Amber Care (East Anglia) Ltd

Stewton House

Inspection report

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13 September 2016

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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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We inspected Stewton House on 6 and 13 September 2016. This was an unannounced inspection. The service provides care and support for up to 48 people. When we undertook our inspection there were 42 people living at the home.

People living at the home were mainly older people. Some people required more assistance than others either because of physical illnesses or because they were experiencing difficulties coping with everyday tasks, with some having loss of memory.

There was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves. At the time of our inspection there was no one subject to such an authorisation.

We found that there were insufficient staff to meet the needs of people using the service. The provider had not taken into consideration the complex needs of each person to ensure their needs could be met through a 24 hour period.

We found that people's health care needs were assessed, and care planned and delivered in a consistent way through the use of a care plan. People were not involved in the planning of their care. The information and guidance provided to staff in the care plans was clear, but was not always followed by staff. Risks associated with people's care needs were assessed and plans put in place to minimise risk in order to keep people safe.

People were treated with kindness and respect. The staff in the home took time to speak with the people they were supporting. We saw many positive interactions and people enjoyed talking to the staff in the home. The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported to maintain their independence and how they chose to live their life.

Staff had taken care in finding out what people wanted from their lives and had supported them in their choices. They had used family and friends as guides to obtain information.

People had a choice of meals, snacks and drinks. Meals could be taken in a dining room, sitting rooms or

people's own bedrooms. Staff encouraged people to eat their meals and gave assistance to those that required it.

The provider used safe systems when new staff were recruited. All new staff completed training before working in the home. The staff were aware of their responsibilities to protect people from harm or abuse. They knew the action to take if they were concerned about the welfare of an individual.

People had been consulted about the development of the home, but they had not received any feedback from concerns they had raised. Quality checks had not been completed to ensure services met people's requirements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were insufficient staff on duty to meet people's needs.

Staff in the home knew how to recognise and report abuse.

Medicines were stored and administered safely.

Is the service effective?

Requires Improvement

The service was effective.

Staff received suitable training and support to enable them to do their job.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were understood by staff and people's legal rights protected.

Is the service caring?

Good

The service was caring.

People were relaxed in the company of staff and told us staff were approachable.

People's needs and wishes were respected by staff.

Staff ensured people's dignity was maintained at all times.

Staff respected people's needs to maintain as much independence as possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care was not planned and reviewed on a regular basis with them.

Care plans were up to date and consistence was poor.

Activities were planned into each day and people told us how staff helped them spend their time.

People knew how to make concerns known and felt assured anything raised would be investigated, but did not always receive feedback.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Audits were not undertaken to measure the quality of delivery of care, treatment and support given to people against current guidance.

People's opinions were sought on the services provided, but they did not always receive feedback on points raised.

The views of visitors and also other health and social care professionals were not sought on a regular basis.

Stewton House

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 6 and 13 September 2016 and was unannounced.

The inspection was undertaken by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

We also spoke with the local authority who commissioned services from the provider in order to obtain their view on the quality of care provided by the service. We spoke to health and social care professionals during the inspection.

During our inspection, we spoke with five people who lived at the service, seven relatives, four members of the care staff, three trained nurse, two members of the housekeeping staff, an activities organiser, a cook, the hairdresser, a physiotherapy assistant, the manager and the area manager. We also observed how care and support was provided to people.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at nine people's care plan records and other records related to the running of and the quality of the service. Records included maintenance records, staff files, minutes of meetings and audit reports the manager had completed about the services provided.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at the home. They told us staff treated them well and were caring, but that their needs were not always met in the timeframe they would like. People who required help with their mobility told us they felt safe, but that assistance was slow to come. One person said, "Totally reliant on carers for my mobility. My day consists of laying on my bed, watching TV, eating food, and going to the toilet. Due to the lack of staff even these tasks,needs are not being met. The issue is purely the staff to resident ratio."

Staff told us that the staffing levels were poor. They said that this sometimes impacted on when people wanted to go out and attend events. One staff member said, "Staffing is still a problem. We need more help." Another staff member told us, "Staffing varies, it's hard to predict. People's needs exceed what the care staff can do." One other staff member said, "Although we pass this on to managers, they think we have enough, but it's not just about the numbers." Staff told us they had passed their concerns on to previous managers, but do not think their opinions were valued on this topic. The current manager had only been in post for two weeks prior to our visit.

