Sunrise Operations Bassett Limited

Sunrise Operations Bassett Limited - Sunrise of Basset

Inspection report

111 Burgess Road, Bassett, Southampton, SO16 7AG
Tel: 023 8070 6050
Website: bassett.ed@sunriseseniorliving.com

Date of inspection visit: 8 and 12 May 2015
Date of publication: 01/02/2016

Ratings

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

Overall summary

This inspection took place on 8 and 12 May 2015 and was unannounced. The service provides accommodation for up to 104 people who have nursing needs and/or are living with dementia There were 84 people living at the service when we visited. The service is split into two areas. The first for people with nursing and personal care needs is called the assisted living unit which covers three floors: terrace (lower ground), ground and first floor which provides a service for up to 74 people. Reminiscence, on the second floor, is for people living with dementia and can accommodate up to 30 people.

The service did not have a registered manager in place. However, the current manager had applied to become registered with CQC. 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.

At the last inspection on 19 June 2014, we asked the provider to take action to make improvements to care

Summary of findings

plans, ensure people received the personal and health care they required and that quality assurance systems were effective to protect people. We also asked for improvements to ensure people's nutritional needs were met, their dignity and legal rights were protected, suitable seating was available for all people and staffing levels were adequate to ensure people received prompt care. We set compliance actions and the provider sent us an action plan telling us they would meet the requirements of the regulations by December 2014.

At this inspection we found the provider had made improvements to staffing levels, meeting nutritional needs and availability of specialist equipment. However, they had not made the necessary improvements to other areas of concern.

Most people and relatives were positive about the service they received. They praised the staff and care provided.

Quality monitoring systems were not always effective. Staff were not following the providers procedures for reporting incidents which meant senior staff were unaware incidents had occurred. Therefore incidents were not properly investigated and action not taken to reduce the risks to people, visitors and staff. The concerns we had identified in our previous inspection report in relation to the safety, effectiveness and responsiveness of the service had not all been addressed.

People did not always receive the health and personal care they required. Action was not always taken when routine observations indicated a need to seek medical advice and the provider's policies and National Institute for Clinical Excellence (NICE) guidance for monitoring people who had suffered head injuries were not always followed. Care plans were not always representative of people's current needs and others did not have all necessary information.

Pain assessments and 'as and when necessary' (prn) care plans did not contain sufficient detail for people who were unable to state they were in pain. When appropriate, people were supported to self-administer their medicines promoting their independence.

Staff did not always follow legislation designed to protect people's rights. Although staff showed an understanding of the Mental Capacity Act (2005) legislation and people were asked for their consent before care or treatment was given, care records demonstrated that staff did not understand how to legally make decisions on behalf of people who lacked capacity.

People were encouraged to eat well and were positive about the meals provided. People were cared for with kindness and compassion and could make choices about how and where they spent their time. When staff provided support for people to move from one position or location to another, they explained what they were going to do and checked people were ready to move. People's preferences, likes and dislikes were recorded and known to regular staff. A range of group and individual activities were provided although these were not recorded and we did not see many activities occurring in the reminiscence unit.

There were enough staff to meet people's needs. Contingency arrangements were in place to ensure staffing levels remained safe. The recruitment process was safe and ensured staff were suitable for their role. Staff received appropriate training and were supported through the use of one to one supervision.

People and relatives were able to express their views through meetings with senior managers and the provider's representative, and through surveys of people and their relatives. Information about the complaints procedure was available and people and visitors were able to make a complaint. These were investigated and where necessary action taken to prevent recurrence of the issue.

We found of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we have taken 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?

Requires improvement

The service was not always safe.

The provider had failed to ensure that appropriate action was taken when incidents occurred between people, placing people at risk of harm. Staff had not identified incidents as abuse.

The provider had not ensured that best practice guidance in respect of medicines management for the disposal of unused medicines and administration of as required medicines was followed.

There were enough skilled and experienced staff to meet people's needs although agency nurses and care staff were regularly required. The recruitment process was safe and ensured staff were suitable for their role.

