

Sunglade Care Limited

Benedict House Nursing Home

Inspection report

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Ratings

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

Summary of findings

Overall summary

Benedict House Nursing Home provides accommodation and nursing care for up to 41 older people. At the time of this inspection the home was providing care and support to 27 people.

This unannounced inspection was carried out on 20, 22 and 23 June 2016. At this inspection we found several breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities), Regulations 2014 in relation to safe care and treatment and person centred care and good governance. We found that action had not always been taken to support people where risks to them had been identified and that the provider's systems for monitoring the quality of the service were not operating effectively as we found some issues with care plans and risk assessments that the provider had not identified. We took action to impose urgent conditions on the provider. These required the provider to carry out a thorough and comprehensive review of all people using the services care plans and risk assessments to ensure they fully reflected people's current needs and to undertake monthly audits of care plans and risk assessments and send the Care Quality Commission a report of any actions taken as a result of these audits each month.

We also found that staff were not always aware of people's care needs. Staff were not always following the guidance as recorded in some people's care files. Staff did not assess risks to people using the service in a timely way following falls. Some staff had not received the appropriate training to enable them to carry out their duties. Leadership within the home was inconsistent. There was a high turnover of managers and nursing staff at the home. You can see what action we told the provider to take at the back of the full version of the report.

The home did not have 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. A new home manager started work at the home in April 2016. They had begun the process of applying to the CQC to become the registered manager for the home.

At our last inspection of the service we found breaches of legal requirements relating to regulations 9 and 18 of the Health and Social care Act 2008 (Regulated Activities) Regulation 2014. These related to staff supervision and appraisals and a lack of activities for people using the service. At this inspection we found that the provider had addressed these breaches.

There were safeguarding adult's procedures in place and staff had a clear understanding of these procedures. There was a whistle-blowing procedure available and staff said they would use it if they needed to. People's medicines were managed appropriately and people received their medicines as prescribed by health care professionals. There were arrangements in place to deal with foreseeable emergencies. People had individual emergency evacuation plans which highlighted the level of support they would need to evacuate the building safely. Appropriate recruitment checks took place before staff started work.

Recruitment for nursing staff was on-going. The provider had yet to establish a full complement of qualified nursing staff to support people using the service with their health care needs. The provider had limited the numbers of people they would support at the home until the home had established a fully functional nursing team that would meet people's health care needs.

Staff had completed an induction when they started work. The manager and staff understood the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and acted according to this legislation. People were receiving the food and fluids as recorded in their care plans. People had access to a GP and health and social care professionals when they needed them.

Staff spoke to and treated people in a respectful and dignified manner and people's privacy was respected. People using the service and their relatives, where appropriate, had been consulted about their care and support needs. There was a range of activities available for people to enjoy. People and their relatives knew about the home's complaints procedure and said they were confident their complaints would be fully investigated and action taken if necessary.

Staff said they enjoyed working at the home and received good support from the new manager. The provider took into account the views of people using the service and their relatives about the quality of care provided through relatives meetings and surveys. The manager used the feedback from the meetings to make improvements at the home. The manager carried out unannounced visits to the home to make sure people were receiving appropriate care and support.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we may take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Where risks to people's health and safety had been identified action was not always taken to reduce the likelihood of these risks occurring. Risk assessments were not always updated following falls.

People using the service were not being supervised safely at all times.

There were safeguarding adult's procedures in place and staff had a clear understanding of these procedures.

Appropriate recruitment checks took place before staff started work.

People's medicines were managed appropriately and people received their medicines as prescribed by health care professionals.

There were arrangements in place to deal with foreseeable emergencies.

The home was clean throughout and there were effective systems in place to reduce the risk and spread of infection.

Inadequate ●

Is the service effective?

The service was not always effective

Some staff had not received all of the appropriate training to meet peoples care and support needs.

Staff had completed an induction when they started work. Staff were receiving regular formal supervisions and an annual appraisals of their work performance.

The manager and staff understood the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and acted according to this legislation.

Requires Improvement ●

People were receiving the food and fluids as recorded in their care plans.

People had access to a GP and health and social care professionals when they needed them.

Is the service caring?

Good ●

The service was caring.

Staff spoke to and treated people in a respectful and dignified manner and people's privacy was respected.

People using the service and their relatives, where appropriate, had been consulted about their care and support needs.