People told us that when they rang their call bells staff were often slow to respond. People in one sitting room could not easily access the call bell system in that room. We observed them shouting for assistance. Staff immediately ensured they could reach a call bell. Staff told them it was because of low staffing levels. One person said, "Staff eventually arrive but sometimes just switch the call bell off and say that they will be back, but do not come back." A relative told us, "[Named relative] has to wait to go to the toilet." Another relative told us, "In the past I have had a phone call from [named relative] and I have had to ring the office to get them to answer the call bell." Staff stated to us they sometimes told people staffing levels were low so they would not be disappointed if they had to wait a little longer for some needs to be completed. Throughout the day the call bells being sounded was constant. During the day we timed the call bells and found them to build up. For example at one point during the day the call bells were showing for four rooms. These were all ringing for over five minutes. Staff told us they were answering them as they appeared on the board. One staff member said, "This is not unusual, but we try our best."

The manager told us how the staffing levels had been calculated, which depended on people's daily requirements. These were completed on a weekly basis by the manager from information submitted by staff. This had been more consistently completed since July 2016. The manager stated they believed that currently the dependency levels of people were not correct and were reviewing the evidence. They said this would affect the staffing levels required. Contingency plans were in place for short term staff absences such as sickness and holidays. We saw the staff rota for the previous month. There had been many changes to the rota due to staff absences, but most shift times had been covered.

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

Staff had received training in how to maintain the safety of people and were able to explain what constituted abuse and how to report incidents should they occur. They knew the processes which were followed by other agencies and explained how investigations would take place by, for example the local authority. This ensured people could be safe living in the home.

Accidents and incidents were recorded in the care plans. The immediate action staff had taken was clearly written and any advice sought from health and social care professionals was recorded. There was a process in place for reviewing accidents, incidents and safeguarding concerns on a monthly basis. However, this had been inconsistently completed. The provider's policy stated the analysis should take place monthly. There was no analysis between March 2016 and July 2016, but one had been completed for August 2016. This prevented the staff from seeing if there was a theme or trend in the accidents and so they would be able to monitor the safety and abilities of people.

To ensure people's safety was maintained a number of risk assessments were completed and people had been supported to take risks, for example, where people had a history of falls and difficulties mobilising around the home. Falls assessments had been completed. Staff had sought the advice of the local NHS falls co-ordinator to ensure the correct mobility equipment was in place for each person. This was recorded in each person's care plan. We observed staff assisting people to use a variety of walking aids throughout the day. When people had a history of seizures, each one was recorded and how effective treatment was before and after the event. Care plans were in place to ensure the environment could be made safe in case anyone had a seizure and what actions staff should immediately take to prevent each person harming themselves.

People had plans in place to support them in case of an emergency. These gave details of how people would respond to a fire alarm and what support they required. For example, those who needed help because of mobility problems. The last fire and rescue report gave a number of requirements to be completed by the provider to ensure the home was safe to live in, visit and work in. The provider was gradually working through those tasks, which had a finish date of 4 October 2016. We saw two outside fire doors propped open during the first day of our visit, which was against the provider's fire policy to prevent a fire from spreading. Remedial action was taken immediately by staff. A plan identified to staff what they should do if utilities and other equipment failed. Staff were aware of how to access this document.

We were invited into seven people's bedrooms to see how they had been decorated. People told us of their involvement in the layout of the bedrooms. They told us they were happy how their rooms were kept clean. Staff had taken into consideration when writing the care plans of environmental risks for some people, especially those with loss of vision and mobility needs. This included ensuring rooms were free of trip hazards from trailing wires and ensuring furniture was in a good state of repair.

On the first day of our visit we observed a water boiler set up in a dining area which was full of boiling water. People were observed going in and out of this room. There were no safety signs to show the danger this could cause and people were not restricted entry to that area. We pointed this out to the manager who took immediate action. Access was restricted to only certain staff and safety notices put on display, but the movement of people was restricted in this area, unless staff were present. Staff informed us the boiler had been set up because the floor area where it normally stood was being replaced. We observed this to be the case, but no thought had been given to the risk to others this may cause.