Procedures were in place, which staff were aware of, to deal with foreseeable emergencies such as fire or when accidents had occurred.

Is the service effective?

Requires improvement

The service was not always effective

Where people lacked the capacity to make decisions themselves legislation designed to protect their rights was not correctly applied.

It could not be confirmed that action had been taken when health monitoring indicated a new risk or that medical test results were followed up.

People were offered a choice of nutritious meals and appropriate support to eat and drink.

Staff were suitably trained and received appropriate support from the manager and management team.

Is the service caring?

Good

The service was caring.

People's privacy was protected and confidential information was kept securely.

People were supported to express their views and actively involved in making decisions about their care, treatment and support. People's likes and dislikes were recorded and known to regular staff.

Is the service responsive?

Requires improvement

The service was not always responsive.

Care plans had not always been updated following changes in the person's needs and therefore did not reflect people's current health and personal care

Summary of findings

needs. People did not always receive the correct healthcare and health monitoring they required. Action was not consistently taken following falls or when routine observations had indicated a concern. People had developed skin damage which may have been avoidable.

A range of group and individual activities including outings were provided but it was not clear who had participated or if this had met their needs. We did not see many activities in the reminiscence unit and daily records did not detail if people had attended activities.

People and visitors were able to make complaints. These were investigated and, where necessary, action taken to prevent recurrence of the issue.

Is the service well-led?

Requires improvement

The service was not always well led.

The monitoring systems were not effective. Concerns we had identified in our previous inspection report, in relation to the safety and effectiveness of the service had not been addressed.

Incidents that caused harm to people were not always reported to the manager which meant they were not investigated appropriately.

People, relatives and staff said the home was run well. Feedback from people and staff was sought and the information used to improve the service.

Sunrise Operations Bassett Limited - Sunrise of Basset

Detailed findings

Background to this inspection

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

This inspection took place on 8 and 12 May 2015 and was unannounced. The inspection team consisted of three inspectors and a specialist advisor in the care of older people.

Before the inspection we reviewed information we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 12 people using the service and 4 family members. We also spoke with the provider's Operations Support Manager, the general manager, the manager, three nurses, 15 care staff, the activity coordinator, maintenance manager and the cook. We looked at care plans and associated records for 13 people including care pathway tracking, staff duty records, five staff recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records. We observed care and support being delivered in communal areas.

Requires improvement

Is the service safe?

Our findings

At our last inspection in June 2014 we made a compliance action as the registered person had failed to ensure people were safe. The provider sent us an action plan in December 2014 stating they were meeting the requirements of the regulation. At this inspection we found people's safety was still not assured at all times.

Staff had failed to follow the provider's procedures for reporting incidents between people. One part of the home was dedicated to the care of people living with dementia. The deputy manager told us the provider's policy was for all incidents to be reported to them so that trends could be identified and plans implemented to help prevent events in the future. However, daily records showed that not all incidents had been reported or recorded on incident forms or behaviour charts. This included incidents where people had physically assaulted other people. Because they had not been recorded, senior managers had been unable to undertake an analysis of the incidents and action taken to reduce the potential for future incidents. People remained at risk due to a failure to follow the provider's procedures.

Staff had not identified incidents where people living with dementia were physically assaulting other people as possible abuse. One staff member said, "they have dementia and don't know what they are doing, it's not abuse". No action had been taken in relation to another incident recorded within a person's daily records. Additional information provided by staff and other records viewed showed that the person may have been abused. Senior staff were unaware of the incident and had not taken any action. This and other incidents between people had not been reported to the local authority safeguarding team.

Staff told us they had received safeguarding training. Records confirmed this was included in the induction undertaken by all new staff. Staff were aware they should report any concerns to the deputy manager and of how to contact external safeguarding teams. However, as staff had not recognised incidents as possible abuse they had not followed procedures and people were not being protected from the risk of abuse.

