Care Quality Commission

Bupa Care Homes (BNH) Limited

The Arkley Nursing Home

Inspection report

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Date of inspection visit: 7 & 8 January 2015
Date of publication: 21/04/2015

Ratings

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

Overall summary

This inspection took place on 7 and 8 January 2015 and was unannounced. When we last visited the home on 21 May 2014 we found the service was not meeting two of the regulations we looked at.

The Arkley Nursing Home is a nursing home that is registered to provide accommodation nursing and personal care for up to sixty people.

The home had a manager who was in the process of applying to register with the Care Quality Commission (CQC). A registered manager is a person who has registered with 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 2008 and associated Regulations about how the service is run.

Risks to people who use the service were not identified and managed appropriately. There were not always sufficient staff available to meet people's needs, and medicines were not managed safely.

People were not always involved in decisions about their care, and there were gaps in some of the records kept about their care and the running of the home.

Summary of findings

The provider's did not have effective systems for monitoring the quality of the service and people and their relatives did not always feel confident to raise complaints so these could be addressed. Staff did not receive all the necessary training and support to carry out their role.

Staff understood people's preferences, likes and dislikes regarding their care and support needs.

Staff knew what to do if people could not make decisions about their care needs, and the procedures for reporting abuse. Safe systems were in place for recruiting staff, and the home was kept clean and hygienic.

People were provided with a choice of food, and were supported to eat when this was needed. People had a range of activities available to them.

At this inspection there were breaches of regulations in relation to the care and welfare of people using the service, staffing numbers, management of medicines, respecting and involving people, supporting workers, records, managing complaints and quality assurance. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. The risks to people who use the service were not managed appropriately and there were not enough staff available to meet people's needs.

The provider was not managing medicines safely and this was putting people at risk.

Staff knew the correct procedures to follow if they suspected that abuse had occurred.

The home was clean and hygienic.

Is the service effective?

Requires Improvement

The service was not always effective. There were gaps in staff training and support to provide them with the skills and knowledge needed to care for people effectively.

People received a choice of meals and staff supported them to meet their nutritional needs.

People's health care needs were monitored. People were referred to the GP and other health care professionals as required.

Staff understood people's right to make choices about their care and the requirements of the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not always caring. Some practices within the home were not caring, although most staff were caring and knowledgeable about the people they supported.

People and their representatives were not always consulted about their care and support.

Is the service responsive?

Requires Improvement

The service was not always responsive. There were some gaps in care monitoring records for people, and people using the service and their relatives were not always encouraged to give feedback on the service using the complaints system.

Care plans were in place outlining people's care and support needs.

Staff were knowledgeable about people's support needs, their interests and preferences in order to provide a personalised service. A range of activities were available for people including occasional trips out of the home.

Summary of findings

Is the service well-led?

The service was not well-led. The home's systems for assessing and monitoring the quality of the service did not pick up on a wide number of areas needing improvement. Insufficient action was taken to address issues raised at the previous inspection, and there were a number of gaps in records relating to the running of the home.

Inadequate

The Arkley 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 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.

At the previous inspection of the home on 21 May 2014 we found that the home was not meeting two of the regulations inspected. Prior to the current inspection we reviewed the information we had about the service. This included information sent to us by the provider, such as action plans for rectifying the breaches identified at the last visit and notifications of incidents that had occurred.

This inspection took place on 7 and 8 January 2015 and was unannounced. The inspection was carried out by an inspector, a development manager, a professional advisor who was a nurse with knowledge of older people's needs, 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 care service.

During the inspection we looked at the care plans, risk assessments, and daily records relating to 12 of the 39 people who were living at The Arkley Nursing Home. We also spoke with 13 people using the service, two relatives of people using the service, a health care professional, the manager of the location, three nurses, five care staff and four other staff on duty. We looked at seven staff files, a month of staff duty rosters, accident and incident records, selected policies and procedures and 12 medicine administration record sheets.

