Maria Mallaband 17 Limited

Bowerfield Court

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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 15 and 16 August 2016 and was unannounced. The provider had changed legal entity in 2015 and this was the first inspection under this new provider registration.

Bowerfield Court is a nursing home in High Lane, Cheshire. The home is a purpose built facility registered to provide accommodation and nursing care for up to forty people including younger people with high level physical needs and older people, some of whom were living with dementia. The home also supports respite placements and provides end of life care. At the time of the inspection there were 38 people living at the home.

The manager told us she had recently been subject to a fit person interview by a CQC registration inspector and was awaiting final confirmation of her registration. We noted subsequently that her registration with the CQC had been approved. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People said they felt safe living at the home and said the staff treated them well. Staff had received training with regards to safeguarding and demonstrated an understanding of potential abuse. We initially found that stairwells and fire exits were used for the storage of equipment and wheelchairs, including an electric wheelchair with it's battery charging. By the second day of the inspection exits and stair wells had been cleared to allow safe evacuation of the building in an emergency. Windows on the upper floor did not have restrictors or devices that met with current Health and Safety Executive guidance for care homes and no risk assessments were in place. The manager told us she would immediately address this. Other checks and risk assessments on fire equipment, water systems and electrical and gas installations had been undertaken.

The home was generally clean and tidy throughout the inspections, although dining areas were not always well cleaned after meal times. The home used an electronic system to help manage medicines safely, although there were no clear systems in place to ensure people received topical medicines (creams and lotions). Topical medicines were not always dated when opened to ensure they remained in date to use and were always effective. Clinical rooms where medicines were stored were often at a temperature in excess of 25 degrees Celsius, meaning some medicines may cease to be safe or effective.

Suitable recruitment procedures and checks were in place, to ensure staff had the right skills to support people at the home. People told us there had been frequent use of agency staff in recent months and felt that staffing was not always sufficient to meet their needs. The manager and regional manager told us dependency assessments showed the home was properly staffed, although we noted the dependency tool did not specifically highlight the high physical needs of some people. We have made a recommendation to the provider regarding staffing at the home.

Most people told us they were happy with the standard and range of food and drink provided and could request alternative dishes, if they wished. Kitchen staff had knowledge of specialist dietary requirements. Soft or pureed diets were presented in a manner that supported people's dignity.

People and relatives told us permanent staff had the right skills to look after them, although were less sure about agency staff. Staff confirmed they had access to a range of training and told us, regular supervision took place. The manager told us annual appraisals were due to be undertaken.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 (MCA). These safeguards aim to make sure people are looked after in a way that does not inappropriately restrict their freedom. The manager told us a number of DoLS applications had been made, although none had currently been granted. There was some evidence that, where necessary, decisions had been made in people's best interests, in line with the MCA. However, some relatives had signed consent forms on behalf of people without the home being clear they had the authority to do so, through the legal granting of Power of Attorney.

People's health and wellbeing was monitored, with regular access to general practitioners and other specialist health or social care staff. People told us they were happy with the care provided. We observed staff treated people patiently and appropriately. Staff demonstrated an understanding of people's particular needs. People said they were treated with respect and their dignity maintained during the provision of personal care.

Care plans reflected people's individual needs and were reviewed to reflect changes in people's care. Daily records were not wholly person centred and tended to highlight care plan details rather than people's personal progress or outcomes. Some activities were offered for people to participate in including; entertainers visiting the home and group events. People and staff said they would like to see more activities at the home, especially for individually focussed events. The manager said this was an area she wished to develop in the near future. People and relatives told us concerns or complaints were dealt with appropriately. Formal complaint records were maintained and showed details of action taken.