The failure to identify people were at risk of being abused and take action to protect them is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a process for recording medicine errors. This identified four errors between 13 April 2015 and 7 May 2015 including two occasions when people were given more medicines than they had been prescribed. Also noted on 22 January 2015 one person was given "extra dose at 1900hrs" of a prescribed medication. The provider told us that when medicine errors occurred the staff responsible were provided with additional training and there was consultation with gp's where necessary.

We saw in the Medicines Administration Records (MARs) for four people that they were prescribed a medicine which is required to be given on an empty stomach with water and no other food or drink (including other medicines) at the same time and for at least 30 minutes afterwards. We saw that all these people received other medicines at the same time meaning the precautions in the manufacturer's guidance to prevent complications were not being followed. People were therefore not always receiving their medicines as prescribed or safely. The provider subsequently arranged for the MARs to be amended.

Medicines that were no longer required and were waiting for disposal were recorded in a records book and then placed in an open topped container within the locked medicines room. NICE guidelines state medicines for disposal should be secured in a tamper proof container within a cupboard until they are collected or taken to the pharmacy. Although best practise guidance for the storage of medicines waiting disposal had not been followed, medicines were in a secure room only accessible to staff.

Most Medicines Administration Records (MARs) were up to date, fully completed and included as and when necessary (prn) protocols. This included personalised information about the signs people may show when they experienced pain. However, the records viewed for three people living in the reminiscence area showed they had been prescribed prn medicines but there was no protocol in their records. Staff administering medicines in this area included agency nurses. They may not have known people well enough to make consistent decisions about administration of as required medicines without specific guidance being

Is the service safe?

available. A staff member said they were reviewing the PRN guidelines. These people may not have received as required medicines when they required them or had them when they did not need them.

We recommend the provider ensures best practice guidance in respect of medicines management for the disposal of unused medicines and administration of as required medicines is followed.

Medicines in use were stored securely and the provider had an effective system for ordering medicines and stock control. We observed staff administering medicines. They provided clear information for people, explaining what the medicine was for and how it could help people. One person told us how they were supported to manage their own medicines and others told us they received their medicines from staff. People were happy with their individual arrangements.

People and relatives said there were usually enough staff to meet their needs although several raised the concern that staff may not be as available at busy times such as meal times. One person told us they waited 25 minutes for meals to be served on their table. People and relatives also felt staff did not have time to sit and talk with people.

People and relatives told us staff usually responded promptly when call bells were used. One person said "they seem to come quickly most of the time". We were told new systems had been introduced so that if call bells remained unresponded to for in excess of ten minutes, additional staff were alerted to the call bell and they would respond. We saw on the call bell system that bells were generally answered within ten minutes with only a couple of occasions during the inspection when bells took longer to be responded to.

The provider had a dependency assessment tool which helped them calculate the number of care and nursing staff required. Staff told us they felt they had time to meet people's needs and were aware of the need to respond to bells in other areas of the home if the new alert system showed they had not been responded to by the staff in that area. We saw that when necessary agency care staff and nurses were employed to cover short term staffing shortfalls.

The process used to recruit staff was safe and helped to ensure staff were suitable for their role. Interviews included relevant questions to assess the applicant's knowledge and attitudes and were structured to the role people were applying for. Relevant checks were completed to make sure staff were of good character with the relevant skills and experience needed to support people appropriately. This included checking the registration of nurses with the relevant regulatory organisation, references from previous employers and criminal record checks. Staff confirmed this process was followed before they started working at the home. One said "I had to wait a while as my checks took a long time to come back". Systems were in place to ensure agency nurses or care staff had undergone the same pre-employment checks.

Most risks to people were recognised and assessed and when a risk was identified a care plan was created to advise staff as to how the risk should be managed. When people had been identified as having care and support needs relating to moving and handling the provider had ensured equipment such as hoists were available. Staff told us they had received training in moving and handling, including the effective and safe use of equipment used to assist people to mobilise or transfer from, for example, bed to chair. We observed moving and handling procedures which were competent and safe with staff using the procedures and equipment correctly.