People using the service and their relatives were provided with appropriate information about the home before they moved in.

Is the service responsive?

Requires Improvement ●

The service was not always responsive

People's needs were assessed and care and treatment was planned, however care was not always delivered in line with their individual needs.

Staff were not always knowledgeable about people's needs and how to meet these needs.

There was a range of activities available for people to enjoy.

People and their relatives knew about the home's complaints procedure and said they were confident their complaints would be fully investigated and action taken if necessary.

Is the service well-led?

Inadequate ●

The service was not well led

Leadership within the home was inconsistent. The home did not have a registered manager in post. The current manager had begun the process of applying to the CQC to become the registered manager for the home.

There was a high turnover of nursing staff at the home.

The provider's quality monitoring systems were not operating effectively.

The provider had failed to notify the Care Quality Commission of an allegation of abuse in relation to a person using the service.

Staff said they enjoyed working at the home and received good support from the new manager.

The provider took into account the views of people using the service and their relatives about the quality of care provided through relatives meetings and surveys.

The manager used the feedback from relatives meetings to make improvements at the home.

The manager carried out unannounced visits to the home to make sure people were receiving appropriate care and support.

Benedict House 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 was planned to check whether the provider was 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. The inspection was also undertaken to check on concerns we had received in relation to safety.

This unannounced inspection was carried out on 20, 22 and 23 June 2016. The inspection team on the first day consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. One inspector returned to the home on the second and third day.

Before the inspection we looked at all the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required by law to send us. We spent time observing the care and support being delivered. We spoke with twelve people using the service, five visiting relatives, a visiting health care professional, five members of staff, the chef, the maintenance person, the homes administrator, the home manager and the registered provider. We looked at records relating to the management of the service including quality monitoring records, the care records of six people using the service, medicine's records, staff training and supervision records and six staff members' recruitment records.

We also contacted the local authority responsible for monitoring the quality of the service to seek their views. We used this information to help inform our inspection.

Is the service safe?

Our findings

People using the service said they felt safe and staff supported them safely. One person told us, "I feel safe. No one has mistreated me here." Another person said, "I feel safe. There's no problem with all the helpers, they are excellent." Despite these positive comments we found that the service was not safe.

The care records of one person using the service recorded they had a chronic medical condition. This condition would require their diet and fluid intake to be monitored. On the second day of our inspection the manager told us there was no care plan in place for this person's medical condition. They produced a care plan on the third day of the inspection. Although the care plan stated that the person should be provided with a low salt diet, the care plan did not refer to monitoring their fluid intake other than monitoring oral intake and outtake. Another person's falls care plan recorded they had a history of collapsing in the street and they had deteriorating eyesight due to a medical condition. This person had on two occasions got lost outside of the home. There was no risk assessment in place to ensure this person's safety whilst they went out in the community. On the third day of the inspection the manager showed us a new "leaving the premises" risk assessment for this person. Although the risk assessment referred to the person's deteriorating eye sight and getting lost it did not refer to them collapsing in the street. The provider had not taken steps to mitigate the risks to these people and care was not being provided in a safe way.

Where risks to people's health and safety had been identified action was not always taken to reduce the likelihood of these risks occurring. People were not being supervised safely at all times. On the first day of our inspection we saw a person using the service sitting in the front lounge of the home alone. When we spoke with them they said, "I can move around but I need a Zimmer to go myself. If I need help, I have to go to the call bell over there on the wall." The person's Zimmer frame was not in the lounge and the call bell was well out of their reach. This person was observed to be left unattended by staff at various times throughout the day. This person's care file recorded they had a falls in November 2015 and May 2016. Their manual handling risk assessment, dated November 2015, recorded that they needed assistance from two staff and a Zimmer frame. They required staff support at all times. There were no records confirming that this person's care plan or risk assessments had been reviewed after they fell twice in May 2016. These issues meant that safe care and treatment was not being provided to this person because their care plans and risk assessments were not being reviewed after they fell and did not contain the latest information about the risk of them falling.

Another person's mobility care plan, March 2016, recorded they were able to mobilise with a Zimmer frame, which they refused. They were at risk of falls as they could become unsteady on their feet. Staff had to remind them to use the walking frame. Their care plan evaluation records for April and May 2016 recorded "Can mobilise with one staff assisting". We saw this person sitting in the main lounge during the first morning of our inspection. They did not have a Zimmer frame with them. An activities coordinator was supervising them and four other people using the service. We saw this person get up, unassisted, and walk to get some fruit. The activities coordinator went to assist them and asked them to sit down. Other people whose care plans showed they required walking aids did not have them visible near them. One member of staff told us walking aids were moved away to reduce the risks of people mobilising if staff were not present.