The registered manager told us she carried out regular checks on people's care and the environment of the home. These audits and checks had not always identified some of the short falls highlighted at the inspection. Staff were positive about the manager and the changes in the service since her arrival. Some people questioned the effectiveness of her managing this home and the sister home next door. The manager told us that effective deputy arrangements were in place to support the situation. People told us there were regular meetings at which they could express their views or make suggestions to improve their care. Records were generally maintained and stored effectively, although some room based records were not always dated or detailed.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to Safe care and treatment and Good governance. We have also made a recommendation to the provider in relation to staffing at the home. You can see what action we told the provider to take at the back of the full version of the report.

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.

Some windows in the home did not have restrictors in place that met current guidance from the Health and Safety Executive and risk assessments had not been undertaken. People told us they felt safe living at the home and staff had undertaken training on safeguarding issues.

It was not possible to be certain that topical medicines had been administered in line with prescribed guidance and tubes of creams and other medicines were not always dated when opened. Clinical rooms, where medicines were stored were not maintained at a temperature to ensure medicines were safe and effective.

Suitable recruitment processes were in place to ensure appropriately skilled and experienced staff worked at the home. Some people and staff felt staffing numbers were not always sufficient, although managers said staffing hours were above calculated levels. The home was generally clean and tidy.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered manager was aware of the Mental Capacity Act 2005 (MCA) and formal applications under the Deprivation of Liberty Safeguards had been made. There was some evidence of best interests decisions being undertaken, although some relatives had signed consent forms without the home having clear evidence they were legally entitled to do so.

People told us food and drink at the home was plentiful and the enjoyed the meals. Meals for people requiring a softer diet were served in a manner that promoted dignity. The social aspect of meal times was not always considered.

People said staff had the right skills to support them. A range of training had been provided and staff received regular supervision and annual appraisals. People had access to health and social care professionals for health assessments and checks.

Is the service caring?

Good

The service was caring.

People told us they were happy with the care they received and were well supported by staff. We observed staff supported people appropriately and recognised their needs, likes, dislikes and personal preferences. Staff had a good understanding of people as individuals.

Some people told us they were involved in their care through regular reviews and frequent "residents' meetings." Relatives were kept informed of any changes to people's care or condition.

Care was provided whilst maintaining people's dignity and respecting their right to privacy. Where appropriate, people had plans in place detailing their end of life preferences.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

Some activities were available for people to participate in, including entertainers visiting the home. People and staff felt there could be more activities and more personalised activity time. People told us they were able to make choices about their care, including what they ate, whether they wished to remain in their rooms and what activities they engaged in

People and relatives told us the home was responsive to their needs. Care plans were in place that reflected people's individual care requirements. Plans were reviewed and updated as people's needs changed, although reviews could be limited. Daily records were not always person centred.

People were aware of how to raise complaints or concerns and said the manager responded to these issues. Formal complaints were logged with details of action taken. The manager said she was trying to encourage complaints as a way of improving quality at the home.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well led

The manager regularly undertook checks to ensure people's care and the environment of the home were monitored. However, these checks had not identified some of the issues noted at the inspection.

Staff told us the manager was still quite new in post but talked positively about the support they received from her and the deputy manager. People and their relatives described the manager as approachable.

There were meetings with people who used the service and they said they were able to express their views in these meetings. Records were maintained, although some room based records were undated and lacked detail.

Bowerfield Court

Detailed findings

Background to this inspection

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

This inspection took place on 15 and 16 August 2016 and was unannounced. This meant the provider was not aware we were intending to inspect the home.

The inspection team consisted of one inspector.

Before the inspection, the registered provider completed a provider information return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the home, in particular notifications about incidents, accidents, safeguarding matters and any deaths.

We spoke with five people who used the service to obtain their views on the care and support they received. We also spoke with a relative of a person who used the service, who was visiting the home on the day of our inspection. Additionally, we spoke with the acting manager, regional manager, deputy manager, a member of the nursing staff, two care workers, a member of the laundry staff and the cook.

We observed care and support being delivered in communal areas and viewed people's individual accommodation. We reviewed a range of documents and records including; four care records for people who used the service, the home's electronic medicine administration and recording system, four records of staff employed at the home, complaints records, accidents and incident records, minutes of meetings with people who used the service or their relatives and a range of other quality audits and management records.

