or for agitation and distress to ensure a consistent approach by staff. The nurse in charge told us this would be addressed.

Staff were trained in handling medicines and a process had been put in place to make sure each worker's competency was assessed. Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines.

Regular analysis of incidents and accidents took place. The registered manager said learning took place from this and

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Is the service safe?

when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. Records showed a person who had fallen more than twice was referred to the falls clinic.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plan was reviewed monthly to ensure it was up to date. This was for if the building needed to be evacuated in an emergency.

We spoke with members of staff and looked at five personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before they were offered their job. Records of checks with the Nursing and Midwifery Council to check nurses' registration status were also available and up to date.

Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people..

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and two maintenance people were employed. Routine safety checks and repairs were carried out such as for checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Requires improvement

Is the service effective?

Our findings

We had concerns not all areas of the home were well-maintained for the comfort of people who lived there. The rehabilitation suite was showing signs of wear and tear. The carpets in the lounge and some bedrooms were marked. The furniture in the lounge was worn and showing signs of wear and tear. Paintwork was scuffed and chipped on skirting boards and doorways in some areas including corridors and bedrooms. The glass was cracked in an outside hall door by the smoking area. Some bedroom walls and doorways were marked. The flooring in some en-suite lavatories required replacement as the linoleum was discoloured and lifting from the base.

On the nursing suite people were not encouraged to maintain their orientation and independence to help them identify different areas of the home. There was no appropriate signage on doors such as lavatories, bathrooms and bedrooms for people to identify the room to help maintain their independence. Not all communal areas of the nursing suite contained items of interest to help people relax or remain involved and aware of their surroundings. We saw no pictorial aids or orientation aids, such as activity boards, calendars, clocks, newspapers, magazines or books to help remind people of the date and time. This meant people were not helped, by their environment, to remember and be mentally stimulated.

On the nursing suite upstairs unit lounge there were six armchairs to accommodate the 15 people or their visitors. We observed a number of people around the home sitting in wheelchairs either in the lounge or their bedroom. We were told some people went for bed rest during the day. As there were not enough specialist chairs people sat in their wheelchair. We observed people who required a specialist chair were sometimes assisted to use the specialist chair of other people when they were having bed rest rather than having their own specialist chair. The staff told us five people upstairs required specialist chairs and some were waiting to be assessed for a chair. We observed staff left their bags and personal belongings in the corner of the dining area. This was not very secure and did not make the area look tidy. We were told there was no available locker space or any other secure area to lock staff belongings.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had opportunities for training to understand people's care and support needs and they were supported in their role. Support staff said they received regular supervision from one of the home's management team every two months and nurses received supervision from the registered manager. Staff comments included, "I supervise new starters," "The registered manager does my supervision," "The nurse in charge does my supervision," "I get supervision every three months," and, "We receive supervision regularly to discuss how work is going." Staff also received an annual appraisal to evaluate their work performance and to jointly identify any personal development and training needs. A staff member commented, "I have an appraisal annually."

Staff members were able to describe their role and responsibilities. Some staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. One staff member told us, "I've worked here for years but I do remember when I started I shadowed a more experienced member of staff as part of my induction." A new staff member told us, "I'm just finishing my induction and I also have meetings with my line manager which I find useful." The business manager told us new support workers were to study for the Care Certificate in Health and Social care as part of their induction. Existing staff would also have the opportunity to study for this qualification to further their knowledge of care settings.

The staff training record showed regular staff were kept up-to-date with safe working practices. However, arrangements were not all in place to check other staff who worked at the service received the necessary training before they started to work there. Two staff commented, "It was six months before we received health and safety and moving and handling training." We were told this was being addressed by management.

The registered manager told us there was an on-going training programme in place to make sure staff had the skills and knowledge to support people. The staff survey results sent out by the provider in 2015 showed 39 of the 51 staff members surveyed had responded they either 'stongly agreed' or 'agreed' they had the 'correct training for the job.' Staff training courses included, dementia care, palliative care, hydration and nutrition, catheterisation,

Is the service effective?

mental capacity, deprivation of liberty safeguards, equality and diversity and a range of management courses for senior staff. A new staff training matrix showed that an extensive range of courses was planned to take place over the next twelve months including updating clinical competencies to check staff had the knowledge to meet peoples' care and treatment needs.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive possible.