The entrance to the home was through a door which we saw was left open all day of the first day of visit and most of the time on the second day. We were able to enter the home unchallenged at the beginning of each day. We saw other people enter the home in the same way. Not every one used the visitors' book to sign into the building so staff had no record of how many visitors were in the home, in case they needed to evacuate

the building. We also observed some relatives entering by a side door which was nearer to their family member's room. Again staff had no record of their time in the building. All areas of the garden were safe to walk in, but had a shared drive with the sheltered housing complex, which was in the grounds of the home. We observed lots of people coming and going from the complex, which made it hard for people to negotiate cars and people. All bedroom areas had locks on the doors and could choice to lock those doors. No-one had requested keys to lock their bedroom door at the time of our visit.

People had name plates on their bedroom doors, which enabled them to identify which room was theirs. However, there were no directional signs in corridors to direct people around the home, other than fire exits. This could mean that people who had a poor memory could walk for a long time until they found where they wanted to be.

We looked at three personnel files of staff. Checks had been made to ensure they were safe to work with people at this location. The files contained details of their initial interview and the job offered to them. There were currently staff vacancies for trained nurses and care staff.

People told us they did not always receive their medicines on time, but understood why they had been prescribed them. One person said, "I like my medicines on time, but don't always get them, I think it's a staffing thing." Another person said, "I have to ask for my medication, timings are random, yesterday they ran out of my medication." Medicines had been explained to people by GPs' and staff within the home. This was recorded in people's care plans. People told us that if required the staff would contact the person's GP if medicines needed to be changed. Staff were observed giving advice to people about their medicines. Staff knew which medicines people had been prescribed and when they were due to be taken.

Medicines were kept in a locked area, but the area was small. Staff told us it was difficult to work in this area due to the cramped conditions and of how much was required to be stored in the area. Staff told us the ordering system with the local pharmacy was hard to follow, which often caused delays in medicines being received. We observed staff on the telephone to the pharmacy chasing medicine orders for three people whose medicines had been delayed. The manager told us they were escalating this problem to the area manager for the local pharmacy as the incidents of people waiting for their medicines had increased in the last year.

Records about people's medicines were not accurately completed. There were gaps on some of the medicine administration record sheets (MARS), so we did not know whether people had received their medicines. Medicines audits we saw were completed by staff at the home and the dispensing pharmacist. We saw the last audit completed by staff at the home from April 2016 which highlighted actions. There was no record of whether these had been completed. The local pharmacy had also completed an audit in January 2016 and this also had some actions to be completed, but there was no record of whether these had been done.

We observed medicines being administered at lunchtime and noted appropriate checks were carried out and the administration records were completed. Staff informed each person what each medicine was for and how important it was to take it. They stayed with each person until they had taken their medicines. Staff who administered medicines had received training. Reference material was available in the storage area. Two people had the ability to administer their own medicines. We saw there were assessments in each of the people's care plans to show how their capacity to take medicines had been assessed.

Requires Improvement

Is the service effective?

Our findings

People we spoke with and relatives told us they thought the staff were trained and able to meet their or their family's needs.

Staff who had been newly recruited told us their induction period had suited their needs. They told us what the programme had consisted of which followed the provider's policy for induction of new staff. Details of the induction process were in the staff training files. The manager told us that they had begun to embrace the new Care Certificate. This would give everyone a new base line of information and training and ensure all staff had received the same type of induction process.

Staff said they had completed training in topics such as manual handling, fire and health and safety. They told us training was always on offer and it helped them understand people's needs better. The training records supported their comments on courses completed. Staff had also completed training in particular topics such as dementia awareness, pressure area care and hydration and nutrition. This ensured staff had the relevant training to meet people's specific needs at this time as it was specific to the needs of the people. This recorded what topics staff had covered and when updates were required with timescales for refresher training.