Requires Improvement

Is the service safe?

Our findings

On the first day of the inspection we walked around the home on our arrival. We noted several stairwells had been used for storage of items of equipment and wheelchairs. There were also several wheelchairs stored on the landing areas and in some cases partially obstructing a fire exit. It is important fire exits are kept clear and no potentially flammable material is stored in stairwells, which are a means of escape in the event of a fire. We also noted a battery for an electric wheelchair was being charged on a landing area, whilst placed on the material part of the wheelchair. This could pose a potential risk if the battery overheated during charging. We brought these concerns to the attention of the manager. By the second day of the inspection we found stairwells and landings had been cleared to ensure emergency exits were not blocked or restricted.

We also noted during our walk around the home several cupboards containing linen and incontinence equipment were left open or unlocked. The cupboard doors clearly stated these were fire doors and should be kept locked for safety. This meant there was a potential risk that combustible material was not effectively stored in the event of a fire. We again spoke with the manager who ensured doors were kept closed.

Windows on the upper floor of the home had window restrictors fitted. However, we noted they did not meet the full Health and Safety Executive specification for window restrictors in care home, in that they could potentially be loosened. We asked the manager if there were risk assessments in place in relation to the window restrictors at the home. The manger confirmed there were no current risk assessments, but felt that the current client group at the home were at low risk of falls. However, she said she would look to address the matter as soon as possible. This meant there was a potential risk to people because the proper equipment was not in place and appropriate assessments had not been undertaken.

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

The home used an electronic medicines management system, to record people's medicines and ensure they were administered correctly. Nursing staff demonstrated how the system worked including the number of failsafe systems to limit any missed medicines. Staff showed us how photographs of individuals would not grey out until all their medicines had been recorded as given. There were also systems in place to ensure new medicines were entered correctly with a signature required from a second nurse when any new medicines were added to the system. There was also an indicator that stated what percentage of medicines had been completed at any one time and nurses said they always checked this said 100% before leaving their shift. Nursing staff said the system had only recently been introduced and that it was still a slow process, as they were still learning how to use if effectively.

We noted a number of people at the home were prescribed topical medicines for certain conditions or to protect their skin. Topical medicines are those applied to the skin, such as creams and lotions. Nursing staff told us these were recorded on the electronic system as being either self-administered or that care staff had administered them. We saw there was no other record of whether these topical medicines were

administered by care staff and therefore could not be sure they were always used in line with the prescription instructions. We also saw some creams and medicines kept in people's room were not dated when opened. Many creams have a limited shelf life once opened and so it is important to identify the date they were first used. One item found in a person's room was un-named, so we could not be sure the cream was being used solely for the individual. This meant there was no system in place to ensure topical creams at the home were applied safely and effectively. We spoke with the manager about this and she told us on the second day of the inspection that action had been taken to address the matter.

We also noted the clinic rooms where medicines were stored were excessively warm. Medicines should be stored at a temperature of 25 degrees Celsius or below to ensure they are maintained in good condition. For one clinical room the temperature was recorded as being above 25 degrees for 15 days in the previous month. The deputy manager stated fans had been placed in the rooms, but these had not been effective. She said the provider's estates department were looking at how to tackle the problem. This meant medicines were not stored in such a way to ensure they were safe and effective when administered.

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

People told us they felt there was not always enough staff. They said that because a number of staff had recently left, there had been a high use of agency staff, although they also commented the home tried to use regular agency staff who were familiar with people's needs. Some people in particular raised the issue of nursing staff numbers in the afternoon and on the night shift. Comments from people included, "They always seem pushed to the limit"; "The staff seem pushed to the limits; they are really feeling demoralised"; "They could do with more staff in the evening. I sometime have to wait for them to come" and "There are never enough staff. You could always have more." One relative told us, "There are times when there are not enough. Weekends are sometimes short staffed and sometimes at night." One person suggested medicines at night could sometimes take an unfamiliar nurse a number of hours to complete.