Zimmer frames were kept in the toilet away from them as they would be at risk of falls if they were near. The member of staff said there were usually staff in the lounge but they may have to leave for a minute. These issues meant that where people were assessed as being at risk of falls they were not being supported in line with their care plans and risk assessments.

We found that two people using the service had medical conditions which required regular blood sugar monitoring tests to be carried out and recorded. One person's blood sugars were required to be monitored and recorded four times each day. This person's blood sugar monitoring had been recorded only once on the 15, 17 and 19 June 2016. Another person's blood sugars were required to be monitored on Mondays and Fridays of each week. We found gaps in this person's blood sugar monitoring record between Monday 18 and Friday 29 April and 31 May and 17 June 2016. Their blood sugar monitoring records were not completed on the 22 and 25 April 2016 and 3, 6, 10 and 13 June 2016. These issues meant that people were being placed at risk of unsafe care and treatment because staff was not consistently monitoring the risk to their health.

These issues above demonstrate a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). CQC is considering the appropriate regulatory response to resolve the problems we found in respect of this regulation. We will report on action we have taken in respect of this breach when it is complete.

On each day of this inspection we found there were five health care assistants, an activities coordinator and one registered general nurse (RGN) on duty. The manager said staffing levels were arranged according to the dependency needs of people using the service. Four people using the service told us there was enough staff on duty. One person using the service said, "I think they are short staffed." A member of staff said, "We do our best, we are busy but I think we have enough staff to cover everyone." Another member of staff told us, "Staffing levels depend on people's needs and demand. Sometimes it's quiet sometimes it can be busy. I think staff levels are all right, we have enough to meet people's needs at the moment."

On the first morning of our inspection we observed care staff supporting people in the main lounge and an activities coordinator providing activities. We saw care staff leave the lounge to provide personal care and support to people who stayed in their rooms. This meant the activities coordinator was left alone to look after the people in the main lounge. On one occasion we saw that the activities coordinator left the lounge for a short time leaving people using the service unattended. We advised the provider and manager about our concerns relating to people using the service being left unattended. The provider and manager told us they had been reviewing the staffing levels at the home. They told us they planned to increase the staffing levels the day after our inspection adding an extra health care assistant to the roster each morning. We were not able to assess the impact of any changes the provider had made to the homes staffing levels at the time of inspection.

Thorough recruitment checks were carried out before staff started working at the home. We looked at the personnel files of six staff. We saw completed application forms that included references to their previous health and social care experience, their qualifications and their full employment history. Each file included two employment references, health declarations and proof of identification and evidence that criminal record checks had been obtained. We saw that checks were carried out to make sure nurses were registered with the Nursing and Midwifery Council (NMC). The administration manager told us that they monitored each nurse's NMC registration to make sure they were able to practice as nurses. The manager monitored the on-going suitability of staff and took disciplinary action in line with their policy in relation to concerns about staff suitability.

The home had a policy for safeguarding adults from abuse and a copy of the "London Multi Agencies Procedures on Safeguarding Adults from Abuse". The manager was the safeguarding lead for the home. Staff demonstrated a clear understanding of the types of abuse that could occur. They told us the signs they would look for, what they would do if they thought someone was at risk of abuse, and who they would report any safeguarding concerns to. Three members of staff said they would report their concerns to the local authority safeguarding team and the CQC if the concerns they had raised had not been addressed at the home. They told us they were aware of the provider's whistle-blowing procedure and they would use it if they needed to. Staff training records confirmed that all staff had received training on safeguarding adults from abuse.

At the time of this inspection a safeguarding concern was being investigated by the local authority. We cannot report on safeguarding investigation at the time of this inspection. The CQC will monitor the outcome of the investigation and actions the provider takes to keep people safe.

The home was clean throughout and there were effective systems in place to reduce the risk and spread of infection. The provider had appointed a housekeeper whose role included monitoring infection control procedures within the home. We saw completed daily and weekly cleaning schedules which included deep cleaning people's bedrooms, sluice rooms, toilets, bathrooms and clinical areas. We found that sluice rooms were clean and tidy and monthly infection control audits were being carried out.

