Laudcare Limited

Kingsmead Lodge

Inspection report

West Town Road,
Shirehampton
Bristol
BS11 9NJ
Tel: 0117 9823299
Website: www.fshc.co.uk/kingsmead-lodge-care-home/

Date of inspection visit: 11 & 12 May 2015
Date of publication: 11/08/2015

Ratings

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

Overall summary

This inspection took place on the 11 and 12 May 2015 and was unannounced. The previous comprehensive inspection took place on 23 and 29 September 2014. Following this inspection we took enforcement action and a warning notice was served in relation to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the obtaining, recording and safe administration of some medicines.

A further inspection was undertaken on the 2 December 2014 in relation to the warning notice. We found the provider had still not met the legal requirements in relation to Regulation 13 but had made some improvements. . We served another warning notice in relation to Regulation 13. A warning notice was also served in relation to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider had not responded appropriately to an allegation of abuse to protect people and failed to report the safeguarding concern promptly. The provider

Summary of findings

produced an action plan identifying how the legal requirements would be met. Our recent inspection found that improvements had been made to meet the relevant requirements.

Kingsmead is registered to provide accommodation and personal care with nursing for up to 81 older people across two floors. The upper level of the home is known as Nightingale and provides nursing care and support to people. The ground floor area is known as Kingfisher and offers support to people with living with dementia. At the time of our inspection there were 44 people using the service.

There has been no registered manager in place for over 6 months. 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.

The service did not consistently ensure that each person received appropriate person-centred care and treatment that was based on an assessment of their needs and preferences.

Staffing levels were not adapted to respond to the changing needs and circumstances of the people using the service.

Staff treated people with kindness, but there was limited social interaction with people. Staff focussed on their tasks and did not spend time talking to people, even when they were assisting them with lunch. Feedback from relatives advised that the care was good most of the time and the carer staff really wanted to provide the best care they could. They thought that they were hampered by being short staffed at certain times.

People's care records were not always maintained accurately and completely to ensure full information was available to enable staff to meet their needs. The service had not protected people against the risk of poor care as not all records were accurate.

Nutrition and hydration needs were not always met. One person's chart indicated they had received no food or drinks for a 56 hour period. We found that the provision of care was not accurately recorded. The food was nutritious and served at the correct temperature and consistency, according to the person's needs. Snacks were available throughout the day. One person commented 'the food is good here and the drinks trolley also offers finger food".

Staff were not consistently supported through an effective training and supervision programme. Although new staff completed an induction programme on-going training was not being maintained. The training matrix demonstrated that staff training needed to be up-dated.

Systems were not being operated effectively to assess and monitor the quality and safety of the service provided. The service had a programme of regular audits, however audits to monitor the completion and accuracy or records were not completed and other audits were not always effective.

People had their physical and mental health needs monitored. All care records that we viewed showed people had access to healthcare professionals according to their specific needs.

We saw information in people's support plans about mental capacity and Deprivation of Liberty Safeguards (DoLS) authorisations had been applied for. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty.

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them.

Maintenance, electrical, equipment and property checks were undertaken to ensure that these areas were safe for people who used the service.

Since the appointment of the manager the overall feedback had been positive and there had been a perceived notable improvement in the running of the service. Staff spoke positively about the manager. A member of staff told us 'she is brilliant and looks after her staff properly. She has reviewed care plans, brought in the key worker system, resident of the day review system and has consulted with family members." Relatives also told us that they had confidence in the manager. We were told that the manager was often seen 'walking the floor' and talking to people who use the service and their relatives.

Summary of findings

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

Requires improvement

The service was not always safe.

Suitable systems were in place for the ordering of medicines and people's medicines were available for them. Administration of medication at specific times requires improvement.

The service did not consistently conduct risk assessments to support a person's needs.

Staffing levels were not adapted to respond to the changing needs and circumstances of the people using the service.