Staff we spoke with said they it depended on the shift, but sometimes it could be busy and it didn't take "much out of the ordinary" to make the shift seem pressured. The deputy manager told us she had been concentrating on clinical shifts at the home, rather than utilising her administrative time, to help maintain consistent nursing levels. She said senior care staff had been trained to support nursing staff with additional activities, such a flushing PEG tubes (percutaneous endoscopic gastrostomy). A PEG is a tube that goes directly into a person's stomach where they cannot eat normally or can only take a limited amount of food orally. However, nursing staff were still required to give medicines via PEGs. One nurse told us the majority of nursing time on an afternoon shift was spent supporting people with their medicines, because there were so many people with a variety of abilities and needs and only nurses currently administered medicines.

We looked at the duty rotas for the home and saw each day shift was covered by two nurses and seven care workers in a morning and one nurse and six care workers in an afternoon. Staffing numbers listed on the daily handover sheets did not always tally with the rota numbers. Duty rotas confirmed several shifts required cover by agency staff or existing staff working additional hours. We saw in one set of staff minutes that nursing staff had said they 'felt vulnerable' with only one nurse on an afternoon shift. We also noted there was a single laundry worker, working only six hours a day. We spoke with a member of the laundry staff who told us that night staff and care staff tried to help, but it could be difficult at times. They said there were often six bags of heavily soiled linen, which could take an hour each to wash, and additional machines may also be helpful.

We spoke with the manager about staffing. She confirmed that because a number of staff had recently

moved on, this had left a gap in staffing, particularly nursing. She confirmed agency staff were used at the home and that they tried to get regular agency staff to provide continuity of care. She said that since her arrival at the home one of her priorities had been to increase staff recruitment. She told us nurses from other areas of Europe had been recruited and were currently awaiting their registration in the UK from the Nursing and Midwifery Council.

The manager and regional manager demonstrated the home's dependency tool to us. The regional manager stated the home was staffed above the calculated hours as detailed by the dependency tool. They showed us the home's dependency report for July 2016, which was used to determine staffing hours. The report covered areas such as support required to transfer position, support with continence and any behavioural issues. Whilst the tool considered people's general physical daily care needs, we noted there was little reference to the more extensive health needs of the particular group of people living at the home. In particular, there was no reference to the extensive use of PEG feeding systems at the home or other more detailed care. One person told us they required three staff to assist when they were hoisted.

We recommend the provider considers adaptations to the dependency tool for the home to take account of the high level of health and nursing needs of people living at the home and reviews nursing and general staffing numbers for the home.

People and their relatives told us they felt safe living at the home. They said they felt safe when staff supported them and that the staff's approach was good. One person commented, "I feel safe with the staff; they are okay." A relative told us, "I trust the care. I feel that they are in safe hands." Staff told us, and records confirmed they had received training in relation to safeguarding vulnerable adults. Staff were able to tell us what actions they would take if they had any concerns about people's safety at the home. Records showed there had been six potential safeguarding incidents logged since the start of 2016 and action had been taken accordingly. The manager told us about a recent event she was in the process of referring to safeguarding and we noted she was following the correct procedure.

A range of risk assessments and checks were being undertaken at the home. These included checks on fire equipment, such as extinguishers, emergency lighting and door closing systems. Checks were also undertaken on water systems and lifting equipment to confirm it was safe to use. We saw copies of electrical and gas certificates and Portable Appliance Testing (PAT) on small electrical items. People's care plans contained risk assessments related to the delivery of their care and each person had a personal evacuation plan regarding the action that should be taken to support them in the event of a fire or other emergency. Accidents and incidents were recorded and reviews took place to help identify any concerns or trends that may emerge from such incidents.

