Care Quality Commission

Doncaster Property Investment Fund Limited

China Cottage Nursing Home

Inspection report

154 Owston Road Carcroft,Doncaster, South Yorkshire DN6 8EA
Tel: 01302 724815
www.chinacottagecarehome.co.uk

Date of inspection visit: 06 & 13 October 2014
Date of publication: 17/12/2014

Ratings

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

Overall summary

This was an unannounced inspection carried out on 6 and 13 October 2014. We last inspected the service in November 2013 and found they were meeting the Regulations we looked at.

China Cottage Nursing Home is a care home situated in Carcroft, Doncaster which is registered to care for 33 people. The service is provided by Doncaster Property Investment Fund Limited. At the time of the inspection the home was providing nursing and residential care for 24 people.

There is a registered manager, however she has been absent from China Cottage since May 2014. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

The provider appointed an acting manager to oversee the day to day management of China Cottage in the absence of the registered manager. She was the deputy manager at the time when the registered manager became unavailable for work.

Summary of findings

Following this inspection the provider sent us an action plan which clearly sets out how they will address the breaches we found on inspection. The provider has agreed to send us weekly updates on their progress.

People were not kept safe at the home. There were poor arrangements for the management of medicines that put people at risk of harm. We found that staff did not understand the legal requirements as required under the Mental Capacity Act (2005) Code of Practice. The Mental Capacity Act 2005 sets out how to act to support people who do not have the capacity to make a specific decision.

Although people's needs had been assessed and care plans developed these did not always adequately guide staff so that they could meet people's needs effectively. People's food and fluid intake was not monitored sufficiently. People were not referred to the speech and language therapist in a timely way. The privacy and dignity of people living at the home was not always maintained.

The provider was not adequately monitoring the quality of the service and therefore not effectively checking the care and welfare of people using the service. In addition to this the provider had failed to provide information requested by CQC about the service.

Staff were recruited safely although they did not receive formal supervision regularly, as required by the provider's policy. Clinical supervision did not take place. This is required by relevant professional bodies to ensure their continued fitness to practice. There were no records to confirm competency checks had taken place in areas such as medication administration. There were not always enough staff to provide people with individual support. The provider did not have a system to assess staffing levels and make changes when people's needs changed.

You can see what action we told the provider to take at the back of the full version of the report. 'Please note that the summary section will be used to populate the CQC website. Providers will be asked to share this section with the people who use their service and the staff that work there.

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?
The service was not safe.

Safeguarding procedures were not always followed. We found three incidents that should have been reported to the local council safeguarding team and were not.

People were not protected against the risks associated with the unsafe use and management of medicines. Appropriate arrangements were not in place for the recording, safe keeping and safe administration of medicines.

Staff we observed appeared to be rushed and unable to spend the time required to complete tasks at the pace of the person who used the service.

Inadequate

Is the service effective?
The service was not effective.

People we spoke with said they were very happy with the meals provided. However, some people were not always helped by staff at mealtimes so they did not receive a well-balanced diet to meet their nutritional needs. People were not referred to the speech and language therapist in good time.

Mental Capacity assessments and best interest meetings did not take place in line with legislation. Staff showed a lack of understanding in the way consent to care and treatment was obtained.

People we spoke with told us the doctor visited regularly, so if they had any problems they could ask to see the doctor. They told us they could also ask to see the doctor at any time and staff would arrange this for them.

Inadequate

Is the service caring?
The service was not caring

We found a lack of consistency in staff approach and while some individual staff were kind and caring, others lacked compassion and an understanding of how to communicate with people who had complex needs.

Staff had not always appropriately assessed people's care needs. Clear instructions about the care people needed each day were not always provided.

Inadequate

Is the service responsive?
The service was not responsive.

Inadequate

Summary of findings

Care plans did not always show the most up to date information on people's needs, preferences and risks to care. People did not always receive care and support that was personalised.

People could access age appropriate activities. People told us they liked the quizzes and we saw people doing art work for a forthcoming Halloween party.

We found complaints were not fully investigated to a conclusion. Four complaints were seen that did not record a response to the complainant.

Is the service well-led?

Inadequate

The service was not well-led.

