Bange Nursing Homes Limited

Bange Nursing Homes Limited t/a Bradley House Nursing Home

Inspection report

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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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We inspected Bradley House Nursing Home on 15 and 16 December 2015. The first day of the inspection was unannounced.

Bradley House Nursing Home provides nursing care for up to 34 older people. At the time of our inspection there were 32 people living in the home. People were supported in one building over four floors. In the basement area there was room for seven people to receive nursing care; all the rooms were single bedrooms, there was a shared bathroom and a communal lounge and dining area in a large conservatory. Nine people could be accommodated on the ground floor; bedrooms were all singles, there was a shared bathroom, a combined lounge and dining area and a quiet lounge. There were rooms for 13 people on the first floor; these were a mixture of single and twin bedrooms and they shared a bathroom and a communal lounge and dining area. There were five bedrooms on the attic floor; people there shared a toilet and used the communal bathrooms and lounge/dining rooms on the other floors during the day. All floors could be accessed by a lift. A separate part of the basement also contained the registered manager's office, the staff room, some storage areas and the laundry.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our last inspection took place on 14 April 2015. At that time the service was not meeting all the legal requirements. During this inspection we checked to see if improvements had been made.

Some corridors and communal areas were cluttered. There were no risk assessments in place for various aspects of the care home premises; for example, stair gates, steep steps, the kitchen or laundry room.

Not all of the people living at the home had a personal emergency evacuation plan in place. They might therefore be at risk in the event of a fire or other emergency situation.

We found that the registered manager had not reported all safeguarding incidents to CQC as is required by the regulations and staff had not received regular safeguarding training.

Staff training and development was not up to date and the induction process for new staff was not documented.

There was a lack of consistent and effective audit at the service. This was noted at the last inspection and constituted an ongoing breach of the regulation relating to good governance.

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

You can see what action we have told the provider to take at the back of the full version of the report.

Most aspects of medicines management were done well at the home; however, we found that not all 'as required' medications had instructions for staff. We recommended that the registered manager reviews and improves current practice in line with nationally available good practice.

There were enough staff on duty to meet people's needs and the home employed a flexible system to minimise the use of agency care staff. Care workers had time to assist the activities coordinator to provide activities for the people who used the service. There was a full time activities coordinator at the home who kept records of the activities people had taken part in as well as those that people had refused, so that care workers knew which activities individuals preferred.

The registered manager ensured all the necessary checks were done on new staff before they were employed at the home. Appropriate checks were done in relation to existing nursing staff on an annual basis.

At our last inspection there was a breach in regulation as we noted there were issues with cleanliness and some décor was seen to be in need of improvement. During the inspection, apart from some minor issues that we brought to the registered manager's attention, the home was clean and tidy but cluttered in places. People's relatives told us they thought the home was clean.

Staff were receiving regular supervision and were due to receive an annual appraisal at their next planned supervision session. This had been an area of concern at our last inspection but we saw evidence that this had been remedied.

The home was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Applications for DoLS had been made to the local authority and care workers had a good knowledge of the legislation and how it applied to the people they supported. We saw capacity assessments and best interest decision meetings were documented in people's care files.

Feedback on the food served at the home was positive. We saw that people were supported to eat when they needed it. The cook knew people's dietary needs and food preferences and tried to ensure people were provided with food they enjoyed.

People were supported to maintain their holistic health by access to other healthcare professionals, such as GPs, dieticians, podiatrists and mental health specialists.

People and their relatives told us that the care staff were caring. Staff at the home we spoke with could tell us people's likes, dislikes and preferences, as well as details about their personal history. Interactions we observed between care workers and people during our inspection were warm and respectful.

At the last inspection there was a breach in regulation as people's care plans were not person-centred and not always completed fully. At this inspection we found that people's care plans were person-centred and complete and people and their relatives were involved in developing them. People's bedrooms were personalised with their furniture, ornaments and photographs. Relatives told us they could visit at any time and said that they thought the building was homely and welcoming.

We saw that the service referred people to advocacy services when they needed them. The home had received positive feedback from relatives after people had received end of life care there. Care staff we spoke

with were passionate about providing good quality end of life care at the home.

The service was responsive to people's changing care needs. Risk assessments and care plans were evaluated and reviewed regularly. There was a system in place for recording various aspects of care that people received, including an innovative system for recording night care interventions.

The complaints procedure was displayed in the home and there was a policy in place for reporting, recording and responding to complaints. No complaints had been made since our last inspection, however, people and their relatives told us they would speak to the registered manager if they had any problems. Feedback from the people, their relatives and care workers about the registered manager and director was positive.

The home sought the views of people's relatives in order to improve the service. Feedback from the last survey published in April 2015 and an action plan to address the issues raised in the survey was displayed.

Staff had regular team meetings at which good practice was discussed and the management asked for feedback and ideas for service improvement. The service had an 'employee of the month' scheme in order to reward and motivate staff.

We saw that the registered manager was committed to providing evidence-based practice at the home; she provided examples of how national guidance and government advice had been used to update practice at the home.

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.

Staff had not received regular safeguarding training and the registered manager did not report safeguarding incidents to CQC in accordance with the regulations. However, staff could describe the different forms of abuse and said they would report any suspicions.

Not all the people had Personal Emergency Evacuation Plans and various aspects of the building had not been risk assessed.

We identified some issues with medicines management at the home and recommended that practice is reviewed in line with national guidelines.

Recruitment procedures were robust and there were sufficient staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received regular training and there was no formal induction process in place at the home but they were receiving regular supervision.

The home was fulfilling its obligations under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and care workers were knowledgeable about how the legislation impacted upon the people.

People were supported to access to a range of healthcare professionals.

People and their relatives were happy with the food provided by the home. The cook was knowledgeable about people's nutritional needs, likes and dislikes.

Is the service caring?

Good

The service was caring.

The interactions between care workers and people we observed were positive and supportive. People were spoken to and supported respectfully.

People and their relatives were involved in people's care planning and staff knew people well as individuals. Care plans were person-centred.

People's bedrooms were personalised with their own belongings and relatives told us they were welcome to visit the home at any time.

People had access to advocacy services and were referred to advocates when they needed them.

Is the service responsive?

Good

The service was responsive.

People's risk assessments and care plans were evaluated and reviewed regularly.

People's health and well-being was monitored and any changes were recorded and acted upon appropriately.

People had access to activities that were personalised to suit their own preferences.