There were plans in place to deal with foreseeable emergencies. Staff had undertaken first aid and fire awareness training. They were aware of the action they should take in emergency situations. Personal evacuation plans were available for all people. These included individual detail of the support each person would need if they had to be evacuated. A duty manager described the action they would take in a variety of emergency situations and additional support they could access if required.

Requires improvement

Is the service effective?

Our findings

At our last inspection on 19 June 2014, we found the Mental Capacity Act (MCA) 2005 was not being used correctly to ensure people's rights were protected. We made a compliance action and the provider told us in December 2014 that they were now compliant with the regulations. At this inspection we found staff were not following the principles of the MCA. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant. People's records did not contain decision specific mental capacity assessments in line with the MCA Code of Practice. Care records for people living with dementia lacked detail as to what decisions people required support with and how this support should be provided. Where people were unable to make decisions best interest meetings had not taken place in accordance with the MCA. For most people relatives had signed care plans, including when people had the capacity to sign their own care plan. There were no records to show people had agreed to the sharing of confidential information with relatives. For other people, staff had made decisions without having first assessed the person's mental capacity. People's rights, therefore, had not been legally ensured.

The failure to follow the principles in the MCA is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 19 June 2014, we found people had not received all the nursing and personal care they required. We made a compliance action and the provider told us in December 2014 that they were now compliant with the regulations. At this inspection we found people were not always receiving the nursing care they required. People received healthcare from the trained nurses. This included wound dressings, blood sugar monitoring and insulin injections. However, records did not always show that action had been taken when routine observations identified a concern. One person had a recorded monthly blood pressure reading which was significantly higher than previous recordings. This placed the person at risk of further health problems. However, there was no record that any action had been taken as a result of the high reading.

We asked the manager about this and they were unable to tell us what, if any, action had been taken by the nurse who had completed the recordings. In the same person's daily records we saw that a GP had requested blood tests. These were taken but there was no record of the results of these or if any treatment changes were required. The deputy manager was unable to provide this information until they later consulted with the GP. The absence of a formal procedure to follow-up on the results of medical tests meant people may not have their health needs met.

The failure to ensure people received all the health care they required is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 19 June 2014, we found there was a lack of monitoring and support to ensure people received an adequate nutritional intake We made a compliance action and the provider told us in December 2014 that they were now compliant with the regulations. At this inspection we found action had been taken and people were encouraged to eat well. Staff provided consistent support to those who required it. When people did not eat their meals, staff tempted them with alternatives, such as sandwiches or fresh fruit and gave people time to eat at their own pace. Where necessary staff were recording the food and drinks people were receiving however, these were not always fully recorded and did not show if people were offered or encouraged to have evening drinks and snacks.

People told us they really enjoyed the food and that there was plenty available and lots of choice. One person told us, "The food is good and you always get a choice" People were offered varied and nutritious meals including a choice of fresh food and drink. Kitchen staff were aware of people who needed their meals prepared in a certain way or fortified. People were encouraged to take their meals in the dining room. A staff member told us "this encourages people to socialise and residents will often eat more when they eat at the same time as others". People confirmed they could choose where to eat on a daily basis.

The Deprivation of Liberty Safeguards (DoLS) provide a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and they may present a risk to themselves if they

Requires improvement

Is the service effective?

are able to leave the home freely. We were told that DoLS had been applied for everyone living within the reminiscence unit of the home. These had yet to be assessed by the local authority.

A programme of induction training was completed by all new staff. In addition, new staff 'shadowed' experienced staff by working alongside them until they were confident in their role. Training records showed most staff had completed all essential training required by the provider. Staff training was provided in a variety of formats, including face to face and by viewing DVDs. The DVDs included a knowledge check at the end of the training which checked staff had gained the necessary knowledge. New staff were positive about their induction and other staff said on-going and refresher training had been of value.

Staff received appropriate support through the use of one-to-one sessions of supervision and appraisals. These provided opportunities for them to discuss their performance, development and training needs. The manager monitored senior staff who completed supervision for junior staff. Records viewed showed that 79 per cent of supervisions had been completed on time as per the provider's policy of every two months.