Systems to monitor the quality of the service were not effective. For example audits were not sufficiently robust to monitor the safety and quality of the service. Risk were not being analysed to reduce further occurrences.

The acting manager did not understand fully her legal responsibilities to notify CQC about incidents and accidents that occurred in the home.

Staff and residents meetings did not take place at regular intervals and staff were not given guidance to support people who used the service.

China Cottage Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6 and 13 October 2014 and was unannounced.

The inspection team consisted of a lead inspector, and a second inspector. Before our inspection we reviewed all the information we held about the service. The provider had completed a provider information return that helped us to plan and identify areas to focus on in the inspection; the provider information retrunis the provider's own assessment of how they meet the five key questions and how they plan to improve their service.

We also spoke with the local authority, commissioners, Healthwatch Doncaster and looked at the NHS Choices web site. These people told us the provider and manager followed procedures and worked with them to improve the service provided. They had no concerns at the time of the inspection.

During the visit we spoke with 10 people who used the service and 11 friends and family members, who were visiting at the time. We also spoke with the acting manager, regional managers, two nurses, the cook, nine staff and the activity co-ordinator who were on duty during the two days of this inspection

We observed people who used the service and recorded their experiences at regular

intervals. This included people's mood, and how they interacted with staff members, other people who used the services, and the environment. This method of observation is called the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at five people's care records and policies and procedures in relation to the management of medicines, staff recruitment, how people are kept safe, activities, how people were involved in their care and how consent to care and treatment was obtained. We also looked at how the service obtained the views of people and how the service managed concerns and complaints.

Inadequate

Is the service safe?

Our findings

People who used the service told us they felt safe in the home. One person said, "I went to hospital a while ago and the nurse saw a bruise on my arm, she reported it but I kept telling them I did it on a drawer at the home. I feel safe and staff know how to look after me very well."

We spoke with four staff about their understanding of protecting vulnerable adults and they told us they had undertaken safeguarding training and would know what to do if they witnessed poor practice. Staff had a good understanding about the whistle blowing procedures and they said they would report anything straight away to the nurse in charge or the acting manager. However staff were unclear about who they would report to outside of the service. For example, the local authority or CQC. Staff had to be prompted about who they should also inform if they needed to report allegations outside of the home.

We looked at training records with regard to the protection of vulnerable adults and we found most staff had received refresher training. However the training was completed using on-line training. The staff had not completed the local councils safeguarding adults training which was recommended by the commissioners. Commissioners are people within the council that set up contracts with the service to provide care to people who used the service.

We looked at the systems in place for managing medicines in the home. This included the storage, handling and stock of medicines and medication administration records (MARs) for five people.

We found staff who administered medicines did not record the amount of medicines received or the amount carried forward from the previous month. This made it difficult to account for medicines received, administered and ensure the current stock levels were correct.

We saw there were a large amount of medicines hand written on the MAR's, which also did not have the correct amounts recorded. Staff told us that if an entry was hand written it should be signed by two nurses to confirm that it had been checked and was correct. Although we found two nurses had signed the hand written entries, the entries had not been fully completed. It was therefore not possible to determine the current stock levels of medicines in the home.

We looked at PRN (as required medicines) protocols and saw these just directed staff to give medicines as required. The protocols provide guidance for staff about when to give PRN medicines. For example there was no guidance for staff to determine how people presented when they were in pain and when PRN medicines should be administered. Staff told us one person had no verbal communication skills and did not have the capacity to tell staff when they were in pain. Another person had very little verbal communication and staff told us, "They are very confused." So they were unable to tell staff when they were in pain. This meant the people could be in pain and not have pain relief medication administered as staff did not know the relevant signs to determine if pain relief was required.

We also found staff did not review people's medication. For example one person was prescribed eye drops for glaucoma; the drops reduce pressure in the eyes and help prevent further damage. It was recorded the person had been refusing these drops. We looked at MAR's back to April 2014 and it was continuously recorded as 'R' for refused on the records. This had not been reviewed with the person's GP.

