Palm Court Nursing Home

Palm Court Nursing Home

Inspection Report

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Summary of findings

Overall summary

Palm Court is a care home registered to provide nursing and personal care for up to 38 people. At the time of the inspection there were 30 people using the service. The majority of people who received care at the home were older people. This included people who required care due to their dementia and people at the end of their life.

People we spoke with said that staff were kind and polite. We observed that staff assisted people with their care in an unhurried manner. However we also saw that people's privacy and dignity was not always respected. We found the home needed to make improvements in this area. We have told the provider to take action about these concerns.

We found people were involved in assessments of need when they arrived at the home but there was limited on going involvement. This was particularly noted for people who were unable to express themselves verbally. No alternative methods of communication such as pictures or objects were used to assist people to understand choices offered or how to make a complaint. We found improvements were needed in this area. We have told the provider to take action about these concerns.

The building and equipment were adequately maintained to ensure a safe environment. One part of the home provided care for people who had dementia. We found that this area did not provide a suitable environment for the people who lived there. There was no signs or points of reference to assist people to orientate themselves or maintain independence. We found the home needed to make improvements in this area. We have told the provider to take action about these concerns.

The management in the home carried out quality monitoring to assess the quality of care provided and plan on going improvements. These included audits of practice and satisfaction surveys for people who used the service and their representatives. We noted that some changes had been made in response to audit findings and feedback from people. However we found the home's quality monitoring systems were not always effective in highlighting and addressing shortfalls in practice. We have told the provider to take action about these concerns.

Each person had a care plan that outlined their needs and the support required to meet those needs. People received care that met their physical needs although we found there was limited support in place to meet people's emotional and social needs. Risk assessments had been written and measures had been put in place to minimise the risks identified by the assessments.

Although there was some information about people's likes and interests there was limited social stimulation for people. There was no activity programme in place and we did not see any staff engaging in activities with anyone who lived at the home.

There was a management structure in the home which gave clear lines of responsibility and accountability. There was always a trained nurse on duty which helped ensure people's clinical needs were met. People had access to healthcare professionals according to their individual needs.

We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards with systems in place to protect people's rights under the Mental Capacity Act 2005.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that the service was safe but some improvements were needed.

The building was maintained to a safe standard. Records showed equipment in the home was regularly tested and serviced to make sure it was safe to use.

Bedroom doors were left open through the day which did not help to keep people's personal belongings safe.

We looked at four care plans and saw risk assessments were in place to assist people to take part in activities with minimum risk to themselves or others. However during the inspection we observed that people were not supported to take risks in everyday activities. This resulted in people not being encouraged to maintain their independence. We saw that people were not encouraged to help themselves to drinks or take an active role in daily tasks around the home.

The majority of staff had received training in the protection of vulnerable adults. Staff we spoke with knew how to report concerns.

Staff were aware of the Mental Capacity Act 2005 and how to involve appropriate people, such as relatives and professionals, in the decision making process if someone lacked mental capacity to make a decision.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards.

We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards.

While no applications had been submitted, proper policies and procedures were in place but none had been necessary. Relevant staff have been trained to understand when an application should be made, and in how to submit one.

Are services effective?

The service was not effectively meeting the needs of the people who used the service.

People who lived at the home told us they were not fully involved in decisions about when they received support from staff. One person said "They have their times for doing things." Another person told us

Summary of findings

"You don't have much choice about getting up. I would like to be up and have breakfast by 9.15am but it is usually around 10 by the time they get to me. In the evenings I have to wait until they are ready to help me to bed."

Part of the home cared for people who required care and support due to their dementia. The home did not provide a suitable environment for people with dementia. There were no signs so people may easily get lost. Bedroom doors had very small name signs on that were not clearly visible. This meant that it would be difficult for people find their own bedrooms without staff support. We saw that bedrooms had not been personalised and the lounge area did not contain objects for people to interact with or assist them to occupy themselves.

People we spoke with felt that their physical healthcare needs were effectively met by the home. One person said "They are always quick to get a doctor if you are unwell." Another person told us they saw a specialist on a regular basis. They said that usually a relative took them to their appointment but the staff were always willing to take them if their relative was unavailable.

Are services caring?

The home was caring but some improvements were needed to make sure people's privacy and dignity were respected.

People's privacy and dignity was not always respected. We saw that the majority of bedroom doors were left open when the occupants were elsewhere in the home which did not promote privacy or respect.