Staff told us the provider was encouraging them to expand their knowledge by setting up courses on specific topics. This included national awards in care and being encouraged to attend local support groups in topics such as infection control. The registered nurses were not being supported to maintain their registration with the Nursing and Midwifery Council (NMC). The provider did not have any systems in place to ensure each trained member of staff was ready for their revalidation work to be submitted to the NMC. This could mean that their registration with the NMC may lapse and the provider would then be short of nurses to deliver care to people, especially those with specific nursing needs. However, one of the trained staff, who had already completed their revalidation, was assisting others.

Staff told us a system was in place for formal supervision sessions every 12 weeks and yearly appraisals. They told us that they could approach their supervisor at any time for advice and would receive help. The records showed when supervision sessions had taken place, which was in line with the provider's policy, which had been reviewed in November 2015. There was a supervision planner on display showing when the next formal sessions were due. There was currently no system in place for clinical supervision of the trained nurses although the provider was aware this was part of the NMC requirement for registered nurses progress reports. The manager told us that this was to be completed this coming year, but this had lapsed due to staff changes.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider had followed the requirement in the DoLS. No applications had been submitted to the local authority. The provider had trained and prepared their staff in understanding the requirements of the MCA and DoLS, but their learning was not always applied to the principles of MCA and DoLS.

Staff told us that where appropriate capacity assessments had been completed with people to test whether they could make decisions for themselves. We saw these in four of the care plans. However, these had not always been consistently completed, with some showing gaps in the information being collated. They did not show the steps which had been taken to make sure people who knew the person and their circumstances had been consulted. Staff had recorded the times best interest meetings had been held and assessments completed to test their mental capacity and ability. However, this information was not consistently applied in each of the care plans we reviewed. The checklist being used to assess people's mental capacity did not follow the latest guidance. They were also not all completed in the same way with some gaps in dates and reasons why an assessment had been completed. Although staff had received training in DoLS they were not applying their knowledge base to the assessment process.

People were given choices throughout the day if they wanted to remain in their rooms or bed or where they would like to sit. Some people joined in happily and readily in communal areas. Others declined, but staff respected their choices on what they wanted to do. There were a number of different rooms for people to sit in, including a library and a conservatory. There were also quiet areas in corridors where people could sit. We observed people in those areas, some with their relatives, and some with staff.

People told us medical help from GPs and community nurses were accessed quickly and efficiently by staff. This was also confirmed by the health and social care professionals we spoke with before our visit. Information leaflets were on display about a variety of topics such as; local health care services and leaflets on specific illnesses.

People told us that they liked the food. One person said, "Food is top notch". Another person said, "Food is superb." A relative told us, "We come in once a week for lunch." However, people told us they had no reminders of what they had ordered each day and there were no menus on the tables. They also raised concerns that they had to wait for a long time for their meals. We observed that a board stating the menu of the day was the wrong one on the first day of our visit and there were no menus for people to read. This meant people had no reminders of the menu of the day or what was planned for other meals. However, a poster on display in the main entrance showed the results of the catering questionnaire people had received in February 2016. There had been 25 responses out of 40 sent out. The overview stated by the manager was, "Generally this has been a positive response to meals provided at Stewton House, however there were a few areas that do jump out as possible areas of concern." Staff told us these had been addressed through changes to menus.

We observed people were brought into the main dining areas, if they could not walk themselves, a long time before the lunch was served. Some people sat for over 30 minutes. After lunch people had to wait equally as long to go back to areas of the home they wanted to reside in. One relative told us, "[Named relative] has to wait to be put in a chair after lunch." This meant people were not always able to access the areas of the home they wished and move on to other events for the day.

Staff knew which people were on special diets and those who needed support with eating and drinking. Staff had recorded people's dietary needs in the care plans such as when a person required a special diet and where they liked to have their meals. We saw staff had asked for the assistance of the hospital dietary team in sorting out people's dietary needs. The cook also kept a dietary profile on people in the kitchen area. This included people's likes and dislikes, foods to avoid and the type of diet required. This ensured people received what they liked and what they needed to remain healthy.