Staff files contained evidence of an effective recruitment process. We saw evidence of an application being made, references being taken up, one of which was from the previous employer, and Disclosure and Barring Service (DBS) checks being made. Where the member of staff was from outside the UK, additional checks had been undertaken, including a check on the person's right to work in Britain. Information also confirmed an appropriate induction process had been followed when staff first started working at the home. This verified the registered provider had appropriate recruitment and vetting processes in place.

The home was generally clean and tidy and staff had access to personal protective equipment (PPE) to help limit possible cross infection. The laundry area of the home was also clean and tidy. We noted that on both days, dining areas were not always effectively cleaned once people had finished their meals, with crumbs and dropped food remaining on the floor for some time. People's en-suite areas in their room were used excessively for storage. This meant these areas were difficult to keep clean because the areas were overfull

and not clear of items not currently required.

Requires Improvement

Is the service effective?

Our findings

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 take 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 for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The manager told us there were currently four applications made to the local authority in respect of DoLS, although none had yet been formally granted. We saw documents in relation to these applications. There was some evidence of best interests decisions being made for people who had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders in place. Some people had bedrails in place, but did not always have the capacity to make decisions about this. In some cases relatives had signed consent forms to say the agreed to this form of restraint and indicated they had formal Power of Attorney (PoA) in place. We asked the manager if she had copies of the PoA to be sure the relatives had the legal authority to make such decisions. The manager thought the home did have copies but was unable to locate them. She contacted one family, who said they did have a formal PoA and would bring a copy in to the home. The manager said she would ensure the matter would be followed up with families. This meant the home could not be sure relatives signing to give consent had the legal authority to do. The manager subsequently sent us a copy of one PoA form to demonstrate this had been received and the contents noted.

Where people did have the capacity to make their own decisions then consent forms had been completed. People told us they had agreed to bedrails being put in place to keep them safe or for staff to share information with other professionals.

People told us they felt permanent staff at the home had the right skills and knowledge to support them. One person told us, "The staff are absolutely phenomenal" and "The senior care workers are very good. They know their jobs very well and love what they do." A relative told us agency care workers did not always know their relation's needs in detail, but said of the regular staff, "The care workers are unbelievable." They told us regular staff knew exactly what to do to help their relative and had the right skills to deliver care.

The manager showed us the home's training matrix which detailed the training staff were required to undertake on a regular basis. The system was colour coded to alert the manager when training was approaching a refresh date or when training became out of date. She said she was aware a small number of areas were out of date but was working to address these. She said the provider was also monitoring that training was brought up to date. Staff told us they had access to regular training and could ask for additional training if necessary. Staff records showed training courses had been completed and also senior care workers had had their competencies checked to ensure that could deliver support to people with a PEG or

other more detailed areas of care. This meant staff were supported to develop and maintainer their skills to deliver effective care.

Staff also confirmed they had access to regular supervision, where they could discuss issues or identify future training and development needs. Staff files contained copies of supervision documents. The manager told us she was aware annual appraisals were due. She said she had only been at the home a couple of months and whilst she had identified the issue had not had time to start the process fully.

People were supported to maintain their health and well-being. Care records showed there was regular contact with people's general practitioners, specialist nursing staff and other health professionals. People told us that if they were concerned, they could speak to staff who would arrange for them to be seen by a GP or other health worker. During the inspection we saw a number of healthcare professionals coming into the home, reviewing people's care and offering advice to staff. This meant people were supported to maintain good health and had access to services where there were any concerns about their well-being.

People told us they were happy with the food at the home. Comments included, "The food is very nice. You have a choice and can ask for alternatives as well. I can't swallow really well and have to avoid certain things. So they will offer me something like fish on a Sunday instead of meat" and "You get a choice of foods. The food is very good. There are certain foods I can't have, like sugar, and they make sure that I don't get sugar." Kitchen staff were knowledgeable about people's particular dietary needs and had information about people's likes, dislikes or any particular food they were unable to have. They also had information about those who had swallowing difficulties and needed a pureed diet.