People who lived at the home told us that staff were generally kind and polite. People said staff assisted them in a manner that was gentle and respectful. One person told us "They are all kind and caring" Another person said "They are alright and kind but they don't seem to have as much time for me as they used to." We asked people what changes they would like to see made. One person said "Better organisation of staff and working practices so people are there when you need them". A relative told us they would like to see "a more consistent team looking after their relative."

There was a team of staff who had worked at the home for some time and knew people well. New staff said they had always worked with more experienced staff to enable them to get to know people and how they liked to be assisted. People we saw throughout the day were clean and looked physically well cared for. This showed that staff took time to assist people with personal care.

Summary of findings

Are services responsive to people's needs?

The service was responsive to people's needs but improvements were needed.

People who were able to verbally express their views said staff listened to them and tried to provide care and support in line with their wishes. One person told us "If there's anything you want to do you can." We saw that people who were unable to express their views verbally were not assisted to do so using alternative communication methods, such as pictures or objects. We saw that some people had a copy of the complaints procedure in their bedroom. The procedure was not written in a format that would be understandable to everyone who lived at the home. This could mean that people who were unable to read or understand the procedure would be unable to make their dissatisfaction known.

All rooms had call bells to enable people to summon assistance. We saw that some people had been provided with pendant call bells. One person told us their call bell was broken and they had to shout if they needed assistance. The person said that when they called out there was a slow response to their requests because staff were not always nearby so could not hear them. On the day of the inspection we noted that call bells were answered promptly, however people told us this was not always the case. One relative we spoke with said they had observed someone wait for 20 minutes before their bell was answered. One person who lived at the home said "You have to wait quite a while for someone to come. Well it feels like a long time when you need something." This could place people at risk of not receiving assistance when they required help.

Are services well-led?

Some improvements were needed to make sure the home was well led and took account of people's views.

There were systems in place to assess and monitor the quality of care provided. The manager carried out monthly 'Continuous Quality Improvement reviews.' From these reviews action points were set with dates to ensure improvements were put in place. We saw that the action point for one review was to put in place a key worker system. The date for this to be achieved had passed but the action had not been completed. This meant that the audits carried out did not always achieve the desired improvements in a timely manner.

There was a staffing structure which gave clear lines of accountability and responsibility. There was always a trained nurse

Summary of findings

on duty who took a lead role in ensuring people's clinical needs were met. There was also a senior care worker on duty who was responsible for ensuring other care staff knew what their role for each shift was.

There were enough staff on duty but they were not always deployed to best meet the needs of the people who lived at the home.

Summary of findings

What people who use the service and those that matter to them say

During the inspection we spoke in depth with eight people who lived at the home in depth. We also spoke with five visiting relatives.

People who lived at the home told us that staff were kind and polite. One person told us “They are all kind and caring” Another person said “They are alright and kind but they don’t seem to have as much time for me as they used to.” We asked people what changes they would like to see made. One person said “Better organisation of staff and working practices so people are there when you need them”. A relative told us they would like to see a more consistent team looking after their relative.

Visitors said their relative was “kept clean” and there were no complaints about laundry which was said to be efficiently organised. People had no complaints either about the food and several mentioned the cook as a particularly caring person who would ask them what they’d like and prepare food for relatives as well as people who lived at the home.

Some visitors recalled discussing the care plans when their relative entered the home. However people we spoke with, including visitors, felt that there was very little on going involvement in decisions about care and support. This meant that people who lived at the home had limited opportunities to express their views about the care provided at the home.

Two visitors said that they would not feel comfortable making a complaint and they would not trust that any complaint would be dealt with.

Palm Court 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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1

This inspection was carried out on 3 April 2014. During the inspection we spent time talking with people who used the service, members of staff and visitors to the home. Some people who lived at the home were unable to verbally express their views. We therefore spent time observing care practices and interactions in the home.

The inspection team consisted of a lead inspector and an expert by experience. The expert had personal experience of caring for older people's services.

The inspection was part of the first test phase of the new inspection process that we are introducing for adult social care services.

Before the inspection we reviewed all the information we held about the home. At our last inspection in November 2013 we did not identify any concerns with the care provided to people who lived at the home.

During this inspection we looked around the premises, spent time with people in their personal rooms and in communal areas. We observed the main meal of the day in both dining rooms in the home. We also looked at records which related to people's individual care and to the running of the home.

At the time of the inspection there were 30 people living at the home. We spoke with eight of these people in depth and others briefly. We spoke with five visiting relatives and interviewed five members of staff. We spoke with other members of staff throughout the visit.