We observed the lunchtime meal. We observed staff sitting with people who needed help to eat and drink. They spoke kindly to them, maintaining eye contact and informing them what was on the plate. People were offered extra meat and vegetables, which some people accepted. Staff took meals to people who preferred to eat in their rooms or the library. They ensured each person was sitting comfortably and had all the utensils and condiments they required. One person was refusing to eat. Staff noticed this and a different member of staff assisted the person and then the person ate their meal completely. Staff told us this was a strategy they had developed with that person and it worked. This was in the person's care plan. People were offered hot and cold drinks throughout the day and there were jugs of fruit juice and water in sitting room areas, which staff told us people could safely handle. Each bedroom area had a jug of water in the room.

We observed staff attending to the needs of people throughout the day. For example, one person had a change in their care of their pressure ulcer so staff discussed the treatment with them. Staff were later heard speaking with health professionals on further changes which may have to be made to the person's exercise routine. One person told us how staff had helped them after some hospital treatment and what on-going care and treatment they were receiving. They told us this was discussed with them and they had the option to refuse. We heard staff speaking with relatives about hospital appointments and home visits, after obtaining people's permission. This was to ensure those who looked after the interests of their family members' knew what arrangements had been made. All events and comments we saw staff record in the care plans.

People told us staff obtained the advice of other health and social care professionals when required. One person said, "When I need an optician they get one." In the care plans we looked at staff had recorded when they had responded to people's needs and the response. For example, when people's needs had changed near the end of their lives. Staff had called on the assistance of specialist palliative care staff and ensured medication was in place in case people wanted more pain relieving medicines. Staff had recorded when people had seen the physiotherapist and dentist. Several people had hospital appointments which they had attended. Staff had recorded outcomes of those visits.

Good

Is the service caring?

Our findings

People told us they liked the staff and felt well cared for by them. One person said, "I couldn't wish for any more care than I get here." Another person told us, "I think the staff are wonderful." A relative told us, "Nurses are very good."

The people we spoke with told us they were supported to make choices and their preferences were listened to. One person said, "They allow me to do what I can." A relative told us, "Nice homely atmosphere."

All the staff approached people in a kind, friendly and sensitive manner. They showed a great deal of consideration to people. For example, when someone was becoming anxious because they could not remember the time of day. Staff continually told them the time and when thanked made remarks such as, "you are very welcome" or "it's no trouble." There were clocks and calendars displayed around the home to help people orientate themselves to day and time.

Some people either through their own choice or because they were ill remained in bed. We observed staff attending to people's needs. They ensured each person had everything to hand including their call bell before leaving the room. When two people were required to help a person in bed, staff informed them who was attending to them. For example a staff member was heard to say, "Hello, [named person] it's [named staff member] and [named themselves] would it be alright if we changed your bedding?" The person then had the right to refuse. Staff ensured they had everything to hand before entering a room so as not to keep a person waiting.

Relatives told us how staff had supported them when their family members' lives were drawing to a close. They told us staff had been very comforting to them as well as their family members. They had been kept informed about events and felt included in discussions. Staff were described as empathetic and knowledgeable.

Throughout our visit we saw that staff in the home were able to communicate with the people who lived there. The staff assessed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. They also gave people the time to express their wishes and respected the decisions they made.

We observed staff helping to make decisions about outings and hospital appointments. The staff ensured they had all information to hand before approaching a person so they would not inconvenience them by hunting for information. Each person's decision was recorded in their care plan. If a person needed staff to make phone calls to hospitals this was offered. One person was attending a family event and staff had arranged to take them and ensured they remembered the time to go and assured the person they could come back whenever they liked. Staff made sure the person had the home's telephone number in case of an emergency.

People told us they could have visitors whenever they wished and this was confirmed by relatives. We saw

signatures in the visitors' book of when people had arrived at the home and saw several people visiting. Staff told us families visited on a regular basis. Relatives told us they were offered refreshment when visiting. This was recorded in the care plans. This ensured people could still have contact with their own families and they in turn had information about their family member. People told us staff would telephone their family members when they wanted to speak with them. There was also a payphone in a quiet area for people to use. A relative told us, "Communication has improved between staff and relatives. I always ask about [named relative] so I don't have a problem."