The medicines were only administered by qualified nursing staff who were appropriately trained to administer medication. However when we asked nursing staff if they received regular competency assessments, they said they could not remember receiving one. When we asked the acting manager about this they said these had not been carried out. Therefore the provider could not determine if the staff were competent to administer medication safely following their policies and procedures.

This is a breach of Regulation13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We spoke with staff who told us staffing numbers had been reduced. The acting manager told us that the provider had told her that once numbers of people using the service dropped below 25 the number of staff should be reduced by one. There were 23 people living at the home at the time of the inspection so staffing numbers had been reduced. Staff told us that a large number of people required two staff to provide care and five people required full assistance with meals and it was difficult to meet people's needs with the reduced numbers of staff, especially at meal times. It also meant at weekends there was no time to do any activities when the activities co-ordinator was not working.

Inadequate

Is the service safe?

We observed lunch over the two days of the inspection. We noted three people in the dining room and two in their rooms required full assistance with their meal. Staff had to leave one person. This person became agitated when they could see everyone else eating and they had to wait. Staff eventually assisted the person when a relative arrived and helped with their mother. Also we were told a person's husband came in every day to help his wife who was in bed.

If relatives had not been available to assist, staff would not have managed. From our observations we found at certain times of the day, such as meal times, staffing levels were not sufficient to meet people's assessed needs.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service effective?

Our findings

During our inspection we spoke with members of staff and looked at staff files to assess how they were supported to fulfil their roles and responsibilities. The members of staff we spoke with said they received regular supervision. We looked at five staff files and found supervision was not undertaken in line with the providers policy on supervision which states 'supervision of staff should take place four times a year'. The acting manager had not received formal supervision since taking over as acting manager. However, she said she felt supported by the regional manager. The acting manager was unsure of her responsibilities to undertake clinical supervision of nursing staff. This is required by relevant professional bodies to ensure their continued fitness to practice. We only found one example of clinical supervision on the nursing staff's files that we looked at.

Staff said they had received training that had helped them to understand their role and responsibilities. We looked at training records which showed staff had completed a range of training sessions. Training was mostly accessed on-line . This included Mental Capacity Act and Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves. It also ensures that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) is part of this legislation and makes sure the least restrictive option is taken where someone may be deprived of their liberty. Decisions about depriving people of their liberty should only be made so that people get the care and treatment they need when there is no less restrictive way of achieving this. The deputy manager said she had undertaken this training but did not fully understand her responsibilities under the legislation.

We looked at the care files and saw that there had been two authorisations to administer a medicine covertly to a person. Administering medicines covertly means that medicines might be given to a person mixed in food or drink where the person might otherwise have refused them. This had been authorised by that person's general practitioner. The acting manager told us that this was in that person's best interest. We did not see any evidence that a best interest meeting had been convened to agree this. A best interest meeting is a meeting of all the people who might have a contribution to make. The members of the meeting collectively decide what to do if someone is unable to make a choice or express their consent to something because they do not have mental capacity.

We found mental capacity was not accurately reflected in the five care plans we looked at. For example, one assessment stated 'She cannot do anything due to her condition.' Then added, 'television left on.' This assessment was not decision specific. The statement was not explained and did not follow MCA guidance. There was no evidence to support how best interest's decisions were made. The person was not able to speak but when we spoke with them they engaged with their eyes and appeared to listen. Staff we spoke with told us, "This person does not speak she does not know what is going on." This shows a lack of understanding by staff when assessing people's capacity to make decisions.

We found other examples relating to lack of understanding in relation to gaining consent. We saw consent forms in care plans regarding taking photographs for care records. However the health professionals records we looked at showed most people had been given the influenza injection but we saw no evidence to confirm how consent had been achieved. The regional manager showed us a consent form that should have been completed for each person. These had not been completed.

This was a breach of Regulation18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw risk assessments identified that two people had not been appropriately referred to healthcare professionals. One person's care plan described them as having swallowing difficulties, but then went on to state 'eats biscuits and cakes' and eats normal diet. The evaluation of the care plan stated that this person should be referred to the speech and language therapist (SALT) for assessment. We spoke with the senior care staff who could not find any evidence that the referral had been made.