Safe recruitment processes were in place that safeguarded people living in the home. Robust checks were made before people started working in the home.

Is the service effective?

Requires improvement

The service was not always effective.

Some people's care records were not always maintained accurately and completely to ensure full information was available

Staff were not consistently supported through an effective training and supervision programme.

Staff understood the basic requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) and the need to gain consent from people using the service.

Is the service caring?

Requires improvement

The service was not always caring.

We observed staff treating people with kindness, but there was limited social interaction with people. Staff appeared to be task orientated and did not spend time talking to people.

Staff were knowledgeable about people's needs and told us they always aimed to provide personal, individual care to people.

Feedback from relatives advised that the care was good most of the time and the carers really wanted to provide the best care they could.

Is the service responsive?

Requires improvement

The service was not responsive.

People's care plans did not always contain person centred information.

There were activities for people, however we received a mixed response from people about their enjoyment and involvement.

Summary of findings

The provider had a complaints procedure should people wish to complain.

Is the service well-led?

Requires improvement

The service was not well-led.

A notification required by law had not been sent to the Commission as required.

Systems were not being operated effectively to assess and monitor the quality and safety of the service provided.

Since the appointment of the new manager the overall feedback has been positive and there had been a perceived notable improvement in the running of the service.

Kingsmead Lodge

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 11 and 12 May and was unannounced. The inspection was undertaken by 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 care service.

We reviewed the information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

Some people who used the service were able to tell us of their experience of living in the home. For those who were unable we made detailed observations of the interactions between staff in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

On the day of our inspection we spoke with 5 people that used the service, 12 relatives and nine members of staff. We also spoke with the deputy and regional manager.

We reviewed the care plans and associated records of five people who used the service and reviewed documents in relation to the quality and safety of the service, staff recruitment, training and supervision.

Requires improvement

Is the service safe?

Our findings

At our last two inspections in September and December 2014 we found that medicines were not handled safely. A warning notice was served on each occasion under the Health and Social Care Act 2008 (Regulated activities) Regulations 2010. This required the provider to become compliant with Regulation 13 by 9 January 2015. The provider sent us an action plan telling us what they were going to do to become compliant. During this inspection we found that improvements had been made. Suitable systems were in place for the ordering of medicines and people's medicines were available for them.

The pharmacy provided printed medicines administration records for staff to complete when people had taken their medicines. Staff had recorded they had given people their medicines as prescribed.

Some creams and ointments were stored in people's rooms and applied by the care staff. Systems were in place for staff to record when they had applied people's creams and ointments; however we found that the record forms were not always completed. Staff told us record in the person's daily records on some occasions. This meant it was difficult to check whether people's skin was protected by having their creams and ointments used as prescribed. The provider had told us that additional storage was in place for keeping creams and ointments more safely in people's rooms. However during the inspection staff told us these cupboards had been ordered but they were not yet in place.

Some people were prescribed medicines which need to be given at specific times for them to be most effective. We saw information in people's care plans about the importance of these times and staff on duty were aware of this. However on the day of our inspection we saw one person was given their medicine three quarters of an hour later than specified on the record sheet and another person told us they were concerned they did not always have it at the correct time. Administration of medication at specific times requires improvement.

At the December inspection a warning notice was also served in relation to Regulation 11 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2010. The provider did not respond appropriately to an allegation of abuse to protect people and failed to report the safeguarding concern promptly.

Staff we spoke with said they had received training in how to recognise and report abuse. All staff gave good examples of what they needed to report and how they would report concerns. Staff told us they felt confident to speak directly to the manager or deputy manager and that they would be taken seriously and listened to. They also advised that they would be prepared to take it further if concerns were unresolved.

Systems and processes were now in place and were operated effectively to investigate any allegation or evidence of abuse. We reviewed the provider's safeguarding file. We saw records of appropriate safeguarding notifications being completed. Where issues were on-going minutes from meetings with the local authority safeguarding team were held on file alongside the identified actions to take forward. The action items were regularly discussed with the safeguarding team to ensure people were protected.