Some people could not let us know what they thought about the home because they could not always communicate with us verbally. We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to check that the way staff spoke and interacted with people had a positive effect on their well-being.

Following the inspection we spoke with two relatives and three health care professionals of people using the service, who visited the home regularly.

Inadequate

Is the service safe?

Our findings

We received safeguarding notifications about the end of life nursing care for two people in November 2014 when the syringe driver was not started for two days to provide analgesics (pain relief) when they were in pain, and the current inspection was brought forward as a result.

At our previous inspection in May 2014 people were not protected from receiving unsafe or inappropriate care or treatment. Following the inspection an action plan was provided by the previous registered manager. However during our current visit, we did not find evidence that all actions detailed in this plan had been undertaken.

People told us they did not always get a quick response when they rang a call bell to request support. For example one person told us, "Sometimes staff come quickly and sometimes they don't." Another person suggested that the response depended on why the call bell was pushed and what time of day it was. They said that, during the day, it could take between five to ten minutes whilst, between 8.00pm and 10.00pm, a non-urgent bell may not be answered at all. Two people said that they had waited between one and two hours for care in recent months. Others noted "I rang yesterday and rang and rang and rang and nobody came," and "There is an issue with toileting and the time since pushing the call bell. There are times when I need to wait too long - half an hour, sometimes an hour."

Records of recent call bell response times for the week of the inspection showed an overall improvement in the time taken for calls to be answered. However whilst the target time for responding was approximately five minutes, there were some response times of between twenty to thirty minutes, for example on 31 December 2014 and 2 January 2015.

Following the inspection concerns were raised by a health care professional regarding basic care provision, end of life care provided and communication and handover between staff at the home. Concerns were also raised that one person's seizures were not addressed over a 24 hour period.

We found some gaps in wound care assessments. For one person where these were to be reviewed on a weekly basis, but we found a gap of three weeks in the records which may have placed them at risk of harm. We also found insufficiently clear instructions for staff regarding support required for people who had hypertension, behaviour which challenged or depression to ensure that these risks were managed appropriately.

Staff we spoke with had variable knowledge of emergency provisions within the home such as the presence of resuscitation equipment and glucogel (used to treat low blood sugar levels). In one person's records, the diabetes care plan stated, "Ensure all the staff are aware of the condition and understanding of the signs of hypo/ hyperglycaemia." However there was no further information on what to do if either occurred. One nurse was not aware that glucogel was available in the medicine cabinet to treat low blood sugar. When asked about emergency equipment, one nurse was not aware of the equipment kept at the home.

These issues show that there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As we have identified a continued breach of regulation we will make sure action is taken. We will report on this when it is complete.

Risk assessments were in place to ensure that risks to people were addressed. There were detailed risk assessments covering common areas of potential risk, for example, falls, pressure ulcers and nutritional needs. These were reviewed monthly and any changes to the level of risk were recorded with actions identified to lessen the risk. Staff had a good understanding of general first aid procedures and we checked four first aid kits within the home which were fully stocked and in date.

At the previous inspection in May 2014 we found that there were not always sufficient numbers of suitably qualified, skilled and experienced staff employed at the home. There were not enough staff on duty during busier times and at the weekends to meet the individual needs of the people living at the home.

There were not enough staff working at the home. At the time of the current inspection there were 39 people living in the home. Two staff were on suspension without prejudice, and we were told that there was a rate of 15 per cent sickness within the staff team. The manager advised that a change had been made to the way staff were deployed so that they worked across floors rather than

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being assigned to particular wings of the home. A number of staff had left the organisation in October/November 2014, and the manager was in the process of recruiting new staff. Four new care workers were due to start, and there was one vacancy for a nurse.

One person living at the home said that sometimes they had to wait for their medicines, and said that there was an instance where they had to wait a long time for pain killers. They had asked for them in the morning and did not get them until 2pm. Other people told us "I have to wait before I go to the toilet." They went on to say that this could be up to two hours in the evening. People also told us "I need them to talk to us more. I need a bit of time," and "They don't speak to us a lot." There were not enough staff to meet the needs of people living at the home.