There were arrangements in place to deal with foreseeable emergencies. People had individual emergency evacuation plans which highlighted the level of support they would need to evacuate the building safely. Staff said they knew what to do in the event of a fire and told us that regular fire drills were carried out. Records seen confirmed that a day time fire drill was carried out on 13 May 2016 and was attended by 18 staff. A night time fire drill was carried out on 7 June 2016 and was attended by four staff. Where people were being nursed in bed or sitting in their bedrooms we saw that call bells were available and located within their reach. One person using the service told us, "If I called them, they would come quickly." Another person said, "When I ring the bell, they come reasonably quickly." We observed that staff responded quickly when call bells were activated.

Medicines were administered safely. We spoke to a nurse about how medicines were managed at the home. They told us that only nurses administered medicines to people using the service. We saw medicines competency assessments had been completed by the nurse's before they could administer medicines. We observed the nurse administer medicines to people safely in a caring and unrushed manner. For example, where a person required food with their medicines we saw the nurse requesting support from a health care assistant to provide the person with breakfast before they administered the medicine. We looked at the medicine administration records (MAR) for six people using the service. These were clearly set out and easy to follow and included people's photographs, details of their GP and information about any allergies. The records showed people were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving people their medicines were recorded.

Pain assessments had been completed to check if people needed to take painkillers which were prescribed as required. When medicines were administered covertly to people we saw there were signed agreements in place, which included the signature of the person's doctor and family member. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature. Records showed that controlled drugs were managed appropriately. We saw a controlled drugs record book. This had been signed by two nurses each time a controlled medicine had been administered to people using the service. Daily checks of controlled drugs were in place and were documented in the controlled drugs record book. We saw the last medicines audit had taken place on 12 June 2016 and any concerns were highlighted and action taken. We saw there were also daily checks to confirm the MAR charts

had been fully completed.

Is the service effective?

Our findings

One person using the service told us, "I think the staff are good at what they do. They just get on with their jobs". Another person said, "The staff are all excellent in my opinion. We have a chiropodist and a hairdresser who come to see us regularly. If I'm not well, I ask to see the doctor and they get him in." A relative told us, "All of the medical services are organised by the home." Despite these positive comments our findings did not indicate that the service was always effective.

Some staff had not received the appropriate training to meet people's care and support needs. We looked at the homes record of training attended by staff including annual mandatory training. Mandatory training included topics such as fire safety, moving and handling, safeguarding adults, infection control, basic food hygiene, health and safety, the Mental Capacity Act 2005 (MCA and Deprivation of Liberty Safeguards (DoLS)). We saw that care staff had not completed annual infection control training, six staff had not completed fire safety training, nine staff had not completed basic food hygiene training and five staff had not completed moving and handling training. The administrator told us that some of these staff had commenced employment at the home in February and March 2016 and were covering some of the training topics as part of their induction. Another member of staff that started working at the home in April 2016 was completing the training as part of the Care Certificate. However, we noted that five of these staff had been employed for over two years had not completed the mandatory training at the frequency required by the provider.

These issues were in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

A nurse told us they had completed an induction, mandatory training and other training relevant to their role such as wound care, diabetes, diet and nutrition, fluids and blood testing. Care staff we spoke with said they had completed an induction when they started work and they had completed lots of training. One said, "The training has improved at the home. We do a lot more of it now and that is helping us a lot. I recently received training about dementia. I have more confidence about supporting people living with this condition. I have a better understanding of their needs." Another member of staff told us, "The dementia training was very educational. It has helped me to understand people's behaviours and what I need to do to support them." We saw completed induction records in all of the staff personnel files we looked at. The administration manager told us that all new staff would be required to complete an induction in line with the Care Certificate. The Care Certificate is the benchmark that has been set for the induction standard for new social care workers.

The administration manager showed us a training program for 2016. Training on infection control, fire safety, palliative care, medicines and moving and handling training had been arranged for staff to attend in July 2016. Training on first aid and food hygiene had been arranged for staff to attend in August 2016.