The Registered manager, deputy manager and a representative of the provider all made themselves available to us during the inspection.

Are services safe?

Our findings

We found that the service was safe but some improvements were required.

The home was arranged over three floors with a passenger lift between all floors. All areas were fitted with a fire detection system. We saw records which showed this was regularly checked and serviced by outside contractors to make sure it was in safe working order and protected people who lived at the home.

The home had a variety of equipment, such as moving and handling equipment, to support people when receiving care. We saw records which showed that all lifting equipment was regularly serviced to ensure it remained safe to use. Staff said they had ample equipment to assist people and had received training in moving and handling. One person told us "There are always two staff when they hoist me and I feel quite safe with them."

One part of the home was used to accommodate people who required care due to their dementia. This was a corridor with bedrooms and a small lounge area. The area was separated from other areas of the home by an electronic key pad. Staff told us this was to keep people safe but anyone who wished to access other parts of the home and outside areas could do so with staff support.

We saw that bedroom doors were left open which did not help to keep people's belongings safe. In the part of the home which cared for people with dementia we observed that bed linen had been removed from individual beds. We asked staff about this and were told that they removed people's bedding because one person who lived in the home liked to remove it. Staff said bedding was put back onto beds if anyone wished to return to bed. After lunch we saw that one person had decided to go for a lie down and their bed had been remade for them. There was no information about this practice in individual care plans and no information about what other methods had been considered to keep people's personal space safe from other people who lived at the home.

We looked at four care plans and saw risk assessments were in place to assist people to take part in activities with minimum risk to themselves or others. These included the level of support people required to access community facilities safely, including attending medical appointments. However during the inspection we observed that people were not supported to take risks in everyday activities. This resulted in people not being encouraged to maintain their independence. We saw that people were not encouraged to help themselves to drinks or take an active role in daily tasks around the home.

The majority of staff we spoke with said they had received training in the safeguarding of vulnerable adults. Records of staff training confirmed this. All staff we asked were clear about how to report any concerns and were confident that any issues raised would be taken seriously and fully investigated to make sure people who lived at the home were protected. All staff were aware of the whistle blowing procedure which enabled them to take serious concerns outside the home if they felt they were not being effectively dealt with. This meant that any concerns about the safety of people who lived at the home would be correctly reported to make sure people were protected.

New staff said they had not received formal training in recognising and reporting abuse but had been told to report any concerns to a senior member of staff. The management in the home informed us that formal training in this area was planned for all new staff and other staff who required refresher training.

Staff had a basic understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Staff were aware of the need to involve others in decisions when people lacked the mental capacity to make a decision for themselves. One member of staff told us: "We always try to involve families and professionals if someone is unable to make a decision for themselves." This ensured that any decisions made on behalf of a person who lived at the home would be made in their best interests.

We heard how one person who lived at the home had made a decision about the level of care they were prepared to accept. We saw that they had been assessed as having the capacity to make this decision and staff respected their wishes. This demonstrated that people who had the mental capacity to take risks were able to do so.

We saw some people had care plans in place to advise staff how to react if they displayed agitated or challenging behaviour. We saw that these plans of care described methods to diffuse a situation and were not

Are services safe?

confrontational. When we looked at incident and accident records we saw there was not a high number of reported incidents of aggressive behaviour or injuries to people.

Are services effective?

(for example, treatment is effective)

Our findings

The service was not effectively meeting the needs of the people who used the service.

Care plans showed that people who lived at the home, or their representatives, had been involved in the assessment of their needs when they entered the home. Some visitors recalled discussing the care plans when their relative entered the home. However people we spoke with, including visitors, felt that there was very little on going involvement in decisions about care and support. We saw that care plans had been reviewed and up dated on a regular basis but there was no information about how people had been involved in decisions about changes.

One relative told us they had asked staff when a healthcare professional was visiting. They were told: "Not to worry." They later found they had missed the visit. This meant they had not had an opportunity to be involved in discussions about their relatives care.

People who lived at the home told us they were not fully involved in decisions about when they received support from staff. One person said "They have their times for doing things." Another person told us "You don't have much choice about getting up. I would like to be up and have breakfast by 9.15am but it is usually around 10 by the time they get to me. In the evenings I have to wait until they are ready to help me to bed."