A complaints policy was displayed at the home and people and their relatives said they felt happy to speak to the registered manager if they had any problems.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Proper audits and checks on the quality and suitability of the service were not in place to ensure people were kept safe.

The home had used a survey to generate feedback from people's relatives on the quality of the service provided.

People, their relatives and the staff gave positive feedback about the registered manager and director who ran the home.

The registered manager used national guidance and best practice to ensure care at the home was evidence based and up to date.

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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.

The inspection took place on 15 and 16 December 2015. The first day was unannounced which meant the service did not know we were coming.

The inspection team consisted of three adult social care inspectors and an expert by experience on the first day and two adult social care inspectors on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this inspection had visited family members when they lived in residential care homes.

Before the inspection we reviewed the information we held about the service. This included asking for feedback from the Local Authority funding people living at the home and responsible for safeguarding, as well as Healthwatch Trafford. Neither the Local Authority or Healthwatch Trafford had any concerns.

We also reviewed the latest inspection report provided by the local NHS Trust's infection control lead; an infection control inspection had been carried out in October 2015. The infection control lead had identified issues during their inspection and had drawn up an action plan for the service to implement.

On the day of the inspection we talked with the people who used the service to try and find out what they thought about living at the home. However, as the home specialises in providing care to people living with

dementia, only three people we spoke with could give us answers to the questions we asked. We spoke with five people's relatives, five care workers, the activities coordinator, the registered manager, a director, the office manager, a care worker who also worked as a cook and a kitchen assistant who was covering in the laundry. We also spoke with a visiting healthcare professional from the mental health team.

We spent time observing care in the communal lounges and dining rooms and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us.

We looked around the building including bedrooms, bathrooms, the kitchen, the laundry room, clinic rooms and in communal areas across all four floors. We also spent time looking at records, which included six people's care records, six staff files, the training matrix and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe; those who answered said that they did. We also spoke with people's relatives and asked if they felt people were safe at the home. All five relatives said that they felt people were safe; they told us, "They never leave [my relative] alone", and, "I think [my relative] is safe here."

Our inspection of the building revealed that in places it was cluttered with equipment, for example, hoists and wheelchairs were found in corridors. A visiting healthcare professional commented that there was, "A lot of equipment everywhere", which they felt hindered people's freedom to walk around the building. We also noted that safety gates were in use at the bottom of stairs to prevent people using the service from accessing them. Other parts of the home had steep stairs, such as those leading from the ground floor to the office section of the basement and there were external steps which might become slippery in wet or icy conditions, such as those from the carpark to the laundry. When risks are apparent, they must be assessed and plans put in place to mitigate them in order to make sure people, their relatives and staff are kept safe. Risks assessments would also be expected for areas such as the kitchen and laundry that have known hazards associated. We asked the registered manager for the risk assessments for the building hazards we had identified and were told that none had been carried out. This meant that risks had not been assessed or mitigated by the home and people, their relatives and staff might therefore be at risk.

This was a breach of Regulation 12 (1) and (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service had not assessed the premises to ensure they were safe to use for their intended purpose.

At the time of our inspection there was no signing in book for visitors at the main entrance; signing in books can be used by the emergency services to identify if visitors need to be evacuated from a building. When we raised this with the registered manager she said that they had tried several ways of maintaining a signing in book in the reception area but that it was either removed or damaged by the people using the service who lived with dementia. The registered manager had yet to identify a workable solution and was considering options. This meant that visitors to the building might be put at risk in the event of an emergency situation which required evacuation of the building.

We checked the systems that were in place at the home in the event of a fire or other emergency that would require an evacuation of the people. The home had an emergency evacuation plan but we found that not all the people had Personal Emergency Evacuation Plans (PEEPs). A PEEP is usually a one-page summary which includes a photograph of the person, their bedroom location, how they mobilise and the number of staff they need to do so and any other information emergency personnel attempting to evacuate the person might need to know. PEEPs are often kept somewhere where they can be located quickly and given to the emergency services. The PEEPs we saw were not up to date and people more recently admitted to the home did not have them. We also saw that the home's fire risk assessment had been reviewed in November 2015; actions had been identified but no action plan had been put in place by the time of our inspection. This meant that when actions were identified they were not always followed up and people might therefore be put at risk.

This was a breach of Regulation 12 (1) and (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service had not assessed the risks to the health and safety of service users or done all that is reasonably practicable to mitigate any risks identified.

All the staff we spoke with could describe the different forms of abuse that people might be vulnerable to and told us they would report any suspicions of abuse to the registered manager. One care worker told us, "Mistreating residents, I wouldn't think twice about reporting. I wouldn't turn a blind eye." When we asked staff if they had received safeguarding training one care worker told us they had but could not recall when. Another relatively new member of staff said they had not had safeguarding training in their current role but had received it in their last job. We saw from training records that only seven of the 33 staff had received safeguarding training in 2015, however, safeguarding had been discussed in the home's September 2015 group supervision meeting. This meant that whilst staff had not had regular safeguarding training they were able to recognise abuse and knew how to report it.

As part of this inspection we checked the accidents and incidents that had been recorded at the home since our last inspection. Certain accidents or incidents must be reported to the local authority and to the Care Quality Commission (CQC); the requirement to report safeguarding incidents was also stated in the home's own safeguarding policy and procedure. When we checked the records of accidents and incidents during this inspection, we found that incidents had occurred which should have been notified to both CQC and the local authority but had not been.

We saw that each incident or accident was recorded and investigated properly by the registered manager and measures were put in place. For example, after one incident the registered manager had completed a behaviour risk assessment for the person, the person's care plan was reviewed and amended, the person was referred to their GP for a medication review and also to the dementia crisis team. Staff also completed ABC charts for the person. ABC means Antecedent Behaviour Consequence and is a way of recording people's behaviours to help identify any triggers. Analysing ABC charts can help staff to understand people's behaviour that might challenge others so that situations can be better managed in future. During our inspection we saw numerous examples of care workers diffusing situations between people living at the home that may have led to aggression, by redirecting people with conversation and activities. Records showed that the registered manager was investigating incidents and taking appropriate action and care workers knew how to sensitively support people who were becoming aggressive, however, incidents were not always reported to the local authority or to CQC when they should be. This meant that incidents could not be reviewed and investigated independently and the registered manager was potentially keeping a closed culture on incidents.

We spoke with the registered manager regarding the missed referrals for safeguarding incidents; she was aware that referrals should have been made but said that she had been too busy and that the process was time consuming. During the inspection the registered manager made a referral for a safeguarding incident to the local authority and to CQC so we saw that she did understand the process of making a safeguarding referral.