All members of staff were involved in conversations with people and relatives. Each staff member always acknowledged people when walking around the building. Staff greeted people with a smile and acknowledgement. Staff engaged with people about the person's day, asking a person's well-being or engaging in lengthier conversations.

People told us staff treated them with dignity and respect at all times. One person said, "They draw my curtains when they help me out of bed so people can't look in." Another person told us, "When I go to the bathroom, I can manage on my own, but staff knock on the door before entering and shout to see if I'm dressed." We observed staff knocking on doors prior to being given permission to enter a person's room.

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care could be supported by staff and the local advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. We saw details of the local advocacy service on display. There were no local advocates being used by people at the time of our visit.

Requires Improvement

Is the service responsive?

Our findings

People told us staff had talked with them about their specific needs. This was not recorded in people's care plans. They told us they were aware staff kept notes about them, but were not involved in the care planning process. One person said, "We have not been involved in a care plan."

The record keeping in the care plans was inconsistent. Some record sheets were dated and others were not. For example, when a person required a body map because of a pressure ulcer this was not dated. So we could not see whether the body map referred to the current pressure ulcer. There was also no care plan for the wound being dressed, but there was a wound chart of when dressings had been changed. Where people had problems maintaining a good diet there was often a care plan on that need. However, staff were not recording when they were following the actions required. For example, when a person required twice monthly weights, this was only recorded as taking place once a month.

A number of people had Do Not Attempt Cardiac Pulmonary Resuscitation (DNACPR) forms in place. These had not all been correctly completed by the medical practioners. There was no evidence to state when staff had challenged the incorrect forms. For example, when someone did not have the capacity to make informed decisions about their care, other people had been asked their opinions, but there was no recording of the relationship of that person. When reviews of the DNACPR forms had been required, staff did not record if they had taken place. We brought this to the attention of the manager; as if the forms are not correctly completed it makes them invalid. If a person were to collapse, staff would have to commence CPR which may not benefit that person's quality of life or be against their wishes.

Staff also completed charts when people required to have their position changed in bed and to monitor intake of food and fluids. We looked at the charts of six people. There were gaps in the daily recording of each of the charts. For example, five of those people required fluid and food intake to be recorded as their care plans stated they had either weight loss or had difficulty eating and drinking. The records did not state all the occasions when people had consumed food and drink. Staff told us they did not always record every sip of drink a person consumed. This meant there was no accurate way of knowing if the person had consumed sufficient to maintain a healthy diet. Four of the charts recorded when people had been turned when in bed and also recorded when they sat in a chair. These had not always been completed within the time scales recommended in the care plans. For example, when a person required half hourly turns there was only spasmodic recording of when this occurred and did not follow the care plan. We also observed a person sitting in a chair, yet the last recording was when they had been in bed. The advice given on the care plans was not then transferred to the charts which staff used. Staff were unaware the records differed, so did not always give the care as recorded in the care plans.

Staff recorded on a daily basis some basis information about each person. The information appeared to follow a similar pattern for each person, such as if a person had a bath, whether they had dressed and if they had eaten any meals. The information was not person centred and did not tell us how the person had spent the rest of their day. The poor standards of record keeping had a negative impact on the frequency and quality of person centred care that people received.

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

Staff received a verbal handover of each person's needs at each shift change so they could continue to monitor people's care. Staff told us this was an effective method of ensuring care needs of people were passed on and tasks not forgotten. There was also a handover book in use. Staff told us this was used as a reminder of what had been said and useful if they had been on holiday. We observed part of a lunchtime handover. This was unhurried and staff were given time to ask questions, but staff had stayed beyond their shift time to do the handover. Staff told us they did not mind doing this as they wanted to make sure events were passed on correctly. Details included the well-being of each person, what medicines required to be ordered and any wound dressings still to be refreshed.

We were informed that an activities co-ordinator was employed. We saw them facilitating a number of activities throughout the day. Staff told us the activities co-ordinator also helped out with assisting people at meal times and with some personal care with people. However, this prevented the activities co-ordinator from fulfilling their own role at times. One person said, "We should have had bingo yesterday, but [named staff member] was called away to other tasks." Separate records on activities were kept, but these were not up to date. They included events people had taken part in. For example different entertainment they enjoyed such as singers. They also recorded events which had taken place such as walks with people, themed events and visits out. People told us that the events which were organised they enjoyed. Staff told us of events planned for the rest of 2016. They also told us that a programme of events was taken weekly to each person. However, the ones we saw in people's rooms were out of date. The board in the entrance gave a list of the week's activities, but there was no other format for people to access. This could inconvenience people who could not read written English or had poor vision and not keep them informed of events.