People can only be deprived of their libery to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Chase Park records showed three people on the neuro site and six people on the nursing suite were legally authorised. Staff had received MCA and DoLS training.

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals. We were told as the result of a contract with a specialist rehabilitative centre at a local hospital specialist therapy services were provided by a physiotherapist, a speech and language therapist and occupational therapist. They worked full time at the service, on a rotational basis, to provide support to people who had a rehabilitation programme in place. Staff also received advice and guidance when needed from specialists such as, a community nurse, a dietician, a psychiatrist and General Practitioners(GPs). Records were kept of visits and any changes and advice was reflected in people's care plans. The registered manager told us a weekly surgery took place on the nursing site for older people. This was run by the General Practitioner and a specialist nurse. The clinic was held to review people's health needs and to make sure they were treated promptly. It was also to help prevent people's unnecessary admission to hospital.

Relatives were kept informed by the staff about their family member's health and the care they received. One person commented, "My (Name) is always kept informed by staff of what's going on."

People's needs were discussed and communicated at staff handover when staff changed duty, at the beginning and end of each shift. This was so that staff were aware of the current state of health and well-being of people. Staff members comments included, "Communication isn't too bad, there's a handover from day and night shift," and, "We always have a handover between shifts which helps keep everyone upto date with what's happening." We were told a written handover record was also used. However, we saw the record was a list and contained limited information as it only included comments about two people's current state. This meant detailed written information was not available about people's current health and well-being when different staff came on duty to care for people.

We checked how people's nutritional needs were met. Care plans were in place that recorded people's food likes and dislikes and any support required to help them eat. We spoke with the chef who was aware of people's different nutritional needs and special diets were catered for. The chef told us they received information from nursing staff when people required a specialised diet. They explained about how people who needed to increase weight and to be strengthened would be offered a fortified diet and they explained how they would be offered milkshakes, butter, cream and full fat milk as part of their diet. We looked around the kitchen and saw it was well stocked with fresh, frozen, home baked and tinned produce. The catering department also provided food for the café which was available on site and was also open to the public. We saw food was well presented and looked appetising. People were positive about the food saying they had enough to eat and received "nice" food. People's comments included, "The chef goes out of their way to make me something I like to eat," "The food is okay, there is plenty to eat and drink," "When I didn't like either of the meals, I asked for bacon and eggs and got exactly what I wanted," and, "Even through the night I can have a cup of tea and toast if I want." Hot and cold drinks were available throughout the day.

There were systems to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were routinely assessed against

Requires improvement

Is the service effective?

the risk of poor nutrition using a recognised Nutritional Risk Screening Tool (NRS). This included monitoring people's weight and recording any incidence of weight loss. Where people had been identified as at risk of poor nutrition staff completed daily 'food and fluid balance' charts. The food charts used to record the amount of food a person was taking each day did not accurately document the amount of food a person consumed as it did not refer to portion sizes. The person in charge said that this would be addressed.

Is the service caring?

Our findings

Most people who used the service and relatives we spoke with were positive about the care and support provided. People's comments included, "This is a happy place, I'm very well looked after," "I'm looked after day and night, even through the night I can have a cup of tea," and, "The staff always go out of their way to help."

We had concerns about some aspects of care people received.

From our observations we considered improvements were needed to ensure that all staff interacted with people at all times, and not only when they carried out care and support with the person. We saw staff did not take the opportunity to engage and interact with each person and encourage their awareness and interest in their surroundings. We also observed a domestic member of staff on the nursing suite had limited interaction with the people in the lounge as they set the table for the evening meal. When they did acknowledge the people they called them all 'darling'. Although this is a term of endearment it may not have been appropriate or respectful to the person.

We saw people sat sleeping in the lounges on the nursing suite for much of the time. On the ground floor an activities organiser was available but they spent a large amount of time re-assuring a distressed person. Arrangements were not made for other staff to spend time interacting with other people and carrying out activities as the activities person was busy. We saw some staff downstairs were sometimes sitting talking amongst themselves in the conservatory and did not engage with other people who were sitting there. They did not take the opportunity to talk to people and spend time listening to what they had to say. We observed some people also remained in their bedrooms without stimulation and staff did not spend time with them except when they took meals and carried out tasks with them. We saw one person sleeping in their wheelchair in their bedroom in the morning. We had concerns they had no means to summon assistance if they needed to. We checked with the support worker who told us, "They can't fall out, they're fastened in their chair, we pop in and out to check." In the afternoon we saw they were in bed. We observed staff members talked with people when they were in the lounge upstairs.