Care plans we saw contained basic life histories. There was a lack of information about people's interests or preferred daily routines. Therefore staff had very limited information about the lifestyle choices and preferences of the people they supported. This meant that staff may not be able to provide care in an appropriate manner if the person was no longer able to express their wishes. One member of staff told us "We try to get as much information from families as we can so we know the types of things people like." Another member of staff said "Everything people do is their decision. We never force anyone to do anything they don't want to."

The lack of involvement and encouragement to discuss care and support with people who used the service and their representatives demonstrated a breach of regulation 17 (2) (c). The action we have asked the provider to take can be found at the back of this report.

Part of the home cared for people who required care and support due to their dementia. The home did not provide a suitable environment for people with dementia. There was no signs so people may easily get lost. Bedroom doors had very small name signs on that were not clearly visible. This meant that it would be difficult for people to move around or find their own bedrooms without staff support. We saw that bedrooms had not been personalised and the lounge area did not contain objects for people to interact with or assist them to occupy themselves.

There were level access shower facilities with shower seats. There was also an assisted bath but this could only be used safely by a small number of people who lived at the home. We saw risk assessments in individual care plans for the use of the bath which demonstrated why some people could not safely use this facility. This meant that many people in the home were unable to choose between a bath and a shower due to a lack of suitable facilities.

Overall we found some areas of the home were not of a suitable design and layout to promote people's well-being. This is a breach of regulation 15 (1) (a). The action we have asked the provider to take can be found at the back of this report.

People we spoke with felt that their physical healthcare needs were effectively met by the home. One person said "They are always quick to get a doctor if you are unwell." Another person told us they saw a specialist on a regular basis. They said that usually a relative took them to their appointment but the staff were always willing to take them if their relative was unavailable.

A number of people were being cared for in bed. We saw that people looked warm and comfortable. Pressure relieving mattresses were in place where assessments had highlighted a risk of pressure damage to the person's skin. At the time of the inspection we were told that no one had a pressure sore. This showed that preventative measures in place to minimise pressure damage were effective.

No one we saw appeared to be in pain or discomfort. Relatives spoken with confirmed that people were never left in pain and their needs for pain relief were met.

We saw that the home made referrals to outside healthcare professionals to ensure that people's needs were met. We saw an assessment that had been completed by a speech and language therapist for one person. The professional had made recommendations about the consistency of food

Are services effective?

(for example, treatment is effective)

and drinks required by the person to assist them with swallowing. During the inspection we noted that this advice was being followed and the person received food and drinks at the thickness and consistency that had been recommended by the speech and language therapist.

We were told by the management that the home regularly provided end of life care for people who were discharged from hospital but unable to return to their home. Staff spoken with said they had received training in end of life care and felt confident in this area. Records seen confirmed that staff had received this training.

At the time of this inspection no one was receiving end of life care. We saw that people, or their representatives, had been involved in decisions about whether they wished to be resuscitated if they became extremely unwell. This information was recorded and held securely in the main office. One relative confirmed that her relative had made end-of-life plans; others said they had discussed these issues with staff but had not signed anything. This showed that people were involved in planning the care they would like to receive at the end of their life.

Are services caring?

Our findings

The home was caring but some improvements were needed to make sure people's privacy and dignity were respected.

People who lived at the home told us that staff were kind and polite. People said staff assisted them in a manner that was gentle and respectful. One person told us "They are all kind and caring" Another person said "They are alright and kind but they don't seem to have as much time for me as they used to." We asked people what changes they would like to see made. A relative told us they would like to see "a more consistent team looking after their relative."

We saw very little interaction between the staff and people who lived at the home unless a task was being performed. Many people spent their day in the main lounge on the top floor. We saw that staff supported people to sit comfortably and provided drinks when people came into the lounge. However there was very little social interaction and people were placed in front of a large television and not given a choice of any other activity. This resulted in people not having opportunities to take part in activities that interested them or receive social stimulation.

At lunchtime we saw that people who required physical support to eat their meal were assisted in an unhurried manner. There was limited interaction between the member of staff helping and the person who was being assisted. This meant that the main meal of the day was not a social occasion for people.

People's privacy and dignity was not always respected. We saw that the majority of bedroom doors were left open when the occupants were elsewhere in the home which did not promote privacy or respect.

Very few bedrooms had en suite facilities and there were limited accessible toilet facilities. We saw that some rooms which were marked as toilets had the toilets removed and were used for storage of equipment. We observed that the majority of people used commodes in their bedrooms. At one point in the day we saw that one person had been assisted to use the commode and staff had left the bedroom door wide open. The lack of respect for people's privacy is a breach of regulation 17 (1) (a). The action we have asked the provider to take can be found at the back of this report.