At our last inspection 3, 4 and 6 August 2016 we found that staff were not receiving appropriate supervision or annual appraisals of their work performance. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

During this inspection staff told us they received regular formal supervision sessions with senior members of staff or the manager. One member of staff said, "We all get regular supervision every two months now. I have also had an annual appraisal." Another member of staff told us, "I have just passed my six month probationary period. I have had regular supervision since I started working here." We saw a supervision and appraisal matrix and records in the staff personnel files we looked at confirming that staff were receiving regular formal supervisions and appraisals of their work performance.

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. The manager demonstrated a good understanding of the MCA and DoLS. They said that most people using the service had capacity to make some decisions about their own care and treatment. We saw that capacity assessments were completed for some specific decisions and retained in people's care files. Where the manager had concerns regarding a person's ability to make specific decisions they told us they would work with them, their relatives, if appropriate, and the relevant health and social care professionals in making decisions for them in their 'best interests' in line with the MCA. We saw that a number of applications had been made to the local authority to deprive people of their liberty, where these had been authorised we saw that the appropriate documents were in place. An officer from the local authority told us they had been liaising with the manager around the completed DoLS applications and authorisations as the manager was relatively new to the home. The manager showed a record of the DoLS applications and authorisations and told us these were being kept under review and the conditions of the authorisations were being followed.

We saw Do Not Attempt Cardio-pulmonary Resuscitation (DNAR) forms in some of the care files we looked at. The DNAR is a legal order which tells a medical team not to perform Cardio-pulmonary Resuscitation on a patient. However this does not affect other medical treatments. These had been fully completed, involving people using the service, and their relatives, where appropriate, and were signed by their GP.

People were provided with sufficient amounts of nutritional foods and drinks to meet their needs. People's care plans included assessments of their dietary needs and preferences. These assessments indicated their dietary requirements, food likes and dislikes, food allergies and their care and support needs. Care plans included information relating to people's dietary needs for staff to refer to. For example, one person's care plan stated, does not eat pork and needs sugar free diet. Another person's care plan stated, puree diet, average appetite. We spoke with the chef. They showed us documents that alerted kitchen staff to people's dietary risks, personal preferences and cultural and medical needs. The chef said they accommodated people's personal preferences by offering a range of choices each meal time. For example some people using the service were from the Mediterranean area and liked fresh salads with olives, feta cheese and tomatoes. Another person using the service had told them they wanted West Indian food and they regularly prepared this for them.

We observed how people were being supported and cared for at lunchtime. Some people required support with eating and some ate independently. The atmosphere in the main dining room was relaxed and not rushed and there were enough staff to assist people when required. Some people ate their meals in their

rooms. We saw that they received hot meals and drinks in a timely manner. We saw that people were also provided with drinks and snacks throughout the day and these were available in the lounges on each floor of the home. One person using the service told us, "The meals are very good. I can eat almost anything and I can have any drink I like." Another person said, "The meals are very nice. I am very fussy." A third person told us, "I like the food, there's always a choice. They come round every morning and ask what I want for lunch and if I didn't like what's on the menu, I think I could ask for something else." A fourth person said, "The meals are good. We get drinks all day."

People were supported to access care from a range of health professionals for example, chiropodists, dentists, opticians and specialist nurses when required. Health and social care professional's visits were recorded in all of the care files we looked at. Where there were concerns people were referred to appropriate health or social care professionals. For example we saw that the manager had contacted one person's GP requesting a referral to the Community Mental Health Team. This person was also receiving regular twice weekly input from a social work team. The social work team was offering advice to the manager and staff on how to support this person to meet their needs. Another person had been referred to a speech and language therapist for support with eating and drinking. A visiting health care professional told us they had no real issues except sometimes they had to wait for staff to come and assist them and that there were sometimes bank staff on duty who didn't know people well. Referrals made to their practice by the home were appropriate and staff followed any guidance they gave.

Is the service caring?

Our findings

People and their relatives told us staff were kind and caring. One person said, "The staff are wonderful staff, very attentive. They are all very friendly and kind. I can't fault any of them I get breakfast in bed." Another person told us, "The staff are very good, excellent, kind and respectful, I know all of their names." A third person said, "The staff are OK, they normally do what I ask." A relative said, "I am made to feel welcome as a visitor." Another relative told us, "I think my mother is well looked after. She's treated with great respect. The staff are very friendly and caring."

The relatives of people using the service told us they had been consulted about their relatives care and support needs. One relative told us, "I have always been involved in planning for my mums care and support needs. I attend all of her review meetings. The manager or staff always let me know how she is getting on." Another relative said, "I attend my mother's review meetings. The staff are always asking me if there is anything else I can tell them about her needs."