People are actively encouraged to give their views and raise compliments, concerns or complaints. People's feedback was valued and concerns discussed in an open and transparent way. People told us they were happy to make a complaint if necessary and felt their views would be respected. Each person knew how to make a complaint. No-one we spoke with had made a formal complaint since their admission. People told us they felt any complaint would be thoroughly investigated and the records confirmed this. We saw the complaints procedure on display, but this did not give details of other organisations people could approach if they were unsatisfied with the results of any internal investigation. The complaints log detailed the formal complaints the manager had dealt with since our last visit. It recorded the details of the investigations and the outcomes for the complainant. However, an analysis if complaints dealt with had not been completed since March 2016. We could not see any evidence to support lessons learnt from the cases had been passed to staff.

The compliments book was very full and give many positive comments about the care which had been delivered to individuals. Some thank you cards for care recently delivered were on display.

Requires Improvement

Is the service well-led?

Our findings

There was not a registered manager in post. The home had been without a registered manager for 13 months. In the interim period the area manager supported the home on a daily basis and there was a trained nurse employed as a clinical lead. People told us they could express their views to staff and felt their opinions were valued, but did not receive feedback on topics. This meant that people were unsure of the actions they required had happened and if the comments they had made were of value. People told us they did not know who the manager was and that people in that post kept changing. CQC were aware that there had been two managers in post since the registered manager had left, but they had left before registering with CQC.

Questionnaires had been sent to people on topics such as making decisions for themselves This had been sent out in July 2016, but the results had yet to be analysed. There had been no meetings with people or relatives, but staff told us this was difficult as most people were ill when they arrived. The benefit of such meetings give people and relatives the opportunity to express their views.

On the home's website there was a lot of information about the home, but some of this was misleading to readers. This included events and activities which were now out of date. The name of the previous registered manager was still listed as being employed. The website signposted people to the CQC website to look at the last report, but the overall ratings were not obviously displayed. The area manager took remedial action to rectify the website.

Staff told us they worked well as a team and felt supported by each other. They told us as there had been so many changes in manager they had developed their own strategies for dealing with concerns and only escalated this to the area manager if it was not in their powers to complete. One staff member said, "There has been no guidance." Another staff member told us, "I love my work; members of staff work well, like a family." One other staff member said, "We keep each other's spirits up. We can do basic care needs, but feel on the whole we give person centred care."

Staff told us staff meetings had been held in the past, but they had not had one recently. The staff meetings file confirmed this. The manager told us a staff meeting would be held in the coming couple of weeks and we saw a notice explaining the time of that meeting. Staff had been asked for their suggestions for the meeting agenda.

Staff had attempted to complete audits on various processes within the home. In the last six months staff had completed audits within the kitchen and domestic services. The infection control audit been commenced. Weekly checks were completed by the maintenance staff on the environment. However, there was no general maintenance plan for the upkeep of the building and grounds. Some areas of the home were looking worn and required refurbishment, but there was no plan of how this was to be addressed. The manager showed us a file where other audits such as for medicine administration, care plans and the environment had been commenced. They explained they had been in post for only two weeks so this was a work in progress. The manager was aware that some audits had not been completed for a few months, but

the area manager was based at the home so had completed their own audits. This included the safety of the premises, asking senior staff to complete care plan audits and speaking with people, relatives and staff about their needs.

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential. The manager understood their responsibilities and knew of other resources they could use for advice, such as the internet. This home is part of a small company so the manager had the opportunity of meeting with other homes managers and area staff on a regular basis.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The manager of the home had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plan recording was poor and not up to date. Chart recording did not reflect actions from the care plans.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient staff to meet people's needs. The calculation of staffing levels had not taken into consideration people's current dependency levels.