The service did not consistently conduct risk assessments to support a person's needs. We looked at five care plans. As an example they included risk assessments for moving and handling and falls assessments. The quality and content of the plans were variable. In one file we saw a bed rails assessment had been completed for the person, and had been reviewed monthly. Some of the assessments were up to date and had been reviewed to reflect the person's changing needs. This was not the case for all of the plans. One person had experienced a fall. Their falls assessment stated that they had experienced no falls and did not take into account the potential changing needs of the person to protect their safety.

Fire risk assessments had been completed for people, but there were no personal emergency evacuation procedures for individuals in place. This meant that staff did not have the information they needed to keep people safe in the event of fire. From their recent health and safety assessment the manager had identified that this issue needed to be actioned.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service safe?

Staffing levels were not adapted to respond to the changing needs and circumstances of the people using the service. Staffing levels were assessed by using a staffing dependency tool. This was an electronic tool used by the regional manager to input everyone's care needs. This generated the recommended level of staffing that was required for each unit. Owing to their increasing complex needs some people had been moved from the Nightingale nursing care area to the Kingfisher area which offers support to people living with dementia. Although the moves had occurred the staff dependency tool had not been reviewed to ensure sufficient numbers of suitable staff were deployed. We were told by the regional manager that there was a need to review the current staffing levels.

On the day of our inspection there were two members of staff on sick leave. We were told that one member of agency staff had been arranged and they would be arriving later in the morning. Two of the night staff had stayed to assist to work the shift until cover was arranged. Staff told us "it's been busy today because we're short staffed, it's extra pressure" and "when the correct staff numbers are on duty, it's fine and everyone is safe. I think the management are reviewing dependency scores of people too, so staffing levels may go up in the future." Another member of staff said "it's much better; we used to have lots of agency staff, but there are more permanent staff here now." The regional manager told us they were in the process of recruiting nurses and care assistants and that employment offers had been made.

A relative expressed their concerns about staffing levels, particularly at the weekend. They told us "sometimes there was no one in the lounge at all as all the carers were involved with other residents". Another relative told us "the carers are always rushing around and are too busy to stop and do what you ask without having to come back. The weekend is typically bad."

During our inspection we observed call bells were usually responded to in an expected time frame. During lunch a person wanted to leave the dining area without their walking aid. The care worker asked the person to sit down and wait but they still wanted to leave. The care worker took a pudding to another room asking them to wait and left them standing. The care worker told the person "I've only got one pair of hands; I'll be with you as soon as I can." This left the person at risk as they did not have any staff support and were not using the equipment they needed.

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

The provider had appropriate arrangements for reporting and reviewing incidents and accidents. The regional manager audited all incidents to identify any particular trends or lessons to be learnt. Records showed these were clearly audited and any actions were followed up and support plans adjusted accordingly. Where one person was experiencing falls a number of times during certain times of the day they sought advice from an appropriate health professional. Their care plan was amended to follow a new strategy advised by the health professional to mitigate future risks.

Staff understood the term 'whistleblowing'. This is a process for staff to raise concerns about potential malpractice in the workplace. The provider had a policy in place to support people who wished to raise concerns in this way.

Records showed a range of checks had been carried out on staff to determine their suitability for the work. For example, references had been obtained and information received from the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they were barred from working with vulnerable adults. Other checks had been made in order to confirm an applicant's identity and their employment history.

Maintenance, electrical, equipment and property checks were undertaken to ensure that these areas were safe for people who used the service.

Requires improvement

Is the service effective?

Our findings

People's care records were not always maintained accurately and completely to ensure full information was available. We looked at the intake charts of people who were having their food and fluid intake monitored. Some of these were being monitored due to weight loss. Other people's charts we saw were completed in full or part. There was inconsistent reporting which meant people could be at risk of dehydration or malnutrition.