There were not sufficient numbers of suitable staff to provide important end of life care for people. The presence of agency nurses only was a clear factor in the delays in setting up the syringe drivers in two safeguarding cases where people receiving palliative care were not provided with prescribed painkillers for two days. The agency nursing staff on duty had not felt competent to carry out this procedure, which left people to experience severe pain at the end of their lives. Since these incidents we found that on at least nine occasions within the last month, two agency nurses had covered the home at night, and on at least two occasions two agency nursing staff had provided the afternoon/evening care, with no nurse employed by the provider organisation being present. This indicated a failure to respond to the safeguarding issues.

We requested data for the past six months showing staffing hours per resident each week in the home, as recorded by the provider, and compared these with the figures from May 2014. Despite the breach found at the last inspection, there had been no increase in the staffing numbers per resident, and it was significantly lower in August and November 2014 indicating that there was less time available for staff to meet people's needs.

All eight members of staff spoken with said they thought there were not enough staff to meet everyone's full care needs. A nurse stated, "We do not have time to supervise [care workers], or to update care plans." This was evident in the notes of one person who had diabetes recently diagnosed, but this was not recorded in their notes. There was a risk this person would not receive the care they needed.

One person told us that they had difficulty in communicating with some agency staff who had limited English, saying that they could not understand each other. A relative told us that there were not enough staff, and that they had noted a reduction in staff employed in the home over the years. They were told on a recent occasion, "We don't have time to feed [a person who used the service; their relative] has to do it." Another relative expressed concerns over the number of staff on duty at night time and weekends.

A health care professional told us that staff were not visible when they visited, and it could be difficult to find a nurse to consult with. They said that lack of continuity of employed nursing staff was having an impact on communication within the home and affecting the care and treatment provided to people.

These issues show that there was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As we have identified a continued breach of regulation we will make sure action is taken. We will report on this when it is complete.

Medicines were not managed safely. We received mixed responses when people were asked whether they received their medicines on time and had access to pain relief. Some did not have concerns, one person said, "[The nurses] come regularly,' but others said that sometimes they had to wait for their medicines. One person said that there was an instance when they had to wait a long time for pain killers. They had asked for them in the morning and did not get them until 2pm.

A relative told us that there had been incidents of missed medicines, including a specific medicine to treat a medical condition for which their relative had been hospitalised.

Medicines were not stored safely. We looked at the storage of medicines within two clinical rooms at the home. In the first floor clinical room, from 1 - 24 December 2014 the refrigerator temperature was too high. We were told that all refrigerated medicines had been removed from the

refrigerator at some point during this period, with a sign put on the refrigerator saying 'do not use'. This was not documented. A new refrigerator was in place at the time of the inspection, having arrived within the past two weeks. In the interim period the medicines were transferred to the

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ground floor clinical room refrigerator. However from 1 - 19 December 2014 the temperature of this refrigerator was also too high and this continued to be the case during the inspection visit. There were also significant gaps in records of its temperature in December 2014. The provider's medicines policy was very clear on action to be taken if temperatures were out of range, and these had not been followed, placing people at risk of receiving ineffective medicines due to inappropriate storage.

Medicines were not administered safely. We saw evidence of people's current medicines on the medicines administration records (MAR) and saw that there were also records of medicines received into the home. People had their allergy status recorded to prevent inappropriate prescribing. There were some gaps in recording the administration of medicines. Records were not always clear as to whether medicines had been given to people to take with them on social leave, some symbols used on the charts were not explained and one staff member's signature resembled one of the symbols for non administration. This meant that it was not always possible to be clear whether people had been given their prescribed medicines which may have placed them at risk of harm.