Good

Is the service caring?

Our findings

We found people were cared for with kindness and compassion and could make choices about how and where they spent their time. We saw staff responded promptly to people who were requesting assistance and they did so in a patient and attentive manner. One person told us "I am treated very well, no concerns from me". Another person described staff as "marvellous." A family member said, "Staff are very kind and caring." They described how their relative had become more alert and sociable since moving to the home.

We observed on the reminiscence unit that instead of using people's names the staff on the whole used other terms such as 'darling, sweetheart, honey etc.'. These are not individual terms and when a person has a cognitive impairment such as dementia it is important that people's chosen names are used consistently which helps people maintain their identity and understanding.

Staff spoke with people while they were providing care and support in ways that were respectful. When staff provided support for people to move from one position or location to another, they explained what they were going to do and checked people were ready to move. Where people were not able to respond verbally to questions, staff observed their reactions to assess whether the person understood and was ready to receive the support offered.

People's preferences, likes and dislikes were recorded and known to staff. Records showed support was provided in accordance with people's wishes. People chose when to get up and go to bed and records confirmed their wishes were respected. One person said, "I always choose to get up late and they still ensure I can have my breakfast whatever time it is". We found people, or their families where appropriate, had been involved in decisions relating to end of life care and resuscitation. We heard people being asked for their consent before care or treatment was given. The manager told us how they had recently referred a person for an independent advocate as the person did not have any relatives to support them in making decisions.

Staff communicated effectively with the people they were supporting and treated people with warmth and interest. Regular staff knew the people they were caring for well and were able to deliver care in the way the person preferred. Staff spoke warmly about people which indicated that they held them in high regard. Staff had a good knowledge of individuals and knew what their likes and dislikes were.

People's privacy was protected by staff knocking on people's doors before entering and ensuring doors were closed when they delivered personal care. Staff told us people could request staff of a particular gender to support them with personal care. This would then be recorded in the person's care plan to help ensure their preference was met.

People's views were sought regularly by the provider. Resident meetings were held monthly and minutes viewed showed a range of topics were discussed. People were also able to raise concerns anonymously should they prefer to do this.

Confidential information, such as care plans were kept securely and only accessed by staff entitled to view it. Staff handovers occurred in private and there were a range of meeting rooms available should there be a need to discuss things in private.

Requires improvement

Is the service responsive?

Our findings

At our last inspection on 19 June 2014 we found people were not receiving the health and personal care they required. We made a compliance action and told the provider they must improve. The provider told us in December 2014 that they had taken the necessary action. At this inspection we found people may not have always received the nursing and healthcare they required.

People may not have received as required pain medication when they required it. People living with cognitive impairment such as dementia may not be able to express that they have pain. They may instead show different types of behaviours such as restlessness, agitation or aggression. We observed several people living with dementia who appeared agitated and restless. Staff did not assess the person with a view to pain management and had not explored the possibility that the person could have been in pain.

People were not always adequately monitored in situations where their health may change such as following a fall. The National Institute for Clinical Excellence (NICE) provides guidance for monitoring people who have suffered a head injury. This specifies that neurological observations should be completed half hourly for two hours, hourly for four hours and 2 hourly for 24 hours. We were told the provider's policy was to monitor people with specific neurological observations for four hours after a head injury and then to repeat these three days later. However, the records viewed for two people who had suffered a head injury following a fall showed that neither the provider's or the NICE guidance had been followed. Potentially serious injuries may not have been identified and prompt action taken to prevent further complications.

We found there were gaps in some people's records. Risk assessments and care plans were not always up to date and appropriate. For example, the risk assessments and care plan for one person who was receiving end of life care had not been updated and did not reflect the care they were now receiving. Four people living on the reminiscence unit were receiving a specific medicine which placed them at high risk of gum and mouth problems. They did not have oral health care plans to mitigate against the risk posed by the medicines they were prescribed. This placed them at risk of deterioration in their oral health which could compromise their nutritional intake.