Positioning charts were not consistently recorded to demonstrate when people had been repositioned in line with their assessed needs. Where re-positioning was required on an hourly basis this was consistently not recorded. There were much longer periods of time recorded when re-positioning occurred.

In one care plan we found that pressure ulcer management was not adequately recorded. The photographs of the wound were not clear and could not be used to accurately monitor the wound. The lack of accurate information on the monitoring and management of the pressure ulcer increased the risk that it would not be effectively treated.

We found that the registered person had not protected people against the risk of poor or inappropriate care as inaccurate records were being maintained.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a lack of assurance that people's food and hydration needs were being met. One person's chart indicated they had received no food or drinks for a 56 hour period. We looked at the chart of another person at 14.45. There was no fluid intake recorded for the day in any of their plans. We observed one person in the lounge. A member of staff placed a beaker of tea on the table in front of them a 9.55. At 10.25, another member of staff came into the lounge and placed the beaker in the people's hands and said "don't forget your tea". When they realised it was cold, they took it away. They did not offer a fresh cup. When we checked the person's care plan it stated that staff should assist the person with food and drinks because of their poor vision. Later we saw three people in the lounge being poured tea. All of the people were asleep. One hour later, all of the cups of tea were still there, not drunk.

The lunchtime activity and deployment of staff didn't appear organised. Practice between the two areas of the service differed. The people residing in the Nightingale were not offered a choice of meal when lunch was served. We were told that staff on Nightingale visit people in the morning and record their choice of meals for the day. They were offered options and were able to change their minds prior to meal service, if requested. This practice was adopted as the majority (not all) of the people had capacity and were able to make and verbalise their choices.

In the Kingfisher dementia area people's choice of meal were taken at the dining table just before lunch was served. Where required they showed the person the options of food to enable them to make a decision. People who did not require assistance with eating were provided with their meals first. Staff were also serving food in people's rooms. They returned to the dining room to assist those people who required assistance and were waiting for their food. Those people who required assistance had to wait until staff were available to help. When staff returned to the dining room they had the time to fully assist people and it was less rushed and more interactive.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The food was nutritious and served at the correct temperature and consistency, according to the person's needs. Snacks were available throughout the day. One person commented 'the food is good here and the drinks trolley also offers finger food".

Staff were not consistently supported through an effective training programme. Although new staff completed an induction programme on-going training was not being maintained. The training matrix demonstrated that staff training needed to be conducted as some modules needed to be up-dated. They are below their own minimum target of 92% staff training being up to date. The regional manager advised that their current percentage is 72%. They advised they needed to improve this position as urgently as possible and this formed part of their action plan. Where some staff have not completed required e-learning modules they had been sent a letter to advise of the necessity to complete the training. Failure to so do so could lead to disciplinary action.

Staff we spoke with believed they had the necessary skills to provide effective care to people. They told us that they

Requires improvement

Is the service effective?

had received training in order to perform their roles. One member of staff told us "I intended a palliative care study day with a focus on dementia, which was really interesting and useful". Not all staff felt the training they received was good enough. One member of staff told us "it's nearly all e-learning so you don't get the option to discuss issues or share ideas". The regional manager told us that the training programme is going to change and will be more interactive. Staff will be required to complete a reflective learning account to test their understanding and how it will enhance their practice.

The provider's supervision and appraisal policy was not being adhered to. Staff told us they were not sure how frequently they should attend supervision meetings. Others told us that they never been supervised even though they had been employed for over a year. This position was reflected in the staff records. The supervision policy states "planned supervision is conducted with staff in order to promote high standards of care and service" and that staff would receive supervision "every eight weeks or six times a year". The lack of supervision meant that staff did not have effective support on an on-going basis and training needs may not have been acted upon. The new manager in a recent meeting with senior care assistants provided clear instructions of the need to conduct supervisions. Following the meeting we found that supervisions were beginning to be re-introduced for staff members.