These issues show that there was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with people who used the service and their relatives; they told us that they were safe and could raise any concerns with staff. One person who had very recently moved into the home said that they had been made to feel comfortable and at home. However some of our other findings did not support this. Staff we spoke with understood the service's policy regarding how they should respond to safeguarding concerns. They had good knowledge about who they should report to if they had concerns that somebody was being abused. They had received training in safeguarding adults and we saw evidence that incidents had been reported appropriately.

Safe recruitment procedures were in place to ensure staff were suitable to work with people. Staff had undergone the required checks before starting to work at the service. The four new staff files we looked at contained disclosure and barring checks, two references and confirmation of the staff member's identity. They also included interview records and checks on professional qualifications and registration.

People felt that the service was clean, one person said that staff were "always cleaning," and another person said it was "like a hotel." Overall the home looked clean and airy. We observed cleaning charts in place for the home which showed that there were clear systems in place to ensure that all areas were cleaned regularly. Infection control audits were carried out quarterly.

Requires Improvement

Is the service effective?

Our findings

People spoke positively about the staff support they received. Comments included, “Staff are generally pretty good - I can’t grumble”, “The physio is terrific”, “The regular [staff] are good” and “Generally the standard here is very good.”

However we found that staff had not received all the necessary training and support they required in their work with people. Staff confirmed that they received regular one to one supervision sessions, however records showed that these were not always at the frequency stipulated by the provider of six times a year. There were no clear induction procedures for agency workers covering shifts at the home.

Staff had not received training to support them to meet people’s needs. For example, we found that forty staff required training in dementia care, and there were no records of palliative (end of life care) training or diabetes training. Other staff required training in food hygiene, nutrition, managing behaviour which challenges, pressure ulcer care, and mental capacity and medicines administration. Significant numbers of staff were also due refresher training in safeguarding adults, fire safety, moving and handling and infection control. As a result, the provider could not be sure that all staff had the necessary knowledge and skills to carry out their role safely.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said they were able to make choices about some aspects of their care. They told us that there were no restrictions on their liberty and that they were free to move about if they wanted to. One person told us, “I can move about the house with my Zimmer frame.” They said that when they needed to go out for appointments, staff would accompany them and the home arranged the transport.

We found that the provider had taken action to comply with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). There were assessments in place regarding people’s capacity to make decisions and consent to their care and treatment. Care records contained best interests decisions and made it clear as to whether people had capacity to make decisions. Staff had received training on the MCA. Staff interviewed were very aware of the need to ensure that those with capacity were supported to make their own decisions and choices. This was achieved by the staff always, as a matter of course, asking permission to carry out a task for the people before commencing it and gaining their consent.

People were able to have meals in one of the dining areas or in their room. Tables were laid with tablecloths, serviettes, place mats and cutlery and menus. People had mixed views about meals provided in the home. Comments included, “The food is alright”, “The food is quite reasonable”, “The vegetarian food is very good”, “I get plenty of food”, and “The food could be better”. One person told us, “I’m a little disappointed at the moment about the winter menu. It seems to lack imagination, but not enough to complain about.”

People's nutritional needs were assessed and when they had particular preferences regarding their diet these were recorded in their care plan. The chef was able to explain the dietary needs of people who had diabetes or who were on particular diets. New menus had recently been introduced with a four weekly cycle, taking account of fourteen common allergies. People chose their meals the day before. Snacks were also available throughout the day.

Two people told us that they needed to drink regularly. Both had jugs in their room with a choice of drink, which one person said was changed two to three times a day. We observed that this was the case for other people living in the home and people were given additional food and drink on request.

Staff told us that if someone had a reduced dietary intake, or concerns about their nutrition were identified, food and fluid charts were put in place to monitor the amount of food or drink they consumed. Where necessary we saw that people had been referred to the dietician or speech and language therapist if they were having difficulties swallowing. Nutrition and hydration was monitored by monthly weight records, reporting by care assistants, fluid balance charts and food diaries. Several people received food directly into their stomach by tube and we found appropriate protocols in place for this.