Records of skin care and skin damage did not show people received all necessary care. Wound management plans were in use, however these did not always provide a clear record of the wound and how it should be managed. For example, one person had a wound care plan dating from mid-April 2015. The wound care plan had been inconsistently completed. It stated the wound should be redressed every four days however we found periods of up to six days between dressing changes. Records showed different dressings had been used but the wound care plan had not been updated to explain why these had been used. There were no photographs of the wound. Photographs of wounds are important when reassessing wounds and evaluating how the wound is healing or if it's condition has worsened. The failure to ensure wounds are correctly managed and wound care recorded means people were at risk of deterioration in their wounds.

People who placed themselves or others at risk were not supported appropriately. Whilst viewing care plans we found that staff were recording behaviours in a variety of inconsistent ways. In some instances these were recorded in daily records, or behaviour charts were in use but these were not always used and incident forms were sometimes completed. The provider had an ABC chart for recording behaviours and incidents. Most of these had been completed incorrectly. These charts are designed to identify the triggers to behaviour but instead the staff commonly wrote "agitated", as the trigger but agitation is a behaviour. The failure to follow the provider's recording procedures meant that senior staff were unable to monitor the level and complexity of incidents and prevented them designing individual approaches to supporting people and reducing the incidents of behaviours which challenged. We observed staff did not take action when people were becoming agitated and respond at an early stage.

At our last inspection on 19 June 2014 we found care plans lacked detail as to how people's individual needs should be met. We made a compliance action and told the provider they must improve. The provider told us in December 2014 that they had taken the necessary action. At this inspection we found care plans did not always have specific individual information as to how a persons identified needs should be met. For example one person's care plan stated they had anxiety issues. Their care plan stated "I need lots of reassurance when I am anxious and agitated". This did not give staff clear information about what support the person may require meaning their needs may not be met.

Requires improvement

Is the service responsive?

The failure to ensure people received all necessary health care and that systems including risk assessment and care planning to mitigate against assessed risks were followed at all times by all staff was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's views were not always considered, and care provided in line with their wishes on the reminiscence unit. Eight people were sitting in the lounge with the television on showing a morning programme. A member of care staff asked people "would you like to do a quiz" to which two people said "no" quite emphatically. The care staff turned off the television and proceeded with the quiz. Two people joined in but the others remained quiet. People from the reminiscence unit were told they were going to a garden centre for tea and cake. After the trip we were told they did not get out of the minibus to visit a garden centre. Instead they had driven round the New Forest and had an ice-cream sitting in the minibus. People had not been given the correct information with which to make a decision as to whether to join the outing.

People were satisfied with the quality of care and told us their needs were met. One person said, "I get all the help I need and get baths every week." Similar views were expressed by other people and relatives. One relative raised concerns that their relative was not receiving all the help they required and were talking to the staff about this. They told us they had previously raised this with staff but the situation had not improved.

Where necessary, people had been referred to occupational therapists for assessment to ensure they had the correct equipment including seating to ensure their safety and comfort. Staff said they felt they had access to all necessary equipment to meet people's care needs. Other equipment in use such as pressure relieving mattresses were being used correctly.

We received conflicting information about activities. Whilst many people living in the assisted living area were happy and told us they enjoyed activities which they could choose to take part in, some people were not satisfied with the activities arrangements. We were told by one person that they were bored and would like to have gone out and a relative told us there was a lack of activities and mental stimulation for their relative. Other than a quiz and an outing we did not observe other activities within the reminiscence unit. Activities were organised by activity coordinators covering seven days per week and we saw activities occurring in the assisted living unit but few in the reminiscence unit. We spoke with two visiting activities professionals who were contracted to provide specific activities on a regular basis. Activity coordinators told us additional outings and activities could be organised where demand indicated a need. Daily records in both units did not list any activities which had occurred. This meant it was not possible to determine if individual people were, or were not, receiving adequate mental and physical stimulation especially on the reminiscence unit where people were unable to tell us about how they spent their time.