We spent time observing meal times at the home. We saw that where pureed food was provided, this was done so with each food item served separately, ensuring people's dignity was respected, despite the need for a special diet. People who required assistance were supported. However, we observed that staff did not always consider the social aspect of meal times. Staff did not take the opportunity to converse with people whilst they were supporting them and one staff member was supporting two people, meaning they could not give dedicated individual time to a person. We spoke with the manager about this. She said she would raise the issue with staff.

Good

Is the service caring?

Our findings

People and relatives told us the staff at the home were very caring and dedicated to supporting them. Comments from people included, "There are some nice people [staff] here. I've got friendly with them; we have a bit of a laugh sometimes"; "The care is very good and all the nurses are very good. I have a good laugh with them. They say they'll tell my wife, but it's all in good fun. Overall I'm very happy here"; "The care is good; very good. I'm a big fan" and "The staff are very loyal and hard working. They do it because they care for the residents and love their jobs." One relative told us about the care their relation received, "They always talk to her. The care workers chat and talk to her. It's lovely to see because she does respond. I've seen one care worker give her a cuddle to comfort her, which is lovely."

We spent time observing care delivery at the home and saw there were good relationships between people and staff. Staff had conversations with people as they passed and there was a good deal of joking and laughing at times. Where people were distressed or confused, staff took time to reassure them or help direct them. Staff told us they enjoyed their jobs and felt positive about caring for people. One staff member commented, "I love making people comfortable and happy; knowing there is someone there for them. I find great pleasure in that."

Most people and their relatives told us they felt involved with their care. Comments from people included, "They do sit down and ask about the care. I feel involved and I feel as if I am listened to" and "They do listen to what I want and will come and ask me about things." One person told us they could not recall being asked about their care but said staff asked them things on a day to day basis. Another person felt, particularly when agency staff were on duty, care became less personalised. They said, "Sometime it can feel a little bit like conveyor belt care. Not because the staff want it like that, it's just because the pressure is on."

The manager told us there was no one at the home who was currently supported by an advocate to ensure their wishes were supported and respected. One relative told is they were in the process of applying for Power of Attorney to help support their relation in making decisions, as it was sometimes difficult to fully involve them in care decisions.

Staff understood about the need for confidentiality and most care plan documentation was securely locked away when not in use. We did note some daily records were left out at nursing stations during busy periods. The manager said this was rare and she would ensure personal documentation was kept private. People's privacy and dignity was respected. Room doors were closed when people were receiving personal care and people told us that if they were staying in their rooms they could ask for doors to be closed or left open.

People's independence was supported. People were free to move around the home as they wished and had access to a small garden. They told us they could get up and go to bed when they liked. We saw some people went for a rest in their room during the afternoon, whilst other people got up slightly later, having had a lie in. Many people at the home utilised wheelchairs to get around the home. We saw corridors were generally wide enough to help facilitate this and most amenities were either on a level or accessible via a lift. At least one person had access to the internet. This meant people were supported to maintain their

independence whilst living at the home.

Where appropriate people had made decisions about the type of end of life care they would like and where they would like to be cared for. These plans or wishes were documented in people's care records.

Requires Improvement

Is the service responsive?

Our findings

The manager told us the activities co-ordinator was on holiday at the time we undertook the inspection. People we spoke with told us there were activities at the home, such as events and singers, but they felt there could be a greater range available. We saw posters and information displayed around the home advertising forthcoming events. Comments from people included, "There are no activities at the moment. Not that I can do much as I can't stand up" and "They do have activities like television or being outside, but there could be more. Someone comes and takes me to church." A number of people highlighted the need for more individual activities, particularly for those people who spent a lot of time in bed or in their rooms and were not always able to join in group events. A relative told us, "There is not enough stimulation for them. There is no regular one-to-one to do hand massage and stuff." One staff member told us, "Things seem to have dipped a bit. There is not as much as there used to be."