People said that they had access to health care professionals. They confirmed that the doctor visited the service at least once a week, and they could see a dentist, optician and chiropodist when needed. The service made arrangements for people to either attend outside

Requires Improvement

Is the service effective?

healthcare appointments or for specialist support to visit them. For example, one person was due to have an operation and another had been seen by the dietician and was currently having regular visits from the speech and language therapy team to assess their ability to swallow.

We observed that instructions from the tissue viability nurse (regarding pressure ulcer care) were followed by staff at the home. Clear records were maintained of the outcome of health care professional visits. Health care audits were in place for people in the home including nutrition reviews, pressure ulcer logs and annual health checks.

Requires Improvement

Is the service caring?

Our findings

Most people felt well cared for and listened to, and that they were treated with dignity and respect. They told us, "It is lovely", "I feel settled", "They are very caring here", and "I'm very happy here". Relatives told us "[My family member] is well looked after", "They are friendly", and "The regular staff are very, very good." However there was evidence that some people did not experience caring support.

The relative of one person described distress caused to their relative due to poor continence care. Three people said that they had to wait to be taken to the toilet. We also noticed a lack of respect and consideration in the way that two people were served lunch in one of the dining rooms.

We observed two people at lunch in one dining area with the menu on the table for the previous day. The food was put on the table in front of them. One person, who had pureed food, was not told what the meal was and told us that they had no idea what they were eating. They also noted that, unlike the other person in the dining room, they were not asked what they wanted to eat the day before. They told us, "I have to eat something I don't like." A member of staff cut up the food for the other person without asking if they wanted or needed this to be done for them. In another dining area we observed very helpful and kind interactions, with staff speaking to people before assisting them and explaining what they were doing.

People said that they were not involved in making decisions about their care and none of them had seen their care plan or that of their relative. When asked if they were involved in making decisions about their care, one person said "I don't think so. No, not particularly." We did not see any recorded evidence in people's care plans or daily notes that people living at the home or their relatives when relevant, had been consulted about the care provided.

We observed that the shared bathrooms were not being used, and this was confirmed by people living in the home and staff members. This meant that people at the home were having showers (in their en suite facilities) and not baths. Staff told us that this was people's preference, but most people we spoke with were not aware that this was an option. We also received mixed feedback as to whether people had a choice of what time to get up in the morning.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that rooms had been personalised making each individual room homely. One person said, "I love my room. It has [mementos of] all my friends in it." The atrium of the home had a large notice board displaying photographs of the staff, activities and dates for 'Tea with the Manager'.

We saw many examples of care and kindness in the approach of the staff towards people around the home. During the afternoon activity with a musical entertainer, we observed very positive interactions between staff and 12 people living at the home, and several relatives. Everybody present was enabled to engage with the activity.

Staff told us that if they were unsure of a person's likes and dislikes, and they were unable to communicate their needs, they would always speak to the relatives to ensure they got it right. All staff when asked the question, "How do you show respect to the individual?" told us that it was about the way they spoke to them. They told us that they always knocked on people's doors and waited for an answer before entering, and always explained procedures first.

Staff understood people's needs with regards to their disabilities, race, sexual orientation and gender. Care records showed that staff supported people to practice their religion and attend community groups that reflected their cultural backgrounds. A religious service was available to people on a regular basis and one person said that the service had arranged for a lay preacher to come in to see them once a week.

Requires Improvement

Is the service responsive?

Our findings

People told us, "I find the staff very helpful and amusing", and "They respond quickly." Staff understood how to meet people's needs and responded in line with the guidelines outlined in their care plans when these were present. Care plans were in place to address people's identified needs, and these were reviewed monthly. However they were not always updated more frequently when a change had occurred, for example we found that one person who was recently diagnosed with diabetes did not have this recorded in their care plan, although kitchen staff had been notified.