Failure to report safeguarding incidents to CQC was a breach of Regulation 18 (2) (e) of the Care Quality Commission (Registration) Regulations 2009.

During our inspection we looked at the systems in place for the receipt, storage and administration of medicines. A monitored dosage system was used for most of the medicines with others supplied in boxes or bottles. Monitored dosage systems consist of blister packs made up by a pharmacist, where the tablets each person takes at different times of the day are supplied in separate sealed pots. We looked at medication

administration records (MARs) for six people living at Bradley House Nursing Home. Each person's MAR contained a photograph of them and there were details of any allergies they had. MARs for each person's tablets and liquid medicines were up to date with no gaps in recording. Staff recorded when people had refused medicines. This meant that medicines administration was being recorded properly.

We observed a medicine round on the second day of inspection. People were given their medicines in a patient and caring way; we saw that when people refused their tablets the nurse calmly explained what they were for and encouraged the person to take them. When the person still refused their medication, we saw that the nurse stored them safely in the medicine trolley and tried again later. The nurse had an effective system for remembering which people to go back to so medicines would not be forgotten; the front page of the medicine record for each person who had refused their medication was moved up a hole in the ring binder so that it was clear who had yet to take their medication. The nurse also made sure the medicine trolley was locked when they went to give medicines to each person, ensuring items were kept securely. This demonstrated people were receiving their medicines safely and in a person-centred way.

Two people living at Bradley House Nursing Home were receiving their medications covertly; this meant that their medicines were being hidden in food or drink because the individuals would otherwise refuse them. When people who lack mental capacity refuse medicines they need to keep them well, their GP, a nurse or manager involved in their care and family members can hold a best interest meeting under the Mental Capacity Act 2005 and make the decision to give them their medicines covertly. We saw that best interest meetings had been held and properly documented for the two people who were given medicines covertly. The nurse we spoke with could explain when covert medicines might be required and the process for arranging a best interest meeting. This meant that when people were receiving their medicines covertly it was in line with the relevant legislation which protected their rights.

People's medicated creams were stored in their bedrooms and applied by the care workers after people had been assisted to bathe or wash. Application records and body maps to explain why, how often and where creams and lotions should be applied were kept in people's rooms and signed by the care staff who applied the creams. We checked two people's cream charts and body maps and found they were filled in correctly. This meant that people were receiving their topical medicines as prescribed by their GPs.

We checked the controlled drugs in use at Bradley House Nursing Home. Controlled drugs are prescription medicines controlled under Misuse of Drugs legislation and include medication such as morphine. The controlled drugs were kept in a locked cabinet within a locked room. We checked the controlled drugs book where drugs were recorded when they were received, administered and destroyed; it had been signed by two members of staff each time a change was made and was up to date. We checked a random selection of medication and found that it tallied with the controlled drugs book and was in order. This meant that controlled drugs were stored and recorded safely.

We noted that some people were prescribed medicines to be taken 'as required' which meant they were prescribed to be taken when the person needed them. An example would be 'Paracetamol one or two tablets to be taken up to four times a day for pain.' When people's medicines are managed for them care staff need guidance on when to give 'as required' medicine; this is often called a medicine protocol. A medicine protocol is a list of instructions that details what the medicine is for, the correct dose and how often it can be taken. Protocols are important when people live with conditions like dementia as they might not be able to communicate their need for 'as required' medicines. A protocol may therefore list other signs such as facial expressions or body language that tell care staff when a person needs an 'as required' medicine. The medicine policy and procedure that the home used said that each 'as required' medicine must have a specific care plan (or protocol).

Some medicine protocols were in place at Bradley House Nursing Home but they were not present for every person that needed them. For example, not all people had medicine protocols for 'as required' pain medication, laxatives and inhalers. Some 'as required' medicine protocols we saw for sedatives such as Lorazepam were excellent; they described the behaviours a person must exhibit prior to considering administration and listed other non-pharmacological measures that must be attempted first to calm or distract the person. However, we saw other people who were also prescribed sedatives such as Lorazepam, Trazadone and Diazepam did not have 'as required' medicine protocols. This meant that people might not have been getting their medicines when they needed them.

We recommend that the registered manager reviews and improves medicines management practice at the home in line with current national guidelines and standards.

At our last inspection in April 2015 we identified a breach in the regulation relating to premises cleanliness and identified areas where décor was in need of updating. During this inspection we looked in bathrooms, communal areas, the kitchen and in people's bedrooms to check that Bradley House Nursing Home was clean. We also reviewed the findings of the October 2015 infection control audit by the local NHS Trust. Upon entering the front door of the building on the first day of inspection we noted an unpleasant odour that seemed to be concentrated around the reception area of the house. This odour was not present on any of the other floors. The odour was noted at our last inspection and was also mentioned in relatives' feedback, the results of home surveys and the previous infection control audit; it was clearly a long-standing problem at the home. We spoke with the registered manager who explained that people living at the home had in the past mistakenly urinated in the reception and that was the source of the smell. She described how the area had been deep cleaned, the floor matting had been replaced and air fresheners had been installed. We noted that on the second day of the inspection the odour was much improved. We asked people's relatives if they thought there was an odour at the home; one relative said, "There is no odour", and another said, "The smell has got better." This meant that the registered manager had responded to feedback about the odour and had put measures in place to try and address it.

As we walked round the home we identified some minor issues with cleanliness which we brought to the registered manager's attention, however, the majority of the areas we inspected were clean. This included the kitchen and people's bedrooms. We asked people's relatives if they thought the home was clean. One relative told us, "Yes in the main", a second visitor said, "It's clean but not always tidy", and a third relative told us, "It is clean and tidy." One other relative we spoke with said, "It is clean here yes." The infection control audit in October 2015 had identified some areas which were not clean. We discussed the audit with the registered manager and she said that after the audit she had had a meeting with the cleaning contractors used by the home and a new cleaning schedule had been agreed to tackle the highlighted areas. This meant that the registered manager had put measures in place to address the issues that had been identified.

At the time of our inspection, Bradley House Nursing Home was providing nursing care for 32 people over four floors. We asked the registered manager about staffing levels and checked the staff rotas. When we arrived at 7am there was a nurse and two care workers on duty. We were told that ideally there would be three care workers on at night, but at that time three night time care workers were on extended sick leave, so the home had two care workers and one nurse at night. The night nurse we spoke with said that the night staff could still meet the needs of the people with two care workers.