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

People's rights were being upheld in line with the Mental Capacity Act 2005. This is a legal framework to protect people who are unable to make certain decisions themselves. We saw information in people's support plans about mental capacity and Deprivation of Liberty Safeguards (DoLS) had been applied for appropriately. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely. The regional manager confirmed that DoLS applications had been made and they're currently waiting for the outcome from the local authority.

People's rights were protected when decisions were made on their behalf. Examples of this included bed rails and personal hygiene assessments. Mental capacity assessments were conducted on the specific issues. Where people were unable to make decisions the person's representative and health professionals were involved in best interest meetings. Involving the person's representative enabled the service to take into account the person's wishes, feelings, beliefs and values.

Staff understood the basic requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) and the need to gain consent from people using the service. Two members of staff told us they had completed training on the legislation. However, some staff were not able to explain how the legislation affected their role. Some staff seemed unsure of how consent and best interests were linked to upholding people's rights The training matrix demonstrated that a number of staff had yet to complete the Mental Capacity training.

Staff were able to demonstrate an awareness of a change in people's needs. One person's care record showed that they had recently been assessed by the Speech and Language Therapist. Within the healthcare professional notes of the person's care plan, there was guidance on the specific care staff should provide to meet the person's care needs regarding their diet, assistance required and the food that should be avoided. Staff we spoke with were aware of the change in the level of support the person needed.

People had their physical and mental health needs monitored. All care records that we viewed showed people had access to healthcare professionals according to their specific needs. We saw written entries made from visiting health professionals. On the day of our inspection, a GP was visiting some of the people living in the home. They discussed with the deputy manager each individual's needs and changing circumstances. This information was documented in the individual's care plan and recorded in the handover notes. We also saw evidence in the plans of optician visits and chiropodist visits. We also viewed referrals being made to a Tissue Viability Nurse, Speech and Language Therapist and the Bristol Dementia Partnership.

Requires improvement

Is the service caring?

Our findings

We observed staff treating people with kindness, but there was limited social interaction with people. Staff focussed on their tasks and did not spend time talking with people, even when they were assisting them with lunch. Some care staff communicated with people when providing assistance during lunch, others did not. At times there was little description of the food and limited communication whilst they were assisting people. Other care staff adopted on-going dialogue and were actively engaged with the person. They offered choices, provided reassurance and listened to the person's requirements and adhered to their requests.

During March 2015 an audit was conducted by an internal Care Quality Facilitator which also identified areas of improvement. They observed a lunch time service in the Nightingale area and noted "the two residents being assisted to eat were spoken to during the meal, though it tended to be "are you ready for another one". There was no social interaction noted during the meal with any of the residents – the residents who were eating independently were not asked if they were enjoying their meal, if they would like anything else, etc."

When people became upset or distressed we saw staff reacting swiftly and provided reassurance. Staff interacted in a caring manner and got down to a person's level in order to talk to them and provide their medicines. . A member of the care staff was sitting alongside a person stroking their hand to provide reassurance before undertaking a task. We observed that some people were provided with choices and asked if they would like help and offered further assistance, if needed.

Feedback from relatives advised that the care was good most of the time and the care staff really wanted to provide the best care they could. They thought that they were bring hampered by being short staffed at certain times. One relative said "the staff are lovely and helpful and always treat the residents with respect and dignity. Staff regularly get called away to help other staff". They told us about an incident when a member of staff said they would fetch some glasses but didn't come back.

People's privacy and dignity was generally respected. Staff knocked before entering the person's bedrooms and carer staff and advised how they were respectful when providing personal care. One notable exception of respecting a person's preference was a specification that they did not want young female care staff to provide personal care. On the day of the inspection, all staff on duty were female. When asked staff about the care preferences of this person, they told us "they're usually fine with a female; we've only got a couple of male staff so it's impossible to provide men all the time. We could not see any documentation that showed the person had given their consent of having female care staff when no male staff were available.