We spent time observing events during the inspection. The home had some indoor rabbits, which we saw people holding and cuddling, but for the most time people were sat watching television or in their own rooms. One person told us who they had been adopted by the home's cat and they spent time looking after it. We spoke to the manager about activities. She agreed it was an area that required revising and said she was going to work with the activities co-ordinator to try and develop more individual activity time.

People told us staff responded to their requests for assistance. Comments from people included, "The carers always come" and "I can ask to see the nurse at any time." A relative told us, "The care workers are unbelievable. They are all so helpful that it isn't true." Some people told us agency staff were not always as responsive as permanent staff, as they did not know the individuals as well. One relative told us that regular staff always performed mouth care for their relation but that they sometimes had to remind agency staff. People told us they had access to baths and showers and could request them when they wished, but were supported to have them at least once a week.

Care plans were comprehensive, person centred and related appropriately to the individual needs of the person. There was evidence an assessment of needs had taken place prior to the person coming to live at the home, which highlighted both personal care needs and those related to people's particular health issues.
From these initial assessments, care plans were developed to address people's needs. Care plans covered areas such as, maintaining people's safety whilst at the home, including assessing and monitoring risks around falls and choking. Other care plans covered people's nutritional needs, communication needs, skin integrity, mobility and pain management. Plans contained a range of information, including people's particular likes, dislikes and preferences. For example, one care plan indicated a person liked to be up and dressed by 9.00am and that staff needed to encourage the person to support themselves as much as possible. Another care plan detailed a person should have thickener added to their drinks to the consistency of "runny honey" and stated the person should be supervised when having a drink. This meant care plans were based on an assessment of people's needs and contained sufficient detail for staff to provide individual care.

Care plans were reviewed at least monthly and updated as necessary. Some reviews were limited and contained phrases such as, "care plan remains appropriate" meaning it was not always clear if a full review of care had taken place. Daily records held about people were also not always person centred. Daily records tended to list the number of a particular care plan and statement such as, "all care given" or "nutrition supported" rather than detail about the person as an individual. We spoke with the manager about this. She said she felt it was cultural issue, which she was hoping to change over time. This meant care plans and people's daily care were reviewed although more personal detail could be included in these reviews.

Staff we spoke with had a good understanding of people as individuals, their personal preferences and their family background or history. They were able to describe the support people required and their particular personalities.

People told us they were able to make choices as part of their care delivery. They said they had a choice of meals and whether they spent time in their rooms or communal areas. One person told us they did not like showers and preferred to staff to give them a full body wash each morning. They were keen to emphasise that this was their choice. One person told us they regularly went out for coffee with their friends in a nearby town.

One person told us they had made a formal complaint about staffing at the home, but whilst it was dealt with and things had changed they still had some concerns. We saw there had been another formal complaint from a visitor about the rabbits at the home and the smell they made. We saw the manager had investigated the complaint. This had included asking people at the home about their views of the rabbits; although we noted most of the questionnaires had been completed on people's behalf by staff. The manager had then met with the individual to discuss they concerns and a further letter was sent on conclusion of the investigation. We did not note any excessive smell from the rabbits during our inspection. People told us if they did raise any issues these were dealt with by the manager and they had not made any recent formal complaints. Comments from people included, "I've not complained; I can't think of anything that would make it better"; "I've never had to complain about anything. Overall I'm reasonably satisfied" and "I've no complaints. I'm settled to a certain extent. You can't find a nursing home that is perfect, because there is none." A relative told us, "I've complained a few times, but they have been sorted. They always respond if I raise any issues." Whilst complaints were recorded, with details of response there was no clear analysis of issues raised. The manager said she had not been in post long but would be looking to do this over time. This meant the home had a system in place to deal with complaints and concerns.

Requires Improvement

Is the service well-led?