Another person's professional's record stated the person was referred to SALT on 2/07/14. A later entry dated 24/07/14 stated the GP was to chase the SALT assessment. No further entries were made in relation to the referral. We observed this person over lunch. We saw that they began to choke on food. Staff gave assistance and the person was removed from the dining area. The person did not eat anything further and no other food was offered.

Inadequate

Is the service effective?

Another person's care plan did not have a mental capacity assessment to make decisions about their care and treatment. We noted that this person often refused eye drops that were essential to treat an eye condition. We found no evidence that the GP had been involved in undertaking best interest decision about this person's treatment.

We noted on this person's care plan that they also often refused meals and care. Weight charts showed the person had lost 7.6kg over two months. There was no evidence that the person had been referred to a dietitian. This meant staff were not acting in the person's best interest in relation to consent or refusal of care or treatment.

People told us they had access to healthcare professionals and that staff would enable them to access those services. One person told us that the doctor visited the home regularly and said, "If I don't feel well I can ask to see the doctor at any time." Staff confirmed to us that they would pass concerns to the nurse on duty who would contact the GP for a visit.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We used SOFI during lunch. We found staff were task orientated rather then person centred and some people were left for long periods without food or their meal. Staff appeared to be rushed as they needed to support people to eat their meal in the dining area and also assist people who were cared for in bed.

Prior to lunch we observed one person who used the service helping to lay the tables. Table cloths and menus were on the tables. The act of laying a table can promote a feeling of belonging to the home and not just being a receiver of care. People were given choices of food and two choices of a cold drink were offered but there were no offers of a hot drink which some people may have preferred.

We observed one staff member sit at a table while two people were eating, the staff member was writing in a book and did not talk with the people sat at the table. One person did not eat all their meal and told staff they did not like cheese sauce, the staff said they would let the cook know. Nothing else was offered. More attention to detail should be given to ensure people's likes and dislikes are taken account off.

We looked at food and fluid charts for a number of people. We saw entries just said meal refused. It did not state what meal had been refused or if an alternative was offered.

One person asked for a small portion, the staff said, "You know that the cook gives large portions, just eat what you can." The person was not happy when the meal came out and it was a large portion, they told us. "I don't like my plate full I can't eat it." The person ate very little of the meal. Another person told us, "I only asked for a pudding as I am not very hungry." They had been given the main meal and had eaten none of it.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We spoke with the cook about people's likes and dislikes regarding the food choices. The cook told us that they had a board in the kitchen. It told them if people were on any special diets or required supplements to boost their nutritional intake. The care plans we looked at recorded that there were records of likes and dislikes and people we spoke with confirmed they were able to choose from a menu which included things they liked. One person told us, "The food is nice as there is always something I like." They said they would ask for an alternative if not.

Inadequate

Is the service caring?

Our findings

We found a lack of consistency in the staff's approach and while some individual staff were kind and caring, others lacked compassion and an understanding of how to communicate with people who had complex needs.

We observed staff interacting with people who used the service. We found some interactions were good but others were not person centred. For example people were moved without being spoken to and drinks were taken away without people being asked if the person had finished drinking. One person we spoke with described some staff as 'Bossy' while others were very caring. We spoke with one relative who raised a concern that their relative was helped to bed straight after tea at around 6pm, and was not offered anything more to drink during the evening and night. Staff we spoke with told us that the person liked to go to bed early and often refused supper drinks. This was recorded in the person's care plan.

We spoke with staff who demonstrated that they understood how to maintain privacy and dignity. For example, when district nurses' visited staff would take people to their rooms for treatment closing door and curtains. One staff member said they would always ensure that they covered the person as much as possible when undertaking personal care. Another staff member said they would offer a choice of clothing to the person they were assisting to get dressed.

However, this was not demonstrated in practice as there were some institutionalised practices. For example, we saw people being weighed in the dining room as they were being assisted to the tables for their lunch. They were not asked for their consent before this was carried out. Staff told us, "We have always done it this way."

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked the acting manager if the service had dignity champions to make sure people were respected and had their rights and wishes considered. The acting manager confirmed this initiative had not been implemented at the home but most staff had attended dementia awareness training which covered respect and dignity.