The day shift, which started at 8am, was staffed by one or two nurses and six care workers. Other staff on duty included a laundry worker, a cook, an activities coordinator, the office manager, a director whose role was that of general manager and the registered manager, who was also a registered nurse and one of the

providers. The home used a cleaning contractor to provide cleaning staff.

We asked people, their relatives and staff if they thought there were enough staff to meet people's needs. Two people we spoke with said they thought there were, one said, "Yes and they come quickly." Relatives we spoke with also felt there were enough staff; they told us, "I think there are enough staff", "There's always somebody [staff] about", "Yes always enough", "There is enough for safety", and, "Yes, as far as I know." All the care workers we spoke with thought there were enough staff. One care worker told us, "I think there are enough staff here", another care worker said, "There are usually enough staff." A third care worker explained that there were enough staff except when emergencies occurred, such as a person needing to go to hospital urgently. However, the care worker said that when this happened they rang the registered manager who would immediately come to the home to assist.

We discussed staffing levels with the registered manager. She explained that they had tried to develop a flexible staffing system whereby care workers also worked in other roles, for example, one of the cooks also worked as a care worker, a laundry worker had been trained to work as a care worker and the activities coordinator helped out in the mornings by supporting people who needed help to eat and drink. The registered manager also did shifts at the home as a nurse and the director had occasionally done shifts as a care worker. The registered manager said the flexibility helped to minimise the use of agency staff and ensured the people who lived at the home were cared for by staff they knew. We saw that the home rarely used agency staff to cover shifts and one relative told us, "I like the fact they don't use agency staff."

We spent two days inspecting the home and this included observing the care people at the home received. We also used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us. Our observations showed that there were enough staff to meet people's needs as people received support quickly if they needed it, those that required assistance with eating and drinking received it promptly and care staff were visible around the home.

We checked the files of three staff members to see how they were recruited. The staff files provided evidence that appropriate pre-employment checks had been made to make sure the staff were suitable to work with vulnerable people and further checks had been made with the Disclosure and Barring Service (DBS). The DBS is a national agency that keeps records of criminal convictions and tells services about people who are unsuitable to work with vulnerable adults. The staff files held an application form, a record of the job interview, two references for each new staff member and photographic proof of identity. We also saw that the registered manager checked the Nursing and Midwifery Council (NMC) register annually to make sure the nurses employed were still registered. The NMC is the regulator for nurses and midwives in England; it maintains a register of nurses who are allowed to practice in this country. This meant that the service made sure the staff it recruited were safe to work with vulnerable people.

We looked at the records for gas and electrical safety and manual handling equipment checks. All the necessary inspections and checks were up to date. Regular fire drills had been held with staff and people at the home in the last year. All the fire extinguishers had been checked and were in date. We saw records of weekly fire checks and 'walk arounds' which included lighting and obstructions. Any actions identified had been passed onto the maintenance man to remedy. We also checked fridge and freezer temperatures and found that had staff recorded these daily.

Requires Improvement

Is the service effective?

Our findings

We asked people and their relatives if the care workers were well trained. One person replied, "Yes they are", and another said, "Yes, I suppose so." All the relatives we spoke with said they thought the care staff were well trained; one relative told us, "The staff know what they're doing", another said, "I watched [my relative] being transformed. She is much better now than she was when she first came in." Another relative added, "They are very competent."

We saw the home's training matrix for 2015 which had training courses identified for staff on a monthly basis. Care workers told us they had received some training, however, records showed that most training had stopped at the home in July 2015 when the previous training coordinator had left their post. This meant that the only training that had taken place in 2015 had been understanding dementia, moving and handling, safeguarding medicines management, health and safety and infection control). This meant that staff had not received training in areas such as fire safety, first aid, MCA/DoLS, record keeping, food hygiene, challenging behaviour or equality and diversity and not all staff had attended the training provided.

We discussed the lack of training provided by the home to its staff with the registered manager. She emphasised that Bradley House Nursing Home had an established and stable team of care workers, many of whom had worked at the home for a number of years, which meant they had a wealth of experience. During the inspection we spoke with the care workers about a range of subjects including dementia awareness, managing behaviour that can challenge others, nutrition, equality and diversity and safeguarding and the staff were able to demonstrate that they had knowledge and could provide examples of using that knowledge as they supported the people living at the home. The registered manager said that she was in the process of accessing other sources of training and was hoping that a newer member of the care team would take over the training coordinator role. At the time of our inspection a comprehensive programme of training was not in place to provide staff with regular training updates. This meant that care workers may not have had the right skills and experience to support the people who used the service safely.

We asked for records of care of workers' inductions but none could be provided. In addition, the home had not implemented the Care Certificate for workers new to care which started in April 2015. The Care Certificate is a set of standards against which the competency of staff new to health and social care can be assessed. It is not a legal requirement but if services do not use it they must be able to demonstrate how their own induction prepares new care workers to support people safely and how care workers' competence has been assessed. We spoke with an experienced care worker who had recently started working at Bradley House Nursing Home. They said their induction had consisted of five weeks shadowing another established member of staff but did not include any other formal training or competency assessment. The home had no formal induction or competency assessment process for new staff, which meant that the people may be supported by care staff without the right skills and experience to do so safely.

This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service had not ensured that staff employed received the appropriate training and support necessary for them to carry out their duties.

At the last inspection in April 2015 we recommended that the service sought advice about formalising and recording staff supervision, as the registered manager had said that team meetings were the only means of staff supervision at that time. Staff supervisions can either be one-to-one with a manager or as part of a group of peers and provide a useful opportunity to discuss training needs, any concerns about job roles or to explore incidents in more detail in order to learn from them. The home's supervision and appraisal policy and procedure stated that staff should receive supervision at least six times a year. We checked six staff supervision records and found that staff were receiving either group or one-to-one supervision in line with the home's policy. Subject areas discussed included training and development needs, infection control, whistleblowing and safeguarding. We saw that staff had yet to receive annual appraisals, however, the registered manager confirmed that the upcoming round of one-to-one supervisions would include an appraisal. This meant that since the last inspection the registered manager had implemented regular staff supervision in line with the home's policy.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures of this in care homes and hospitals, is called Deprivation of Liberty Safeguards (DoLS).