Our findings

A manager was in place who was applying to become the registered manager for the home. She told us she had recently been subject to a fit person interview, as part of the CQC registration process and was awaiting final confirmation of her manager's registration. Records showed following the inspection that the registration had been approved. We were supported throughout the inspection by the manager.

Some people told us the home had been overseen by several managers over the previous months and this had led to a lack of consistency. They felt it was important to have a settled manager to support the home. One person raised concerns that the manager's time was split between this home and a further home owned by the provider. They felt this meant there was insufficient management time at the home. The manager confirmed she was also the registered manager for the sister home next door, which provided support to 24 older people, some of whom were living with dementia. She said each home now had a deputy in place with dedicated administrative time. This time was staggered between the two homes, so either herself or one of the deputy managers was at the home at any one time. She said she felt she had sufficient time and resources to undertake both positions and would not have taken the role on if she did not think she could do both jobs.

The manager demonstrated a number of checks and audits were carried out at the home. These included checks on the care files, infection control, medicines, health and safety, safeguarding issues, the kitchen and the overall presentation of the home. We noted one of the questions on the health and safety audit asked if all stairwells were free from obstruction. The most recent audit had stated that there were no obstructions present, which was at odds with what we found on the first day of the inspection. The audits had also failed to identify the window restrictors did not meet current HSE guidance, or that risk assessments had not been undertaken. The issues related to the safe and effective administration of topical medicines had also not been identified through robust management audits and checks. The provider and manager had also failed to have robust system in place to ensure people's rights were protected and that appropriate consent was sought, based on a legal PoA. The manager agreed these matters should have been identified as part of the audit and checking process and said ongoing audits would appropriately address the matter in the future. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17. Good governance.

Care records held at the home were up to date and kept in good order. We noted some daily records held in people's rooms, and detailing fluid intake or position changes, were not always dated or completed in significant detail. The manager said she would remind staff that these records were as important as other daily records relating to people's care.
People we spoke with told us the manager was new to the home and they had not got to know her very well at this current time. Most people described her as being pleasant and approachable and would look to sort out any issues they had. Staff told us they felt it was important to have a settled manager and they felt the new manager was doing a good job so far. Comments from staff included, "She has made a lot of improvements since she started. She is actively encouraging complaints as a way of improving things. She is doing things properly with safeguardings and she is trying to be really transparent"; "She doesn't take

rubbish; but does it in a nice way" and "(Manager) has been good so far. She has made changes. Nothing major, but changes that any new manager would have brought in."

Staff told us there was a good staff team at the home and they were happy in their work. Comments from staff included, "It's a good group; we all help each other and are always there for support"; "The nurses are good. They are available to give advice to staff"; "I enjoy it. I always enjoy coming to work; even though it is hard work. I wouldn't be here otherwise, would I?" and "I love it here."

People told us there were regular "residents' and relatives'" meetings. Most people told us the manager listened to people's issues and acted on them. However, one person told us, "I've only been to one so far. They may listen, but don't seem to deal with it. It seems some issues are coming up each time." We looked at notes from recent meetings and saw a range of issues had been discussed including concerns over the frequent use of agency staff and the need for more activities. The manager had asked for people to put forward ideas for activities as she wanted to ensure those provided were the choice of people living at the home. We also saw there had been a range of staff meetings when staff had been able to raise any concerns, issues or make suggestions. We saw staff had been able to raise concerns over staffing levels and the manager had reiterated the need for supervisions to be completed as soon as possible.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Processes were not in place to ensure the premises used by the provider were safe to use and proper processes were not in place to ensure the safe and proper management of medicines at the home. Regulation 12.(1)(2)(d)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not in place to ensure there was proper assessment and monitoring of the quality and safety of services. Systems were not significantly robust to assess, monitor and mitigate risks relating to health, safety and welfare, because risks to fire safety and individual safety had not been identified, effective medicine administration had not been maintained and checks to ensure that consent obtained was appropriate and legal had not been undertaken. Regulation 17 (1)(2)(a)(b)(c).