One person, diagnosed with high blood pressure, had no clear plan in place as to how frequently their blood pressure should be monitored. We found that it was measured occasionally, but with no clear plan in place. We also found inconsistencies and gaps in records of waterlow (pressure ulcer risk) assessments, fluid monitoring charts and one to one monitoring records for people who needed additional supervision.

Overall care documentation did not make important information easy to access to ensure people received the right support and care to meet their needs. This was of particular concern when staff who did not know people well (such as agency staff) were on duty.

These issues amount to a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although there was a notice displayed in the home explaining how to make a complaint, people did not always have their concerns addressed. A relative described problems one person had experienced with continence care causing them significant distress. The relative said that they had written a letter of complaint, but they were then questioned by one of the nurses who asked if they were sure they wanted to submit it, as it might result in someone being suspended just before Christmas. We passed this information on to the manager.

One person said that they had complained "loads of times" about the night staff, but we did not find any records of these complaints. One relative told us that they had made a complaint which was being addressed by the manager. They felt that the manager listened to them, but they had not yet received a response.

Instead of residents' meetings, people were invited to afternoon tea with the manager to express and discuss their opinions. The dates were clearly displayed on the doors to the dining rooms. However we were told that these had not been well attended. There had also been no relatives' meetings in the last six months, so people had not had a forum for providing feedback about the home's performance or raising concerns without making a formal complaint.

We found some gaps in the records of complaints, where people were awaiting responses to issues raised.

The above evidence was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A range of activities were available for people to engage in, which included bingo, ball games, quizzes, card games, dominoes and knitting. An entertainer was booked approximately once a month and there was a monthly trip out of the home, with additional trips around Christmas. People also had some one to one support with activities in their rooms. Most recently trips had been arranged for four or five people at a time to visit a variety of shopping areas.

One person told us that they had enjoyed these activities, but no longer felt able to do them due to deterioration in their eyesight. Another person said that they liked to read, but could not do this because they could not see. Neither of these people had books read to them, and we discussed other options with staff such as the provision of talking books which had not been considered to meet their needs.

People also went out with friends and relatives and some trips were arranged to the coast and local places of interest. The activity coordinator said that internet access was being put into every room and described how they were developing the use of the internet with people, including using Google Maps to explore the areas where people used to live and search engines to find information on subjects of interest. The activity coordinator also planned suitable activities to support those people at the end of life.

Inadequate

Is the service well-led?

Our findings

People and their relatives did not feel consulted and involved in decisions about the care and treatment being provided at the home. There had been no recent resident or relatives meetings or feedback questionnaire circulated to determine the views of people living at the home and their representatives.

We were concerned to find that some of the actions that the provider committed to, following two breaches found at the previous inspection had not been completed by the due date. They had been submitted to the Care Quality Commission in the format of an action plan.

The provider's action plan stated that they would address some issues we had identified with call bell response times. The provider had not carried out an assessment of each person's ability to use a call bell, although this was due to be completed by 19 September 2014. There was also no record of the action taken to ensure those people unable to use a call bell were checked regularly (also due by 19 September 2014). There were no records of the manager's daily walk around all the bedrooms and lounges to ensure everyone had a call bell in reach as detailed in the plan (due by 12 September 2014) and we did not find the provider had obtained direct feedback from people as to whether they felt their call bell was responded to in a timely fashion (due by 30 September 2014). At the current inspection we found that there were still unacceptably long call bell response times impacting on the comfort and safety of people in the home.

The provider's action plan also stated that they would address issues we had identified with staffing numbers in the home. They undertook to review staffing levels in each unit within the home by 12 September 2014. However no evidence was available of this review being complete other than a list of the staffing numbers at that time. There was also no evidence that consideration had been given to increasing the time available for nurses to provide staff support as detailed in the action plan (due by 30 September 2014). Staff and management confirmed that there had not been a change in this time provided since the previous inspection.

Following the inspection health care professionals raised concerns regarding the oversight of nursing practices within the home.