All of the people living at the home lacked mental capacity and had complex health care needs which meant they required constant supervision or would be prevented from leaving unaccompanied, so applications for DoLS authorisations were necessary. We checked three DoLS authorisations for people living at the home to see whether the service was working within the principles of the MCA. We saw that capacity assessments and best interest decisions for DoLS had been completed properly by the home and applications had been made to the local authority. The registered manager understood the process of applying for DoLS and had a list of people living at the home whose DoLS authorisations were going to expire and would require reauthorisation. She was also in the process of completing applications for the people most recently admitted to the home. CQC had been correctly notified of applications for DoLS which had been authorised.

We looked in people's care files and found that capacity assessments and best interest decisions had been carried out for the various aspects of care and treatment provided by the home and for the use of bed rails to keep people safe at night. We asked people's relatives if they were involved in making best interest decisions. Three relatives we spoke with said they were involved, one said, "All the time", another said, "Yes they always do. For example I got some cot sides [bed rails] installed."

Best interest decisions were also made for those people with DNACPR forms and had involved a GP and their families. DNACPR stands for 'do not administer cardiopulmonary resuscitation' and people with mental capacity can decide this if they do not wish staff to try and revive them in the event of a cardiac arrest. DNACPR decisions can also be made for people who lack capacity by a GP after a meeting has been held to establish that the decision not to attempt resuscitation would be in a person's best interests.

People's communication care plans contained details on their level of cognition, what decisions they could make for themselves and how they would communicate their consent or otherwise. During this inspection we saw that MCA/DoLS training had been planned for October 2015 but had not been carried out. However, when we spoke with care workers to ascertain their knowledge of MCA/DoLS they could describe aspects

such as capacity, best interest decisions and the process followed when a person subject to a DoLS died at the home. Care staff also gave us with examples of how they promoted people's capacity to make their own decisions by providing choices, for example, different foods to eat, which clothes to wear, what activities to take part in and what time people wished to get up and go to bed. This meant that despite staff not receiving regular training in MCA/DoLS, they were knowledgeable about the legislation and how it impacted on the people they cared for.

We asked people and their relatives what they thought about the food served at Bradley House Nursing Home. When asked if there was a choice of food one person said, "No", and another person said, "Yes." Both agreed that they got enough food to eat at mealtimes. We asked relatives if there was choice at mealtimes, one said, "Yes kind of, but there are certain foods that [my relative] loves but they don't supply", and another said, "If she asks for something they give it to her." One other relative we spoke with said, "The food is great."

Dining tables were set with cutlery and napkins, and people could also choose to eat in their chairs in the lounge areas or in their own rooms. We saw that people had soup and a sandwich for their lunch followed by a piece of cake. The main meal of the day was served at tea time and was shepherds' pie and vegetables on the first day of our inspection. One of our inspection team ate lunch with people using the service. They thought that the quality of the food was acceptable and the portion size was adequate. People who used the service were offered a choice of drinks several times during the lunch time period. During the meal we also saw that care workers promoted people's independence by encouraging them to eat meals by themselves; however, when it was clear that people couldn't manage or required assistance it was provided promptly.

We noted that the service used a four-weekly rolling menu and people using the service were not offered a choice of options for main meals. We were informed by the director that the home used to have two hot meal options per day at tea time but they found that this led to a high degree of food wastage. The cook we spoke with said that instead of offering two main meal options they had learned by speaking with people and their relatives what individuals liked and didn't like; they could describe each person and their food preferences to us. The cook also said that the four-weekly menu could be changed if people did not like certain foods and gave an example of substituting shepherds' pie for liver and onions, as the latter had not proved popular. We also saw that if people did not like the food they were offered at mealtimes they were immediately presented with alternatives to choose from and there was a sign on the wall outside the kitchen that said, "Alternatives always available, a variety of refreshments." During our inspection we observed the cook patiently offering a range of breakfast options to a person who seemed indecisive. The person eventually decided on fried egg and bacon on toast and we saw that it arrived promptly and the person enjoyed eating it. This meant that even though people were not offered a choice of main meals in advance, the cook tried to accommodate people's food preferences and alternatives could be requested.

Records of people's food and nutritional requirements were kept in the kitchen, for example, who was diabetic, who needed assistance with their meals and who needed soft or pureed foods. When people have problems swallowing their food it can increase their risk of inhaling it which can lead to chest infections. People with swallowing problems are referred to speech and language therapists (SALTs) for advice on what consistency of food and liquids is safest for them. We saw that the people who had problems swallowing had all been assessed by a SALT and the cook knew which consistency of foods individuals needed and how to prepare it. We also saw that the different components of a meal, for example meat, potatoes and vegetables, were pureed separately. Care workers supporting the people were also aware of individuals with swallowing issues. During one meal we saw a person starting to cough at the dining table; a care worker noticed straightaway and checked the person was all right and then monitored them for the rest of the meal. This meant that people's nutritional needs had been assessed and they were supported to eat safely.

The cook was also knowledgeable about the methods which could be used to fortify foods for people either losing weight or at risk of weight loss; they also contacted the dietician if they had any questions or queries about which foods to offer people. We looked at the daily records of one person identified as underweight and found that food and fluid charts had been completed for each meal although they did not always record the exact amounts of foods the person had eaten. Failure to weigh people regularly was identified as a breach of the regulation relating to good governance at the last inspection in April 2015, so we checked the weight records of six people whose care plans stated they must be weighed weekly and we found that these were in order. Where people had refused to be weighed this was also recorded. This meant that the service was aware of those people who were either underweight or at risk of weight loss and made sure they were monitored according to their care plans.

We saw that people had access to a wide range of healthcare professionals and facilities. Records showed that staff recognised when people were unwell and sought professional advice. People were supported to attend healthcare appointments such as their GP, the optician, chiropodists, social workers, dieticians and mental health services. This meant that the service supported people to meet their holistic health needs.

We saw that the building had been modified to make it dementia-friendly. There are ways to design environments for people living with dementia in care homes, for example, by the use of plain carpets, wall colour and curtains to reduce visual disturbance as well as pictorial signage and door photographs to help people to navigate. The walls and flooring at Bradley House Nursing Home were either plain or had muted patterns, 'memory boxes' containing people's photographs and other memorabilia were on the walls outside their rooms, picture signage was in use and each person's bedroom door was a different bright colour and had a knocker and letterbox to make it look like a house front door. We also saw corridors had themed photographs, such as black and white movie stars, and there were some distraction objects on walls with moving parts that could engage those living with dementia. This meant that the service had followed up to date guidance to make the environment dementia-friendly for the people who lived at the home.

Good

Is the service caring?