Staff were knowledgeable about people's needs and told us they always aimed to provide personal, individual care to people. Staff told us how people preferred to be cared for and demonstrated they understood the people they cared for. We observed that when drinks and biscuits were offered the carer went away and found an alternative snack for one person who had difficulty swallowing biscuits.

People could be visited by their friends and relatives at any time of day. During our inspection people's relatives and visitors came to the home. One person's relative told us they and other relatives were able to visit whenever they wished.

People were given the opportunity to pass on their feedback in surveys that were sent out by the service. The manager conducted a daily walk about of the service. People's views were sought about their care to ensure they were happy with the service and to discuss any concerns. One relative told "since she has arrived things have got better. She talks to the residents and relatives and wants the place to look nice." Another person commented "things have improved since the new manager arrived and they had now instigated a key worker system which made gaining information a little better."

A person receiving end of life care was being treated with respect and compassion. They did not have capacity to make their own decisions. To ensure the person's wishes, feelings, beliefs and values were taken into account a meeting was held with one of the person's relatives. They told us that their wishes were being taken into account and their relative's care was being delivered in the way they had requested.

Requires improvement

Is the service responsive?

Our findings

The service was not consistently responsive to a person's needs. One of the care plans we saw had been written with the involvement of the person's relative because the person was unable to contribute themselves. The plan was extensive, but was not easy to follow. For example, the person had a pressure ulcer, but the care plan relating to the wound dressing did not provide adequate information for staff to follow. The plan stated that the person should be offered analgesia prior to the wound dressing. There was no evidence of pain assessments being completed to inform this plan. We discussed the wound dressing care plan with the nurse on duty. They went through the plan with us and agreed that it did not provide enough information. They told us "The plans are confusing".

People's care plans did not always contain person centred information. In some cases the "My Choice, My preferences" document was incomplete. The absence of an appropriate record that demonstrated the person's preferences meant the person may receive inappropriate care against their wishes or not receive support in line with their preferences.

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

Care plans were kept in the clinical room and daily journals were kept in another room for care assistants to complete. The care assistants told us "We have access to the care plans, and we report things to the nurses, but the nurses write the care plans" and "We can check the care plans if we want to". Care assistants told us that although they provided a large part of the care for people using the service, they were not involved in the care planning process. They were aware of a person's changing circumstances and the relevant issues were raised during the handover process. To ensure the information was accessible to staff the information was documented in the staff handover notes.

A dedicated activities coordinator was employed by the service. There were normally two coordinators employed by the service and the intention is to recruit another person. There is a structured weekly activities programme. This included one-to-one sessions, exercise classes and gardening sessions. People had been attending to the vegetable and herb patch and were entering the provider's gardening competition. Weekly visits were conducted by the church and outside entertainment groups visited monthly. We observed people engaging in an exercise class. Those participating were engaged and responding positively to the interaction. The coordinator confirmed they worked from Monday to Friday and did not cover weekends.

We received a mixed response from people about the activities provided in the service. One person told us about their love of gardening and how they assisted with watering the plants and spending time in the area with the activities coordinator. One relative felt that the service could improve their activities and should offer outside visits. They told us "my wife is very active but just wanders and down the corridor aimlessly and is totally bored."

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them. One person commented that they take they take their relative out for Sunday lunch.

The service had a complaints procedure. During 2015 the service had received three formal complaints. The provider had systems in place to receive and monitor any complaints that were made. People who were able said they would speak to the manager if they had complaints. Relatives said they would feel comfortable making a complaint if they needed to. One person told us that there were a few teething problems when their relative started living at the service. They confirmed that the initial problems had been resolved. Another relative told us "the manager is approachable and I would be happy to raise a concern or complaint knowing that I would be listened to. If not, I would move x away to another home."

Requires improvement

Is the service well-led?