The above information is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found a number of gaps in records maintained at the home. There were significant gaps in the staffing rotas, so these could not be used to determine the number of staff on duty on any particular shift. Staff rotas for the home dated 12 December 2014 to 8 January 2015 did not provide an accurate record of the number of staff working in the home. There were many gaps and alterations which had not been included on the rota, and it was, therefore, not possible to identify the staff who had worked without looking at the allocation of duties charts for each shift. Management could therefore not easily monitor staffing numbers in the home on a daily basis to ensure that sufficient staff were available to meet people's needs.

Health care professionals we spoke with also noted that they found gaps in care monitoring records which made it difficult to be sure that people were not at risk (of dehydration, for example). They also said that they found it difficult to find information within the care records.

We found that the fire risk assessment for the home had not been reviewed since 2012, and minutes were not available of recent clinical meetings held at the home.

The above information contributed to a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Incident and accident records were recorded with details about any action taken and learning for the service. Incidents and accidents had been reviewed by the registered manager and action was taken to make sure that any risks identified were addressed. The service's procedure for recording incidents and accidents was available for staff to refer to when necessary, and records showed this had been followed for all incidents and accidents recorded.

A new manager had been in place at the home since October 2014. We received positive feedback about the impact of the manager. One person said, "Since the new manager has been here, consistency has improved and the bell is being answered more quickly." Relatives told us that

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the manager listened to them, and that they were optimistic that he would make positive changes in the home. Health care professionals we spoke with were positive about the impact of the new manager.

Some team meetings had been held in July 2014 for catering staff, activity staff, and night staff. The manager had a meeting with six staff members in December 2014, during which issues discussed included bathing people, staff working across the home, smarter working, communication, nursing support and conduct. There were regular meetings held with heads of department and nursing staff approximately three times weekly, however minutes were not available of these meetings so it was not clear that actions agreed were carried out promptly.

We found appropriate health and safety and maintenance records in place for the home including fire safety checks, fire drills and equipment servicing. Monthly maintenance audits were carried out at the home. There had been an on-going fault with the larger of the home's two lifts, and workmen attended the site on both days of the inspection, although they were still unable to repair it. This was causing difficulties for people who were bed bound to leave the home in the event of an emergency (such as requiring urgent hospital care) without the use of a stretcher.

The manager told us that he conducted a walk around the home to check on standards twice daily. However these were not documented. We also met with the quality manager for the provider, who visited the home on a monthly basis. She told us about some of the changes that were being implemented at the home. These included more structured head of department meetings, a new structure for clinical meetings, improving nurses' access to quality metrics, a new falls policy and encouraging more people to eat in the dining rooms. We were unable to monitor the effects of these changes as they were new initiatives.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person was not protecting service users against the risks associated with the unsafe use and management of medicines. Regulation 12(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person did not have sufficiently rigorous arrangements in place in order to ensure that staff were appropriately trained and supported to enable them to deliver care and treatment to service users safely and to an appropriate standard. Regulation 18(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The registered person did not have suitable arrangements in place to ensure that service users were enabled to make or participate in making decisions relating to their care and treatment and protect their dignity. Regulation 10(1)(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not have an effective system in place for identifying, receiving, handling and responding to complaints and comments made by service users or their representatives.

Regulation 16(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not ensure that people were protected against the risk of unsafe or inappropriate care and treatment arising from a lack of proper information recorded about them and for the running of the service. Regulation 17(2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not protect people against the risk of inappropriate or unsafe care or treatment by assessing and monitoring the quality of services provided, and identifying and managing risks to their health, welfare and safety. Regulation 17(1)(2)(a)(e)(f)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person did not ensure that each service user was protected against the risks of receiving care or treatment that is inappropriate or unsafe. Regulation 9(1)(a)(b)(c)(3)(a)(b)(c)(d)

The enforcement action we took:
Warning Notice to be met by 28 March 2015

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person did not ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff to meet the needs of people living at the home. Regulation 18(1)

The enforcement action we took:
Warning Notice to be met by 28 March 2015