We looked at five individual's care files to see if they were person centred. We saw a 'This is your life' document which had sections about how the person liked their care delivered. It also identified people that were important to them, their life history and likes and dislikes. However, in two of the files this information had not been completed. Staff told us that some relatives had been asked to provide the information because their relative could not communicate their wishes, but the information had not been received.

We spoke with the activity co-ordinator about how people could access the community. She told us that occasionally people could go on an outing although one had to be cancelled due to the weather. We saw people joining in activities and people told us they liked the quizzes.

People had chosen what they wanted to bring into the home to furnish their bedrooms. They had brought their ornaments and photographs of family and friends or other pictures for their walls. This personalised their space and supported people to orientate themselves.

We were told there were no restrictions visiting times. One relative told us they visited at different times of the day; others said they liked to visit at lunch time so they could assist their relative to eat their meal.

Inadequate

Is the service responsive?

Our findings

Care and treatment was not always planned and delivered in a way that ensured people's safety and welfare. Each person's care plan outlined the areas where they needed support but gave little instruction about how to support the person. There were risk assessments in place for people, which identified areas of risk associated with their care. However they did not always direct staff how to care for the person so that these risks could be minimised. For example we saw one care plan that stated the person had not been weighed since 20/08/14. Staff told us this was because they could not put her on the scales due to the person's discomfort. There were no other methods used to monitor weight e.g. upper arm measurements to establish the person's body mass index (BMI).

Other care plans we looked at also showed that the monitoring of people's food and fluid lacked detail. For example, care plans stated the amount of fluids people required each day, to maintain good hydration levels. However records we looked at showed people had not achieved the amounts of fluids required to prevent them from becoming dehydrated. Two other people's records showed significant weight loss had occurred. However staff were unclear if they had been referred to a dietitian for advice.

Staff did not always engage with people in a positive way. People were sat for long periods of time in the same chairs not offered the toilet or a change of seat. We observed one person being given jelly sweets. Staff told us the sweets seemed to stop the person being 'noisy'. We observed this happen on three occasions. However, the person had been assessed as at risk of choking and staff did not stay with the person to ensure the sweets were eaten safely.

We also observed one person was given no assistance to drink their cup of tea. It was taken away not drunk; the person was not given an opportunity to drink the tea or provided with an alternative drink such as coffee or juice.

There was very little interaction with people who had no verbal communication, the only time staff did interact was task orientated, for example when assisting with meals and drinks. We also saw staff did not engage with people when giving support to eat their meals.

People did not always receive care and support that was person centred. Staff had not always appropriately assessed people's care needs. Clear instructions for care delivery were not always provided. For example, we looked at a care plan for one person nursed in bed. We spoke to staff about this person's care and they had different answers about the care this person received. From what staff described. it was not clear if it was the person's choice not to get up or if it was easier for staff to nurse the person in bed. When we spoke with the person they told us, "I am bored," "I'm fed up in bed," and "I'm always in bed, I go downstairs and when I need to use the toilet they (the staff) bring me back to my room."

We looked at this person's care plan in relation to pain control. Staff told us the person suffered with extreme pain in their legs and that it was best to give PRN (as required) medication for pain relief before personal care was given and before the person was moved. The care plan did not identify their needs, in relation to pain or discomfort, continence or behaviour that challenges the service.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People who were able to were given the opportunity to join in activities. We observed people joining in a quiz and doing art work for the Halloween party at the end of October. One person we spoke with said "I like to sit in this small lounge and paint. It keeps me busy and away from the people who shout and are noisy." Another person said, "I like the quizzes but prefer to sit quietly and read."

The provider had a complaint's policy although this did not contain enough information about what people could do if they were unhappy with the provider's response. For example, the procedure did not contain the details of the local council who would investigate complaints that were not resolved by the provider. We looked at the complaints records and found four complaints had been recorded since June 2014. The records did not contain details of how they had been investigated or resolved. There was no evidence of lessons learned from complaints so that the service could continually improve.

This was a breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service well-led?

Our findings

The service was not well led. In the absence of the registered manager the provider had appointed an acting manager to oversee the day to day management of China Cottage. She was the deputy manager at the time when the registered manager became unavailable for work. The acting manager told us that she received support from the regional manager, but had no previous experience in managing a care service. We found no evidence that the manager had received clinical supervision.