Staff engaged with people in a calm and quiet way. Most staff bent down when they carried out tasks and talked to people so they were at eye level. They asked the person's permission before they carried out any intervention. However, we observed a staff member assist a person to eat. Apart from acknowledging them they did not talk to the person all the time they helped them, there were no prompts of encouragement, no explanation of what they were doing or what the person was going to have to eat. This was not consistent as we observed positive interactions between other staff members and people they were assisting to have their meal.

We observed some occasions when people's choice was not respected. For example, on the nursing suite upstairs after the lunchtime meal two people were left at the dining table for some time. One person without explanation from the support worker was removed to their room for bed rest. Another person still at the table, was given a cup of tea and a biscuit. They had not finished their cup of tea and they were told they were going to their room for bed rest, the person complained they hadn't finished their drink. The support worker said they could take it to their room, the person was not given a choice or allowed to wait until they had finished.

Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well. Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as showing two items of clothing. This encouraged the person to maintain some involvement and control in their care. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain.

We saw people who lived with dementia were encouraged to make a choice or be involved in decision making with regard to their food as they were shown the choices of food available. In other dining rooms menus were not available in any other format. For example, pictures or photographs if people no longer understood the written word.

Relatives told us they were kept informed by the staff about their family member's health and the care they received. One person commented, "My (Name) is always kept informed by staff of what's going on."

Requires improvement

Is the service caring?

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision themselves. For example, an emergency health care plan was in place for a person. The care plan detailed the "do not attempt resuscitation" (DNAR) directive that was in place for the person. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

We were told the service used advocates as required but most people had relatives. Advocates can represent the views for people who are not able to express their wishes. We were told one person had the involvement of an advocate.

Requires improvement

Is the service responsive?

Our findings

People's needs were assessed before they moved into the home to ensure that staff could meet their needs and that the home had the necessary equipment to ensure their safety and comfort.

We had concerns people's care records did not accurately reflect the care provided by staff.

Records confirmed that pre-admission assessments were carried out. Record keeping for people was not consistent. Up-to-date written information was not always available for staff to respond to people's changing needs. Records showed that monthly assessments of people's needs were not all up to date with evidence of regular evaluation that reflected any changes that had taken place. For example, with regard to nutrition, wound care, mobility and falls and personal hygiene.

Assessments included risks specific to the person such as for falls, tissue viability and nutrition. Most risk assessments were in place but a choking risk assessment was not in place for all those who required one. Risk assessments were not regularly reviewed and evaluated in order to ensure they remained relevant and reduced risk. A staff member commented, "Risk is not well managed here."

Staff at the service responded to people's needs and arranged care in line with their current needs and choices. The service consulted with healthcare professionals about any changes in people's needs. For example, the dietician was asked for advice with regard to nutrition. Staff completed a daily record for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were usually up-dated monthly. Charts were also completed to record any staff intervention with a person. For example, for recording when staff turned a person in bed, where it was identified a person was at risk of developing pressure areas. Records showed these were not always completed after interventions were carried out to accurately reflect the care that had been provided.

Staff knew the individual care and support needs of people, as they provided the day to day support, but this was not always reflected in people's care plans. The care plans did not give staff specific information about how the person's care needs were to be met. They did not give instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. They did not detail what the person was able to do to take part in their care and to maintain some independence. People therefore did not have individual and specific care plans to ensure consistent care and support was provided.

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

People commented there were limited activities and entertainment. One person told us, "I only go out if my relative takes me." Relatives' comments included, "People are not receiving the stimulation or activities they need while they are here and this is vital for their recovery," and, "There was a meeting the other day about entertainment and it quickly got out of hand. Relatives were complaining about the lack of activities and staff, and all the things that were not happening." Resident and relative meeting minutes showed that issues were being resolved and people were being consulted for ideas about what they would like to do. For example, to go out, to have a music evening and age appropriate activities to be available.