There was a team of staff who had worked at the home for some time and knew people well. New staff said they had always worked with more experienced staff to enable them to get to know people and how they liked to be assisted. People we saw throughout the day were clean and appeared physically well cared for. This showed that staff took time to assist people with personal care.

Most visitors said their relative was "kept clean" and there were no complaints about laundry which was said to be efficient. This showed that relatives were happy with the care taken to maintain their relatives' personal appearance. People had no complaints either about the food and several mentioned the cook as a particularly caring person who would ask them what they'd like and prepare food for relatives as well as residents. During the day we observed the cook talking to people and offering them choices of food and drink.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The service was responsive to people's needs but improvements were needed.

People told us they received basic information about the home when they moved in. We saw limited information in the home about the staff, services offered or community facilities. People who lived at the home and visitors were not able to easily identify who to speak with if they wished to make suggestions or share concerns. One relative we spoke with told us they did not always know who the trained nurse on duty was when they wished to discuss their relatives care. The home was in the process of putting in place a key worker system. This will mean that people will have a nominated member of staff to talk with about their care.

People had access to their care plans because they were kept in their rooms. Other information about individuals, including day to day records, was kept securely in the main office to maintain confidentiality. We saw that care plans were regularly reviewed and up dated to make sure that staff had up to date information about people's needs and the assistance they required. Care plans contained some information about people's likes and dislikes to assist staff to support people.

People who were able to verbally express their views said staff listened to them and tried to provide care and support in line with their wishes. One person told us "If there's anything you want to do you can." We saw that people who were unable to express their views verbally were not assisted to do so using alternative communication methods such as pictures or objects. We saw that some people had a copy of the complaints procedure in their bedroom. The procedure was not written in a format that would be understandable to everyone who lived at the home. This could mean that people who were unable to read and understand the procedure would be unable to make their dissatisfaction known.

All rooms had call bells to enable people to summon assistance. We saw that some people had been provided with pendant call bells. One person told us their call bell was broken and they had to shout if they needed assistance. The person said that when they called out there was a slow response to their requests because staff were not always nearby so could not hear them. On the day of the inspection we observed that call bells were answered promptly, however people told us this was not always the case. One relative we spoke with said they had observed someone wait for 20 minutes before their bell was answered. One person who lived at the home said "You have to wait quite a while for someone to come. Well it feels like a long time when you need something." This could place people at risk of not receiving assistance when they required help.

Although some care plans gave information about people's hobbies and interests there was no activity programme in the home. This meant that the home had not used the information to provide social and mental stimulation in line with people's interests. During the day of the inspection we did not observe any activities being carried out with people who lived at the home. One member of staff told us "We don't really have time to do activities." Another member of staff said "One thing I've noticed is there isn't really anything for people to do."

A large number of people spent their day in the main lounge on the top floor of the home. We saw that although at times there was a number of staff in the room they did not initiate any activities or conversations. After lunch some people in the lounge fell asleep but staff did not turn down the television to allow people peace and quiet. This showed that staff did not respond well to people's social needs.

We looked at a sample of daily records for people who lived at the home. These showed that staff recorded any significant incidents which had occurred each day. This enabled changes to be made to the care provided in line with changes in need and behaviour.

People told us there was always a choice of food at each meal. The cook at the home told us they visited every resident each day to ask for their meal preferences. We asked a member of staff about how people who were unable to understand made choices about their meals. We were told 'We know them and what they like'. This meant that assumptions were made for people rather than trying harder to find out their preferences. People were not shown a choice of meals or pictures which may have assisted people to make choices.

At lunch time we observed the main meal in the main dining room and in the area which cared for people with dementia. We saw that meals arrived plated to each

Are services responsive to people's needs?

(for example, to feedback?)

person. This meant that people were unable to make choices about portion sizes. We noted that condiments were not available on some tables. We asked staff why these were not available and were told they could be supplied if people asked for them. Many of the people we met would be unable to ask for condiments without being offered.

Are services well-led?

Our findings

Some improvements were needed to make sure the home was well led and took account of people's views.

The home had a registered manager in place who shared their time between Palm Court and another home owned by the same provider. There was a deputy manager who oversaw day to day running if the manager was not available in the home.

There was a staffing structure which gave clear lines of accountability and responsibility. There was always a trained nurse on duty who took a lead role in ensuring people's clinical needs were met. There was also a senior care worker on duty who was responsible for ensuring other care staff knew what their role for each shift was.