Care staff had not received formal supervision in line with the provider's policy and this had not been identified by the provider on any of the audits completed by them. This meant that the monitoring of supervision was not effective or in line with the providers policy, which stated staff should receive four supervisions each year.

Quality monitoring systems were ineffective. There was no evidence of remedial action being undertaken when issues had been identified. The acting manager showed us a remedial action file but it only showed action required to repair and maintain the building. We looked at a number of audits, for example, care plan audits. The acting manager told us nurses completed about eight care plan audits each month. We looked at five audits which had been completed over two months. They identified parts of people's care plans that required updating. The actions had not been completed so the audits were ineffective and people were placed at risk of receiving care that was inappropriate or unsafe.

We spoke with the acting manager about staffing levels. She told us that they did not use a dependency tool but was told by the provider that when occupancy dropped to below 25 people the staffing should be reduced. There was no effective system to monitor the staffing levels and skill mix to ensure there were sufficient suitably qualified staff to meet the needs of people who use the service at all times.

The medication audit was not fit for purpose. The agency nurse had started a medication audit following our first visit on 6 October 2014. The audit was dated 9 and 10 October 2014, the nurse had identified the amount of tablets in stock for each person. This was then meant to have been transferred to the new medication administration record (MAR) on Sunday 12 October 2014 at the start of the new four week cycle. This had not happened and the agency nurse was trying to do this during our second visit on 13 October 2014.

We looked at previous medication audits. These were a tick list which showed the systems met requirements. For example the audit tool asked the person carrying out the audit to check hand written entries had two signatures and all the required information, this had been ticked on the audit dated September 2014. However we found hand written entries on the September MAR, and the October MAR did not have the amount received or the amount brought forward recorded. We also checked old MAR charts back to April 2014 and the hand written entries did not contain all the relevant information yet the audits always had the box ticked as completed. This meant audits did not identify issues and so these issues were not addressed or resolved.

Notifications were not always sent to CQC. For example, we found three incidents/accidents from May, July and August 2014 that should have been reported, this is a legal requirement. Two of the incidents referred to an altercation between two people who used the service. These should have been referred to the local authority safeguarding team and were not. Another incident involved an agency nurse administering medication to the wrong person. We saw the agency had been informed of the error but no further action had been taken. The acting manager was not fully aware of what should be reported to CQC. The provider had not checked that notifications had been sent to CQC as required. This was because there was no effective system to monitor incidents to make sure these were reported to the appropriate authorities.

We saw people living at the home and family members were involved in care planning and aspects of running the service. Relatives confirmed they were in regular contact with the staff and were invited to care reviews. We saw several relatives who visited the home during our inspection. One relative said, "We visit regularly and the care seems to be okay." Another relative said, "I have attended one relatives' meeting, but they don't seem to be very often."

We asked to see the minutes of staff meetings. These could not be located, however some minutes were sent to us by

Inadequate

Is the service well-led?

email after the inspection. We looked at the minutes from a meeting in March 2014 which included discussions about training and work practice. Minutes were also sent from a meeting that took place after the first day of the inspection which highlighted issues raised about privacy and dignity and the completion of records such as food and fluid charts.

We looked at the statement of purpose for China Cottage and found it required updating to reflect the changes to the status of the person in day to day management of the service and staff working at the service. The complaints procedures also required updating as it did not include the details of the local council complaints department. The statement of purpose also set out the philosophy of the home which stated "The home should not be institutionalised by the requirements of staff." However, we observed staff weighing people who used the service in the dining room just before lunch on 6 October 2014. We asked staff if they gained consent from people who used the service or if they minded being weighed in front of other people. They confirmed that this task had always taken place in the dining area and they had not given consideration to people's views or wishes. There was no effective system to monitor the statement of purpose to ensure that it remained up to date.

This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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 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	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The provider did not have effective systems to regularly assess and monitor the quality of service that people receive. The provider did not have effective systems in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment People did not receive care or treatment in accordance with their wishes. People were not always asked for their consent before treatment was given.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints Comments and complaints people made were not responded to appropriately.