Our findings

We asked the people using the service if the staff were caring. One person told us, "Yes they are caring." We also asked people's relatives if they thought the staff were caring, they told us, "Yes I do", "Very. That is what is so nice here", and, "Yes they are lovely." Another relative we spoke with told us, "I love it – they're great. I don't know how they do it."

During the inspection we asked the care workers about the people that they supported. We found that care workers could list the likes, dislikes and preferences of each person at the home. They also knew people's personal histories, such as which jobs they had done, what activities they liked, where they had lived and who their family and friends were. It was clear that the registered manager and director also knew the people well and both demonstrated a passion for the people they supported. On one occasion we saw one of the people who used the service giving the registered manager a hug. We found there was a relaxed and happy atmosphere at the home and that care workers knew the people they supported as individuals. This finding was supported by the most recent relatives' survey, the results of which were released just after our last inspection in April 2015. 100% of the 16 relatives who responded agreed that all the staff appeared to understand their relative or friend as an individual and knew what was important to them.

We observed the interactions between people and care workers for the two days of our inspection. All the staff we saw spoke to people in a respectful and polite manner and we saw many examples that demonstrated to us that the staff genuinely cared for the people they supported. We also saw humorous banter exchanged between the people and care workers and heard laughing and joking. One example of a positive interaction included a care worker getting down to eye level with a seated person who had a visual impairment in order to speak with them. The care worker was smiling and friendly and explained that they would be back shortly; the care worker then checked that the person had understood and person gave them a kiss on the cheek and waved goodbye. Another positive interaction we saw involved a person who was tired after lunch. A care worker asked the person if "they would like to sit on a comfy chair." The care worker then supported the person to the chair. The whole interaction was respectful and person-centred, with the care worker explaining everything they were doing to the person before doing it. The care assistant ensured the person was comfortable and brought a drink to them before they continued with other duties. Throughout the inspection we saw that care workers knocked on doors before entering people's rooms and referred to people using their preferred form of address. This showed us that the staff were caring towards the people using the service and respected their privacy and dignity.

We noted that the language and terminology used to describe people in written notes and care plans was also appropriate and never negative, even when the people had displayed behaviour that could challenge others. A relative we spoke with about the staff said, "Sometimes [my relative] is so aggressive and angry and yet they're so polite." We also saw staff intervening to try and prevent people who were confused from becoming upset by talking gently to them or inviting them to engage in an activity. This meant the staff understood the people they were supporting and did not judge them negatively if they displayed behaviour that could challenge others.

At the last inspection in April 2015 we identified a breach in the regulation relating to person-centred care, as not all care plans were saw were individualised. In order for care provided to be person-centred, people and their relatives (if appropriate) should be involved in designing care plans and interventions. When people lack mental capacity it is important to involve family and friends who know them well to help plan care that is individualised. We wanted to find out how people's care had been planned so we looked at six people's care files and spoke to people and their relatives. All the care files contained a brief personal history at the front which gave details such as people's past employment and food likes and dislikes. People's care plans were person-centred and demonstrated an understanding of people's personalities and preferences, as well as their care needs. For example, one care plan detailed how a person liked to have their facial hair trimmed in a certain way. We also saw that people's rooms contained a whiteboard that listed people's favourite foods, sporting activities, preferred form of address and other facts, information and preferences. Care staff said that people's relatives were encouraged to write information on the boards to help them provide more individualised care and give ideas for topics of conversation the care staff could engage the person with. We spoke with one person's relative about the poster and they said they had been involved in filling it in and thought it was a great idea.

The people using the service that we spoke with were unable to tell us if they were involved in planning their own care. However, 94% of the relatives who responded to the most recent survey agreed that they were involved in the gathering of information about their relative or friend. One relative had replied, "I feel I am always informed of issues relevant to myself and [my relative]", another relative wrote, "I have been invited in to discuss [my relative's] care and staff are always available for discussion when I visit." All the relatives we spoke with during this inspection said they were involved in the planning of their family member's care. One relative told us, "Yes they tell me what they are going to do." This showed us that when people lacked the mental capacity to help plan their own care, people's relatives were asked for their input so that care plans and interventions could be personalised.

We saw that people's bedrooms had been personalised with their own furnishings, ornaments and pictures. We inspected in December 2015 and noted that the home was festooned with Christmas decorations in both the communal areas and in each person's bedroom. A lot of the decorations appeared handmade and when we asked a care worker we were informed that the activities coordinator had spent the last couple of weeks involving the people living at the home in making decorations. This showed us that people were encouraged to individualise their rooms and the staff also tried to encourage the people to make the building welcoming and homely and respected people's wishes to celebrate Christmas.

People's relatives that we spoke with told us that they could visit the home at any time and were always made to feel welcome by the staff. The registered manager said that relatives were invited to have meals at the home at any time and this included celebrations such as people's birthdays and Christmas Day. One relative we spoke with said, "The staff make me feel welcome and always thank me for coming when I leave."

People living at the home were referred to advocacy services when they needed them and two people at the home at the time of our inspection had an advocate. The registered manager provided examples of when people had been referred to advocacy services; these included when major decisions needed to be made, such as whether a person should have an operation, and when people's relatives disagreed about their care. The registered manager said that at the time of our inspection nearly every person at the home had relatives who visited regularly and were involved in their care and could hence advocate on their behalf when required.

We asked about the end of life care that was provided by the home. The aim of end of life care is to ensure

that people who are dying are as comfortable as possible and can make choices about their care. No person at the home was receiving end of life care at the time of our inspection so we read people's care files and spoke with care staff and people's relatives instead. Only one of the six care files we looked at contained an end of life care plan; it contained information from the person's relative about where the person would most likely want to be cared for when they died.

We asked the registered manager and director why all of the people did not have an end of life care plan in which their wishes or the thoughts, or those of their relatives (if a person lacked capacity) could be recorded. The director said that end of life discussions were delicate and could make people and their relatives get upset, especially when people were first admitted to the home. He said they preferred to wait until they had got to know the person and their relatives better before broaching the subject, but always did so if a person's health deteriorated such that they appeared to be approaching the end of their life. This showed us that the service made plans for end of life care in advance but were sensitive when discussing people's wishes with them or their relatives if the person lacked capacity.

One relative we spoke with said that the registered manager had spoken to them sensitively about their family member's end of life wishes. Another relative had emailed the registered manager in November 2015 to thank her for being sensitive and caring when discussing their relative's end of life needs. We also spoke to care staff about end of life care. One care worker said, "One of the biggest things you can do for people is to help them die with dignity." This told us that the service was prepared to meet the needs of people using the service who were at the end of their lives and did so in a sensitive and caring way.