Our findings

The provider did not notify all incidents that affect the health, safety and welfare of people who use the service as required. We identified an issue that should have resulted in a statutory notification. This was in relation to the person's pressure ulcer deteriorating from a Grade 2 to a Grade 3. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled.

The failure to send this notification was a breach of Regulation 18 of the Care Quality Commission(Registration) Regulations 2009.

Systems were not being operated effectively to assess and monitor the quality and safety of the service provided. The service had a programme of regular audits, however audits to monitor the completion and accuracy of records were not completed and other audits were not always effective. Although action items had been identified such as updating staff training they had not in all cases been monitored and completed. The systems had failed to identify the shortfalls found at this inspection.

Care records and records relating to the management of the service were not always completed or accurate. For example, within one person's care records we found staff had failed to record a person's positioning, food and fluid chart as required. People's care records were not always accurately completed and there was no system in operation to monitor the accuracy and completion of records by staff. The service did not have an effective system that monitored records. This had resulted in some poor or omitted recording keeping by staff not being identified.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager's recent audits had identified a number of failing issues that needed to be taken forward by the service. They are similar to concerns that we have identified during our inspection such as omission of "this is me" documents, record keeping and staff supervisions.

Since the appointment of the manager the overall feedback had been positive and there had been a perceived notable improvement in the running of the service. Staff spoke positively about the manager. A member of staff told us 'she is brilliant and looks after her staff properly. She has reviewed care plans, brought in the key worker system, resident of the day review system and have consulted with family members." Relatives also told us that they had confidence in the new manager. We were told that manager was often seen walking the floor and talking to people who use the service and their relatives.

The manager conducted a daily tour of the home and reviewed a 10 point checklist which assessed areas such as cleanliness, staff interaction and feedback from people. Where actions were identified they were taken forward and resolved.

The manager communicated with staff about the service to involve them in decisions and improvements that could be made; we found recent meeting minutes demonstrated evidence of good management and leadership of staff within the service. Agenda items identified action items which needed to be taken forward with immediate effect such as improvement of handover information. We viewed the handover records and they document in detail issues that occurred during the shift and changes that staff need to be aware of such as a change of prescription.

People were encouraged to provide feedback on their experience of the service. The manager has introduced a residents and relatives meeting to be scheduled every two months. The recent meeting discussed a number of items such as maintenance, activities and the new key worker system. As a result of the meeting two relatives volunteered to assist with the re-decoration needs. The relatives we spoke with found the manager approachable and they felt listened to. The service had installed a computerised feedback system in the foyer. This enabled the service to receive regular feedback and identify issues that required attention. One of the examples advised the manager that their relative was not always being assisted to get up by the night staff as agreed. This issue was addressed and resolved.

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 18 CQC (Registration) Regulations 2009 Notification of other incidents **Regulation 18 CQC (Registration) Regulations 2009: Notification of other incidents** **The provider did not notify CQC of all incidents that affect the health, safety and welfare of people who use the service as required.** **Regulation 18(1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 HSCA (RA) Regulations 2014: Person-centred care** **The provider did not ensure that each person received appropriate person-centred care and treatment.** **Regulation 9(1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 of the HSC 2008 (RA) Regulations 2014: Staffing** **Staffing levels were not reviewed continuously to respond to the changing needs of the people using the service.** **Staff had not received appropriate support, training and supervision to ensure the needs of all people in the service could be met.** **Regulation 18(1)(2)(a)**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 of the HSC 2008 (RA) Regulations 2014: Good governance** **The provider had a system to regularly assess and monitor the quality of service that people receive but this was not effective.** **Regulation 17(1)**

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 **Regulation 12 of the HSC 2008 (RA) Regulations 2014: Safe care and treatment** **The provider did not consistently assess the risks to people's health and safety during their care and treatment.** **Regulation 12(1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **Regulation 14 of the HSC 2008 (RA) Regulations 2014: Meeting nutritional and hydration needs** **People were not protected from the risks of inadequate nutrition and dehydration.** **Regulation14(1)**