A relative told us the home threw a party for their mother's 100th birthday. They said, "The chef arranged a buffet meal; my daughter brought a cake and all the staff turned up to celebrate. It was a great party. My mother and everyone else really enjoyed themselves."

Throughout the course of our inspection we observed staff speaking with and treating people in a respectful and dignified manner. Staff said they ensured people's privacy by drawing curtains and shutting doors. Staff tried to maintain people's independence as much as possible by supporting them to manage as many aspects of their care that they could. They addressed people by their preferred names, explained what they were doing and sought permission to carry out personal care tasks. They told us they offered people choices, for example, with the clothes they wanted to wear or the food they wanted to eat. All of the people using the service we spoke with told us staff showed them respect. All but one person said staff always explained what they were doing for them. This person, who had poor eyesight, told us staff did not always tell them what they were doing. Sometimes they left them food but they didn't know it was there until another member of staff came to take it away. We brought this issue to the attention of the manager who said they would discuss this with staff.

People received appropriate end of life care and support. A local hospice end of life care team had been supporting people using the service with end of life care and support. We saw a "Thinking ahead" document in one person's care file which recorded their wishes regarding their end of life care and support needs. This document had been completed by them, their relative and a nurse from the hospice.

People were provided with information about the home in the form of a service user guide. This was produced in larger print for the benefit of people using the service. We saw copies of the service user guide in people's bedrooms. The guide ensured people were aware of the home's philosophy of care, fire evacuation, meal times and medical services which could be arranged.

Is the service responsive?

Our findings

People using the service and their relatives told us the service met their care and support needs. One person told us, "I definitely get what I need. I've only got to ask and I get it." Another person said, "I feel I am getting the correct care here. There seems to be enough going on." A relative said, "My mother is well looked after so I am happy." Despite these positive comments we found that the service was not always responsive.

People's needs were assessed and care and treatment was planned. However, care was not always delivered in line with their individual needs. Care and health assessments were undertaken to identify people's support needs when they moved into the home and care plans and risk assessments were developed using the assessment information. Care plans included guidance for staff about how people's needs should be met. They included people's personal details, described people's communication methods, their nutritional needs, mobility needs and the support they required with personal and nursing care. The care files included capacity assessments and, where appropriate, Deprivation of Liberty Safeguards authorisations and associated records. We saw that people's care plans and risk assessments were reviewed and signed each month by staff. However we found that these reviews did not always reflect the changes to some people's care and support needs. These issues were referred to in the safe section of our report.

Staff were not always knowledgeable about people's needs and how to meet these needs. We saw in one person's care file that they could not speak English. A member of staff told us it was very difficult to communicate with them as none of the staff spoke their language. Relatives visited the person frequently and we saw a sheet of paper where staff had requested communication information from these relatives. This sheet included limited phrases for staff to use mostly task orientated- like 'are you tired? The sheet also recorded that the person liked to wear a head scarf and skirts and blouse however none of this was recorded in their personal care plan to guide staff. This person was at risk of not having their needs met as staff were not aware of how they needed to communicate and support them appropriately.

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

At our last inspection 3, 4 and 6 August 2015 we found there was no evidence of any specialised activities or resources in place to help staff meaningfully engage with people living with dementia in order to promote their individual wellbeing. This was a breach of regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulation 2014. At this inspection we found that the provider had taken action to improve activities for people living at the home. The home was no longer in breach of this regulation.

At this inspection we spoke with people using the service about the activities provided at the home. One person told us, "Yes, there is enough to do. I like playing dominoes." Another person said, "There is plenty going on but you don't have to join in. I can choose and I'll do what I fancy." A third person told us, "There seems to be enough going on." The home had employed two activities coordinators. These staff provided activities to people during weekdays. We saw one activities coordinator at the home on the first day of our inspection. They were observed to be providing one to one sessions with people sitting in a lounge doing for

example dominoes, reminiscence and reading newspapers. They told us they usually visited people who were nursed in bed to provide one to one sessions such as having their nail painted and hand massages. However we observed they spent most of their time in the lounge as staff were supporting people with personal care tasks in their rooms.