Good

Is the service responsive?

Our findings

At our last inspection we found a breach in the regulations because care plans were not person-centred and varied in the level of detail they contained. As part of this inspection we looked in detail at the care files of six people who used the service. We found that each person's care file had a consistent structure, with personal details first, then risk assessments followed by care plans. We saw that people's risk assessments for aspects such as falls, bed rails, nutrition and pressure areas were updated monthly. The care plans that we saw were very much person-centred and included details about people's preferences and personal history. Whilst they were concise, the care plans gave sufficient detail for care staff to understand how each person liked to be supported. The care plans we saw were evaluated monthly and people's interaction with other healthcare professionals was recorded in the relevant care plan.

We asked the care workers how they ensured the care they provided was person-centred. One care worker said, "I talk to them (the people)", and another care worker said, "It's all about treating the resident as an individual and knowing them well." One member of care staff we spoke with about the care plans in place at the home said they thought they were, "Totally person centred." A comment from the most recent relatives' survey in March 2015 (results complied after the last inspection) stated, "Bradley House is amazing, they look after them (the people), keep them clean, get regular haircuts then treat each person as an individual, not all the same."

The service was responsive to people's changing care needs. The office diary we looked at was used to identify which person's care plan was to be reviewed that day on a rolling programme. We saw an example whereby a person had been referred to a dietician in September 2015 due to weight loss. The care plan evaluation showed that the person was still losing weight in December 2015 despite input from the dietician so the evaluation identified the need for a GP referral. We saw that this was acted upon promptly and the GP was contacted.

In addition to daily records, each person also had a room file in which other aspects of care were recorded. These included a record of the personal care that staff had assisted the person with, topical cream charts and body maps, position charts for those people who need help to turn over in bed and a pressure mattress log, whereby each mattress was checked regularly to ensure it was working properly. We checked six people's room charts and found that they had been completed and were up to date. This meant that people were receiving the care interventions they needed and staff ensured that accurate records were kept.

Bradley House Nursing Home had an innovative method of recording night time care interventions provided by the care workers. Each bedroom had a barcode on the wall next to the light switch which the night care staff swiped with a hand held device as they entered the room. This hand held device was then used to record the care the person was assisted with or other checks that were made, for example, continence care, whether bed rails were in situ or if the person was in bed or not. We saw that the director could interrogate the electronic system to find out what support people had received and when during the night. The director told us that the system was a useful way of understanding the amount of support each person required at night and therefore how care staff time was spent. It also meant that night care workers could focus on

providing care rather than on writing notes kept in people's rooms, thereby allowing people to sleep.

During the two days we spent inspecting Bradley House Nursing Home we saw that the people who lived there were supported to take part in activities and were also provided with other stimulation, such as conversation or music, by the care workers. The home employed a full time activities coordinator who was very enthusiastic about their role. We looked at the records kept by the activities coordinator; they listed people's names, the activities they had done or had chosen not to participate in and the date. Keeping records helped to ensure that the activities coordinator spent time with every person at the home and could identify which activities each person liked and disliked. We asked people if they had enough to do. One person said, "Yes, and I am not bored."

Relatives described the activities that the people at the home had been involved in; these included a canal boat trip in September 2015, entertainers visiting the home, a trip to the zoo, walks around the garden and trips to a local coffee shop. The director said that regular trips were arranged to the local pub, nearby gardens and to the church for coffee mornings. A church representative provided non-denominational religious support for people weekly at the home. We inspected the home in December 2015 and found that a range of Christmas festivities were planned, including a big party for all the people and their relatives with various carol singers and entertainers. Two relatives of one person who lived at the home came in annually at Christmas to sing carols for everyone and there had even been a donkey in the conservatory the week prior to our inspection that the people had enjoyed seeing and touching.

During the inspection we observed the activities coordinator and other care workers engaging people with games and activities, as well as with individual and group chats. We saw that people were asked their preferences as to whether the television or radio was on in communal areas. The home also subscribed to a regular newsletter of historical news reports, poems and old film reviews. The director said that whilst few of the people living at the home would read the newsletter, the staff found it was a useful source of information for starting reminiscence conversations that the people could engage with.

The results of the most recent survey showed that 100% of relatives agreed that their relative/friend was supported to enjoy a range of recreational and social opportunities that were meaningful and enjoyable. One relative commented on their survey, "They have activities for them (the people) to join in and treat everyone as individual." This showed us that people at the home were supported to take part in a range of activities.

There was a system of reporting and responding to complaints and concerns in place at the home and the complaints procedure was clearly displayed. We checked the complaints file and noted that no complaints had been made since our last inspection in April 2015. One person we spoke with said that they had never made a complaint; we asked the person if they knew how to make a complaint and they said, "Yes. I would see the manager." All the relatives we spoke with said they had never made a formal complaint. A relative said that they had reported a problem with furniture in one person's bedroom, but they were happy the issue had been resolved quickly. We asked the relatives if they knew how to make a complaint and all said that they did. They told us, "If there was a complaint I would see the manager", "I would speak to [the registered manager] or [director]", and, "I would speak to [one of the nurses]." This showed us that relatives felt confident to raise any issues or problems directly with the registered manager or other senior staff at the home.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager who had been in post for over five years. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We asked people and their relatives what they thought about Bradley House Nursing Home and the way it was run. One person told us, "The atmosphere is good." Another person described the registered manager as, "Great." Relatives we spoke with said of the registered manager, "She is very hands on", and, "She is very approachable", and of the registered manager and director, "Very good", "They are lovely and very nice people", "If I have any problems or want to discuss anything, they listen to you", and, "I particularly like that the owners run the place."

At our last inspection in April 2015 it was identified that there were issues with consistency in audit at the home which constituted a breach of the regulation relating to good governance. During this inspection we looked at the audit systems that were in place to ensure the quality and safety of the service was maintained and improved. We found that slips, trips, falls and minor injuries were audited as accidents and incidents. Each month the number of incidents were recorded and the way in which each accident or incident was investigated was checked, however, we could not see how this information had been used to create action plans to minimise or prevent future occurrences. This meant that potential trends were not identified so that lessons could be learned.