Two activities organiser were employed for both sites. They arranged a programme of entertainment and activities. Records showed these included singers, entertainers and visits from local school children. The hairdresser visited regularly and clergy visited individual people if they requested it. At the time of inspection when the activities person was not available we did not see staff provide activities for people during the day. In the nursing suite lounge the television was on all day and people were not watching it and staff did not check to see if anyone wanted a different programme.

Regular meetings were held with people who used the service and their relatives. The registered manager said meetings provided feedback from people about the running of the home. November's meeting minutes showed the discussions about activities and the action taken to improve them. We saw the meetings were an opportunity for people to give feedback about the care they received.

People said they knew how to complain. The complaints procedure was on display in the entrance to the home. People also had a copy of the complaints procedure that was available in the information pack they received when they moved into the home. A record of complaints was

Requires improvement

Is the service responsive?

maintained and we saw nine complaints had been received between April and July 2015. Some had been resolved but some complaints had not been investigated satisfactorily as we saw they had been raised by the same complainant on three occasions. Some were in the process of being investigated. The day after our inspection we received a complaint about the service. We returned to the service to check aspects of the complaint and whether they had been resolved.

Requires improvement

Is the service well-led?

Our findings

A registered manager was in post and they had registered with the Care Quality Commission in August 2015. The registered manager understood their role and responsibilities to ensure notifiable incidents such as safeguarding and serious injuries were reported to the appropriate authorities.

The registered manager said they had introduced changes to the service to help its smooth running and to help ensure it was well-led for the benefit of people. They responded quickly to address any concerns. Staff comments included, "The manager is very approachable," "I feel I can go to management about anything," "The new manager is well respected by staff," "(Name) manager is a real asset," and, "(Name) is a good influence." We had been told staff morale was very low and several staff had left. A person commented, "There is a big gap between the staff team and the senior managers. The directives and orders don't respect or value staff and this has led to lots of staff turnover." The provider information showed twenty staff had left in the last 12 months. The registered manager told us they were trying to get more staff as there were eight support worker vacancies. On the day of inspection we saw one of the nurses on duty was from a nursing agency who had not worked at the home before so they had limited involvement with people.

We had concerns the audit and governance processes had failed to ensure satisfactory standards were maintained.

Records showed audits were carried out regularly and updated as required. Monthly audits included checks on, documentation, staff training, medicines management, accidents and incidents, infection control, nutrition, skin integrity, falls and mobility. Although records were audited monthly and included checks on care documentation and staff management, these audits had not highlighted deficits in certain aspects of record keeping to ensure people received safe care in the way they wanted and needed. Three monthly audits were carried out for health and safety, falls and infection control. The registered manager told us monthly visits were carried out by a director to speak to people and the staff regarding the standards in the home. They also audited a sample of records, such as care plans and staff files. These were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required by the registered manager.

Staff told us and we saw staff meeting minutes to show staff meetings took place monthly and these included nurses and senior support staff meetings. Staff meetings kept staff updated with any changes in the service and to discuss any issues. Staff members told us meeting minutes were made available for staff who were unable to attend meetings. We had concerns with regard to the process for obtaining new and replacement equipment that was required and the length of time taken to obtain them. Heads of department meetings took place weekly, the meeting minutes from June 2015 showed various items were requested by staff. For example, kitchen equipment for rehabilitation was requested in June. In September that equipment was still not available. A staff member commented, "There is no equipment in the kitchen for carrying out activities with people. Equipment has to be borrowed from the other site and this cuts into people's activity time." We checked after the inspection and the business manager told us this had been addressed and new equipment had been purchased. A system had also been put in place so there would not be a delay in the future as a business meeting was scheduled to take place every week the day after the head of department meetings. If expenditure required authorising it could be actioned more quickly.

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to staff and people who used the service. We saw surveys that had been completed by staff from the neuro centre in 2015. Findings from the survey were varied and some were positive. For example, staff training opportunities.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had not ensured staffing levels were sufficient to provide safe and person centred care to people at all times. **Regulation 18 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The registered person had not ensured, in relation to the premises, that they were properly maintained with sufficient equipment to provide the service. Regulation 15 (1)(c)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had not ensured systems and processes were established and operated to ensure compliance with the registered persons need to: assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk, by maintaining an accurate, complete and contemporaneous record for each person; evaluating and improving their practice. **Regulation 17 (2)(a)(b)(c)(f)**