On the second day of our inspection we saw an activities coordinator providing one to one support to people in their bedrooms and activities such as board games in the lounge. We spoke with five relatives visiting the home to facilitate the weekly coffee morning. They told us they had been holding the coffee morning every Wednesday for over two and a half years. One person using the service told us they enjoyed and looked forward to these. A relative said, "We like to do things and give the people living here a good time. Its strawberries and cream today but we usually do cakes. We arrange a party every Christmas and bring Easter eggs to people at Easter." Another relative said, "It's very homely here, we are very blessed with the staff here, they are great. The home is always clean and very well presented. If I ever have a problem I go to the manager and they sort things out." A friend of a person using the service was visiting with their dog. They said, "It's a very nice home, the staff are really attentive and very caring. We come here often and bring the dog to see people. I think the people here really like seeing the dog." On the third day of our inspection we saw an activities coordinator providing activities to people in the lounge and in their bedrooms. Members of a local Church also visited the home and held a prayer and hymn service. This was well attended by people using the service.

The home had a complaints procedure in place. People using the service and relatives said they knew about the complaints procedure and they would tell staff or the manager if they were unhappy or wanted to make a complaint. They said they were confident they would be listened to and their complaints would be fully investigated and action taken if necessary. We saw a complaints file. This included a copy of the complaints procedure and forms for recording and responding to complaints. Complaints records showed that when concerns had been raised these were investigated and responded to appropriately and where necessary discussions were held with the complainant to resolve their concerns.

Is the service well-led?

Our findings

People using the service and their relatives told us they felt the service was well run. One person using the service said, "The manager is sociable. I can go to her about anything. I think this place is run well, you can't fault it. To me this is home from home." Another person told us, "It's run well. I've no complaints about that. I'm quite satisfied here." A relative told us, "The new manager is good, easy to talk to and they deal with things quickly. The home seems to be running well." Another relative said, "This place went down a bit last year. It wasn't very well organised then, but it's got a lot better recently." Despite these comments we found that the service was not always well led.

The provider was consistently failing to operate effective systems to assess, monitor and improve the quality and safety of care to people using the service. At our inspection in February 2015 we noted that the provider's quality monitoring system had not identified the issues we had found. In August 2015 we also noted that the provider's quality monitoring system had not identified the issues we had found at that inspection. At this inspection we saw an action plan for the home. This action plan recorded that all care plans were to be reviewed and updated. The manager showed that audits had been carried out on twelve care plans and risk assessments between April and June 2016. They were not able to confirm if any other care plan audits had been carried out at that time. The provider's quality monitoring systems was again ineffective as it had failed to identify that some people using the service did not have care plans relevant to their health care needs and some people using the service did not have appropriate risk assessments in place.

These issues were a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found in respect of this regulation. We will report on action we have taken in respect of this breach when it is complete.

At this inspection we saw that regular audits were being carried out on medicines, infection control, kitchen, health and safety, personal protective equipment and pressure mattresses. The homes maintenance person showed us records confirming that equipment such as hoists, bed rails, wheelchairs, call bells, the lift and fire equipment were routinely serviced and maintained to reduce possible risks to people. Checks were also made on the safety of the home in areas including legionella, electrical and gas installation safety.

The CQC were advised that a safeguarding concern had been raised by the local authority relating to the home in April 2016. We told the provider that the CQC had not been notified about this concern as required by law. The provider told us they were aware of this safeguarding concern and they had assumed that the previous manager had notified the CQC.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. During the inspection the manager formally notified the local authority and the CQC about this incident.

The current manager has communicated effectively with the CQC in relation to notifiable incidents since

their employment at the home.

Leadership within the home was inconsistent. The home did not have a registered manager in post. The previous registered manager left their post in December 2014. Since then four managers had been appointed to run the home. One manager left in January 2015 after a short time working at the home. Another manager, appointed in March, left their post in June 2015. A third manager was appointed on 14 July 2015 and left their post in December 2015. The provider recruited the current manager in January however they were not able to start working at the home until April 2016. The homes head of care oversaw the running of home during this period. The current manager has had many years' experience as a registered manager. Our records confirmed they had begun the process of applying to the CQC to become the registered manager for the home.