Infection control audits in 2015 had focused on the persistent odour noted earlier in this report. We saw that actions had been identified and carried out in response issues that had been identified; for example, one person's bedroom carpet had been replaced due to its smell. However, infection control audits looking at general cleanliness of rooms and equipment had not been carried out. An audit carried out by an NHS infection control nurse found issues with carpet and equipment cleanliness in October 2015 which was addressed by the home, however, there was no evidence that there had been any subsequent auditing to ensure standards were being maintained. This meant that issues may have reoccurred but had not been identified.

We saw that the registered manager was auditing a sample of people's care plans on a monthly basis and that action plans were added to people's care files when issues were identified. Audits of the information recorded in people's rooms, including cream charts, air mattress pressure logs and daily personal care records had each been audited a maximum of three times in 2015. We saw that all but one of these audits had identified actions but no action plan had been drawn up, so that it was not possible to see if these actions had been addressed. For example, one audit of 17 people's air mattress pressure logs in June 2015 found that five people's mattresses were not checked daily and an audit of all people's room records in July 2015 found that two people's cream charts were missing. Audits of the building environment had been carried out twice in 2015; both had identified issues, for example, cluttered communal areas and soiled

carpets, but there was no action plan or other information to show how issues had been resolved. This showed that most audits were sporadic and action plans were not always drawn up when issues were identified, so improvements might not be made when they were needed.

We checked to see how medicines were audited by the service. We found that medicines had been audited by the registered manager once in 2015. This had involved checking the drug trolley, the clinic room, medicine administration records, the system for ordering and returning drugs and an observation of a medicine round. The audit had not encompassed controlled drugs, the stock in the fridge or whether the fridge temperature was recorded. The audit had also not looked to see if other aspects required by the home's medicine policy, such as medicine protocols for 'as required' drugs (discussed earlier in this report) were in place. This meant that medicines were not being audited regularly or comprehensively.

At the time of our inspection the service did not have effective systems in place to monitor and assess the safety and suitability of care provision. This was an ongoing breach of Regulation 17 (1) and (2) (a) (b) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home surveyed people's relatives and friends about the quality of the care and other aspects of the service in March 2015 and the results were made available after our last inspection in April 2015. Thirty surveys were sent out and 16 were returned. 87% of respondents agreed that the service promoted people's human rights and that systems to protect people's safety were in place. Comments made by visitors and relatives in response to the survey included "I have complete confidence in their care for [my relative]", "It's [the home] become tired and in need of upgrading but the care and dedication of the staff is superb", "This is an excellent facility", "Bradley House is a very well run and efficient home and I have complete confidence in their care for [my relative]", "We have good communication with the carers at Bradley House. They let us know if any problems as soon as possible", and, "All round great place, glad [my relative] lives here."

We noted that the survey response summary and an action plan were displayed at the home for relatives and visitors to see. The action plan included addressing the environment and cleanliness of the home (as discussed earlier in this report).

We spoke with the registered manager and director about the methods they employed to generate feedback on the quality of the service. The director said that staff, relatives and other healthcare professionals were surveyed on a rotating basis. The home did not survey the people who lived there. We asked why this was and the director said it was because the people were living with dementia and could not therefore complete a written survey similar to the ones used for other stakeholders. The director said that the service would explore alternative ways of surveying the people, such as asking people's friends and relatives to support them to provide feedback. This meant that that at the time of our inspection the home was not actively seeking the views people using the service on its quality.

The home was not holding meetings for people's relatives and friends at the time of our inspection. The registered manager said that it was not something the home had ever done and was not aware that there was a need for them. She said the home operated an open door policy and relatives were encouraged to feedback any issues to her in person at any time; our discussions with people's relatives supported this. The director told us that the home issued a quarterly newsletter as a way of keeping people and their relatives up to date with upcoming events or any changes at the home. We read the December 2015 newsletter; it contained details of the planned Christmas festivities as well as other news about the home. This newsletter was posted or emailed to people's relatives according to their preference. The registered manager did say that she would contact people's relatives and ask them if they wanted to have a relatives' meeting, and if they did, she would organise it.

We asked the staff if they felt supported by the registered manager; they told us, "Yes, she spoils me", "If I need help, phone [the registered manager] and she comes in", "Yes I feel supported by her and everyone else", and "You can go and talk to her if you have any worries at all. There's an open door policy." Other staff said of the registered manager and director, "If I have a problem I can go to them", "I like it here, the management are very approachable", "Everyone gets on brilliantly with them – they're always there", and, "There's an open door policy." Staff described the atmosphere at the home as, "Very good indeed", "Really good", and, "Very good. Everybody is so friendly and helpful."

Staff meetings were held for care workers every six to eight weeks; discussions were minuted in a book. Care workers we spoke with confirmed they attended the meetings and that they were held at different times to maximise attendance. We checked the minutes of the meetings held in 2015; topics discussed included teamwork, Deprivation of Liberty Safeguards, new advice from the government on hoist safety and the completion of people's cream and food and fluid charts. The registered manager said that care workers were encouraged to feedback their ideas for service improvement at staff meetings. This showed that staff meetings were used as a forum for the discussion of good practice and service improvement.

The home also had an 'employee of the month' scheme, whereby staff at the home voted for the staff member they thought deserved the accolade. The registered manager said that she and the director also fed into the process and made the final decision each month, taking on board any feedback received from people, their relatives or other healthcare professionals about staff performance. This meant that staff at the home were provided with additional incentives to provide quality care to the people.

We asked the registered manager how national guidelines and best practice were used to ensure that the care provided was evidence based and in line with current thinking. She provided us with several examples where government advice and guidance had been implemented at the home. These included good practice in the use of bed rails, the safe storage of thickeners for people's drinks to prevent asphyxiation and the use of National Institute of Clinical Excellence (NICE) guidelines on diabetes and pressure ulcers to write care plans. We also saw that the home's policies and procedures referred to guidance published by bodies such as NICE as well as to the relevant legislation. This meant that the registered manager ensured that nursing and care practice was evidence based and up to date.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had not assessed the premises to ensure they were safe to use for their intended purpose. Regulation 12 (1) and (2) (d) The service had not assessed the risks to the health and safety of service users or done all that is reasonably practicable to mitigate any risks identified. Regulation 12 (1) and (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The service had not ensured that staff employed received the appropriate training and support necessary for them to carry out their duties. Regulation 18 (2) (a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	Safeguarding incidents were not reported to CQC in accordance with the Regulations.

The enforcement action we took:

Fixed Penalty Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	At the time of our inspection the service did not have effective systems in place to monitor and assess the safety and suitability of care provision. This was an ongoing breach from the last inspection.

The enforcement action we took:

Warning Notice