We were told that staff were allocated to specific floors each day to ensure people received consistent care throughout the day. Some visitors that we spoke with expressed concerns about the lack of easily available staff on the ground floor. The only communal area on the ground floor was a large dining room which was kept locked by an electronic key pad. This meant that people who lived on the ground floor and did not wish to go upstairs to the main lounge stayed in their room. During the day we did not see ground floor staff spending time with people in their rooms. This meant that people who did not have visitors received no social stimulation.

There were enough staff on duty but they were not always deployed to best meet the needs of the people who lived at the home. At lunch time we observed lunch being served in the main dining room and the dining room in the area which cared for people with dementia. The main dining room was well staffed which ensured that people received the physical support they required to eat. The other dining room was staffed by an agency care worker. The agency care worker informed us they had worked in the home on a few occasions but did not have an in-depth knowledge of the people they were supporting to eat. This demonstrated that staff were not always arranged in line with the needs of the people who lived at the home. One new member of staff told us "There doesn't seem to be a set location for staff each shift. We just keep swapping around."

Throughout the day we did not see evidence of an open and responsive culture which sought the views of people to make sure the service was run in line with their wishes. One person who lived at the home said "You don't get much choice about things except food. You really have to fit in with the staff. It's fine, I'm very comfortable here."

There were systems in place to assess and monitor the quality of care provided. The registered manager carried out monthly 'Continuous Quality Improvement reviews.' From these reviews action points were set with dates to ensure improvements were put in place. We saw that the action point for one review was to put in place a key worker system. The date for this to be achieved had passed but the action had not been completed. This meant that the audits carried out did not always achieve the desired improvements in a timely manner.

The fact that audits undertaken by the home had not identified shortfalls identified by this inspection showed that audits were not always effective in ensuring improvements. This is a breach of regulation 10 (1). The action we have asked the provider to take can be found at the back of this report.

All accidents and incidents in the home were audited on a monthly basis. The audits looked at who the incident had happened to, what time of day it was and any other circumstances to try and establish patterns. We looked at the last audit and noted there were no patterns in times or locations which may have highlighted a need to change practice. It did identify concerns for one individual's seating. In response to this an outside professional had been contacted and they were due to visit to assess the person the week following the inspection. This demonstrated that the home made suitable referrals to ensure people's needs were met when concerns were identified.

We were told that the home did not hold regular meetings with people who lived at the home but there were some meetings for relatives. The management told us they sent out regular satisfaction surveys to people who lived at the home and their representatives. One survey highlighted people's dissatisfaction with the tea time menu. As a result of this feedback changes had been made and the home was monitoring people's on going satisfaction with this meal.

There were no systems in place to make sure people who were not able to express their views verbally had opportunities to express themselves. In the area which

Are services well-led?

cared for people who had dementia up to date research had not been used to ensure the environment and care provided were based on good practices guidelines. This meant that people were unable to maintain independence or skills. One member of staff said "There is not as much dementia training as I would like. I think we could do so much more with people if we had the time and space."

We looked at the complaints log and saw that action had been taken to address complaints made but there was no written response to the complainants. Two visitors spoken with said they would not feel comfortable to make a complaint. They also said they were not confident that any complaint would be appropriately addressed. We discussed this concern with the management of the home who stated they would look at ways to make themselves more accessible and approachable to people.

All staff at the home had opportunities to take part in group and individual supervision. This meant staff had opportunities to discuss working practices, requirements for training or concerns. It was also a chance for any poor practice to be addressed in a confidential manner. Group supervision was facilitated by someone outside the home and any concerns were passed to the manager anonymously. We saw that some staff had raised concerns about the support they received when dealing with people who displayed behaviour which could be physically threatening or violent. We were told that in response to this induction training was being improved and further training for all staff was being arranged.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 (2) (c) The registered person had not ensured that service users and/or their representatives always had opportunities to express their views and be involved in decisions about their care, treatment and support.

Regulated activity	Regulation
	Regulation 15 (1) [a] The registered person had not ensured that all areas of the home were of a suitable design and layout to promote people's well-being.

Regulated activity	Regulation
	Regulation 17 (1) (a) The registered person did not have suitable arrangements in place to make sure people's dignity, privacy and independence were respected.

Regulated activity	Regulation
	Regulation 10 (1) The registered person did not have effective systems in place to assess and monitor the quality of care to ensure that service users did not receive unsafe or inappropriate care.