There was a high turnover of nursing staff at the home. At our last inspection August 2015 we reported that the provider had yet to establish a full complement of qualified nursing staff. The home had relied on two full time RGNs and agency nurses to cover shifts. A manager, who was an RGN, and another RGN had started working in the home in July 2015. The provider had acknowledged there had been a high turnover of nursing staff. They limited the numbers of people they would support at the home to 30 and told us they would not accept any people with complex needs until the home had established a fully functional nursing team that would meet people's health care needs. Since our August 2015 inspection the home had appointed a clinical lead nurse. They left their post in March 2016 and the manager left their post in December 2016. At this inspection we found that the home was again relying on two full time RGN's and bank and agency nurses to cover shifts. The new manager, an RGN, told us they were in the process of recruiting RGN's to work at the home.

The manager told us they regularly attended care home forum meetings run by the local authority. They said they shared and learned about best practice from the safeguarding, contracts and hospital discharge teams, pharmacists other care home managers and providers. The manager told us they planned to use this learning to make improvements at the home. We saw reports from two unannounced visits carried out at the home by the manager in May 2016. The visits covered staffing issues, the security of the building and the welfare of the residents. Where any issues were identified these were recorded in the report as actions to be taken. The manager told us they carried out these unannounced checks to make sure people were receiving appropriate care and support.

We saw the minutes from relatives meetings held at the home. The May 2016 meeting was well attended by relatives. Topics discussed at the meeting included, for example, updates on care planning, the introduction of the employee of the month scheme, managing diabetes in care homes, meal times and planned activities. Relative's comments and suggestions were discussed and recorded. The manager told us they planned to carry out a satisfaction survey for people using the service, their relatives and staff in June 2016. They said the feedback from these surveys would be analysed; a report and an action plan would be drawn up and shared with people using the service, their relatives and staff. The manager told us they would continually use feedback from the relatives meetings and surveys to evaluate and make improvements at the service.

A member of staff told us that team meetings were held monthly or more frequent if there was something urgent they needed to talk about. They said, "These are very useful as we get feedback from the manager, nurses and senior staff about what we are doing well and where we need to do things better." We observed a handover meeting between the night time nurse, the day time nurse and five health care assistants. They discussed how people using the service had slept through the night and any issues relating to their individual nursing care and support needs. Another member of staff told us about 'flash meetings' that took place daily. These were attended by the manager, the nurse on duty, senior health care assistants, the

maintenance person and the chef. The focus of the meetings was to consider and communicate people using the service changing needs, health care appointments or any new admissions to the home. They said, "The senior staff tell us if there have been changes in people's care needs so we can support them better. We can also feed issues back to senior staff so that they can be discussed at the flash meetings."

Staff said they enjoyed working at the home and they received good support from the manager. There was an out of hours on call system in operation that ensured that management support and advice was available for staff when they needed it. One member of staff said, "I like working here. There is good team work. Since the new manager came we get proper supervision, better training, infection control has improved and the home is very clean." Another member of staff spoke about improved staff morale. They told us about the employee of the month scheme which was underway at the home. They said, "This is a good thing as it encourages and motivates staff work harder. I would feel very proud to win the employee of the month award." A third member of staff told us, "The new manager has an open door policy; we can express our views and feelings. The manager is a very good listener, they are trying their best to get things right."

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Care Quality Commission of an allegation of abuse in relation to a person using the service.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Staff were not always knowledgeable about people's needs and how to meet these needs.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Some staff had not received the appropriate training to meet people's care and support needs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Service users did not receive safe care and treatment. The provider was failing to assess the risk to the health and safety of service users and do all that is reasonably practicable to mitigate such risks. Risk assessments were not updated following falls. Staff did not assess risks to service users in a timely way following a fall. Staff were not following the guidance as recorded in care files.</p>

The enforcement action we took:

The registered provider must immediately commence a thorough and comprehensive review of all service users' care plans and risk assessments to ensure they fully reflect people's current needs and the registered provider must provide the Care Quality Commission with details of the system operated to secure this by no later than 5pm on Friday 08 July 2016.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider was failing to operate effective systems to assess, monitor and improve the quality and safety of care to service users. Failing to assess, monitor and mitigate the risks to service users. The quality monitoring systems had failed to identify that some service users did not have care plans relevant to their health care needs and some service users did not have appropriate risk assessments in place.</p>

The enforcement action we took:

The registered provider must carry out monthly audits of all care plans and risk assessments to ensure they fully reflect people's current needs and must send the Care Quality Commission a report of any actions taken as a result of these audits on the first Monday of each month