The service had a complaints policy and a system to record and investigate complaints. This was provided to people when they moved to the home and displayed on the notice board in the home. This included information about how to make a complaint within the organisation and externally if required. The manager was clear about the way they would investigate any complaints and that this information would be used generally to improve the quality of the service and prevent future similar complaints. We viewed the most recent complaints and saw they had been dealt with promptly and in accordance with the provider's policy. People told us they would feel confident to raise concerns with the staff. Most were clear about who the general manager was and that they could make complaints directly to him if required. One said "I would go straight to the boss man, his name is (general manager's name)".

Requires improvement

Is the service well-led?

Our findings

At our last inspection on 19 June 2014, we found the provider's quality monitoring systems had not been effective in identifying concerns. Systems had not identified risks and ensured action was taken to reduce the risk of recurrence on an individual level. The provider sent us an action plan in December 2014 stating they were meeting the requirements of the regulations. At this inspection we found the monitoring systems were ineffective and concerns we had identified in our previous inspection report, in relation to the safety and responsiveness of the service, had not been addressed. Consequently, people continued to be at risk of not having their health needs met, not being protected from the risk of abuse.

The deputy manager conducted a range of audits and quality monitoring each month. They also completed a monthly quality indicator which covered a range of nursing and care quality indicators such as pressure injuries, falls and infections. Information from the monthly quality indicators was shared with area managers and compared with other homes in the area. The provider's area managers also undertook quality monitoring at the home. The provider's quality monitoring processes relied on accurate information being provided by staff, where this was not provided accurate analysis could not be achieved and risks identified and managed.

The provider had systems for the reporting and monitoring of incidents, however staff were not reporting these and following the provider's procedures. There were no systems in place for senior managers to formally review daily records or to identify that incidents which were occurring were being reported according to the agreed procedures. This meant action was not being taken to reduce the risks to people, visitors and staff. The general manager subsequently told us they were going to take a more direct approach with some quality monitoring saying "I'm going to start looking at daily records every week". Medicines audits had been completed however, the records viewed did not show that action was taken to address errors and reduce the likelihood of recurrence.

The failure to ensure systems are operated correctly to ensure the quality of the service provided was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were management arrangements in place. Although the service did not have a registered manager, the current manager, who had been in post for five months, was going through the process of registering with CQC. Support for the manager was provided by a general manager and an area operations manager. There were regular meetings with the heads of all departments, in addition to shift handover briefings which all staff attended.

The manager had identified a need to change aspects of the organisation and management of the nursing staff. They felt this would provide them with a greater direct oversight of the health care people received. The minutes of a governance meeting held by the manager in April 2015 showed they had identified areas for improvement and had a plan in place to ensure this was achieved. Issues were also identified by the manager to qualified nurses in their meeting in April 2015. The minutes of these meetings showed the manager was addressing issues they had become aware of.

People and visitors views of the service were sought by the provider via surveys and through a suggestion box in the main entrance area. The most recent survey had identified most people were very happy with the service they received. Reviews, in the form of family meetings, were held approximately every six months giving people and relatives a more formal opportunity to discuss any concerns or changes to care they would like.

Regular staff meetings were also held and minutes showed these had been used to reinforce the values and vision of the service. Staff were aware of the provider's values listing these as being promoting people's choices, decisions and independence. Another staff described the values as "residents first". These were echoed by senior staff who described the values as "independence, choice, respect and dignity". Staff said they felt supported by the management structure. One said that since the previous inspection "a lot of things have changed, all positive". Newer staff commented that they enjoyed working at the home, felt supported and that the home had "really high standards".

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The registered person had not made suitable arrangements for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person had not protected service users, and others, against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to regularly asses and monitor the quality of services provided and identifying, assessing and monitoring risks relating to the health, welfare and safety of service users and others.**

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider has failed to ensure people receive safe care and treatment.**

The enforcement action we took:
warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider has failed to ensure people are safe from abuse or improper treatment.**

The enforcement action we took:
warning notice