Barchester Healthcare Homes Limited

Bloomfield

Inspection report

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Ratings

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

Overall summary

We carried out this inspection over two days on 9 and 10 March 2015. The inspection was unannounced. During our last inspection on 17 April 2014 we identified seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider wrote to us with an action plan of improvements that would be made. During this inspection we found the provider had taken steps to make most of the necessary improvements.

Bloomfield is run by Barchester Healthcare Homes LTD who are a large organisation delivering care and support to older people across England, Scotland and Wales. Bloomfield provides accommodation which includes nursing and personal care for up to 102 people. They provide services to older people some of whom are living with dementia. It is spread over two floors and divided into five units. On the day of our inspection there were 73 people living there. One of the units had been closed for refurbishment.

At the time of our inspection the home did not have a registered manager. The management of the service was being overseen by an operations manager, regional

Summary of findings

support nurse and regional operations manager until a new registered manager could be recruited. Recruitment for a new manager was being undertaken. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that records relating to the planning of people's care still required improvement in some areas. People's care plans did not always reflect what care, support or treatment they required for staff to be responsive to their needs.

Whilst the provider had a system to regularly assess and monitor the quality of service that people received but this was not consistently effective.

All of the people we spoke with said they felt safe living at Bloomfield. Staff we spoke with had the knowledge to identify safeguarding concerns and felt confident to act on them to protect people. Staff confirmed they had received training to support them to identify abuse and respond appropriately should it occur.

People's nursing and health care needs were met. Staff treated people using the service with respect and in a dignified way. Staff spoke kindly to people and we heard staff regularly offering people reassurance and explaining what they were doing. We saw staff offering people choices in a variety of ways to ensure they could make meaningful choices. Staff were knowledgeable about people's individual needs and preferences.

People and their relatives spoke positively about the care and support they received from members of staff. People were supported with their personal care in ways which promoted their privacy and dignity and encouraged independence.

Effective recruitment procedures where in place to ensure people were supported by staff with the appropriate experience and character. Staff we spoke with said that they felt supported and received regular supervision meetings with their line manager. These meetings were used to discuss progress in the work of staff members and identify areas of development and training.

We found the service to be clean and tidy. The staff could explain the procedures they would follow to minimise the spread of infection. Housekeeping staff followed a daily cleaning schedule to ensure that all areas of the home were cleaned.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe living in Bloomfield. They said they had confidence in staff who they received their care from. Relatives also told us they were confident that people living in the home were kept safe.

The home had safeguarding and whistleblowing procedures in place. Staff were knowledgeable about the procedures in place to recognise abuse and how to report their concerns. Safeguarding incidents had been correctly reported to the Care Quality Commission and the Local Authority.

Medicines were stored and administered safely

Is the service effective?

Good

The service was not always effective.

People were supported to eat and drink enough to maintain their well-being.

The service worked well with other health professionals to ensure people received consistency of care. Records contained details of appointments with health professionals and any outcomes. We saw referrals were made to the appropriate health services when people's needs changed.

People were supported by staff that had the necessary skills and knowledge to meet their needs. Staff were knowledgeable about the care needs of the people they were supporting.

Is the service caring?

Good

The service was caring.

People and their relatives spoke positively about the care they received. All commented that staff were helpful and friendly.

We saw that staff showed concern for people's well-being. We observed staff seeking people's permission before undertaking any care or support. People's dignity and privacy was respected. We saw staff knocked on people's doors.

Is the service responsive?

Requires improvement

The service was not always responsive.

People were not protected from the risks of unsafe or inappropriate treatment because accurate and appropriate records were not maintained.

People and relatives we spoke with felt that there were insufficient staffing and activities to ensure that people did not become socially isolated.

Summary of findings

People who were able and their relatives knew how to make a complaint. They felt confident that their concerns would be listened to and any actions required taken.

Is the service well-led?

Requires improvement 

The service was not always well-led.

Whilst the provider had a system to regularly assess and monitor the quality of service that people received but this was not consistently effective.

The operations manager had a clear understanding of the changes and improvements that were required.

Accidents and incidents were recorded appropriately. These were assessed by the management team to identify any trends.

Bloomfield

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 9 and 10 March 2015 and was unannounced.

This inspection was carried out by four inspectors, a specialist advisor, who has previously worked in this type of service and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Before the visit we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. Before the inspection, we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking to people, their relatives, looking at documents and records that related to people's support and care and the management of the service. We reviewed 20 care and support plans, staff training records, a selection of the home's policies and procedures and quality monitoring documents. We looked around the premises and observed care practices throughout the day.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

At the time of our inspection there were 73 people living in the home. We spoke with 16 of these people. We also spoke with ten visiting relatives. We spent time observing people in the dining and communal areas. During our inspection we spoke with the operations manager, regional support nurse and regional operations manager. We also spoke with five nurses plus an agency nurse, 19 care staff, the activities co-ordinator, activity assistant, the head of housekeeping and four housekeeping staff, a laundry assistant, the chef, two catering hostesses, the maintenance man and two visiting health professionals. Before the inspection we contacted health and social care professionals the provider worked in partnership with.

Good

Is the service safe?

Our findings

All of the people we spoke with said they felt safe living at Bloomfield. Comments included "I feel safe because I only have to press my buzzer and someone comes", and "I feel safe with staff, they talk to me nicely." One relative we spoke with told us "I feel very confident that (relatives name) is safe here, really very safe." Another relative said "I am happy that she's here as I feel she's safe but I would like a few more staff."

Staff we spoke with had the knowledge to identify safeguarding concerns and felt confident to act on them to protect people. Staff confirmed they had received training to support them to identify abuse and respond appropriately should it occur. They said they would report any concerns and were confident that managers would take any actions required. Staff also said they were prepared to take their concerns further if they were unresolved. One member of staff told us "I haven't had to raise any safeguarding concerns lately, but I have done before. I know how to report anything that concerns me". Another told us "Staff are very capable and we have a good team. People who live here are very safe."

We reviewed the provider's recent safeguarding applications. We saw that the provider had followed the guidance set out by the local authority when raising a safeguarding alert. They had also notified the Care Quality Commission which is a requirement of the regulations. Records included information on why the alert was being made, any actions already taken by the provider and any follow up actions required as a result of any investigations. We saw the provider worked in conjunction with the local authority in maintaining people's safety and wellbeing.

We asked staff about whistleblowing. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. All the staff confirmed they understood how they could share concerns about the care and support people received. They said they were aware of the providers whistleblowing policy and they would use it to report any concerns. They also said they would feel comfortable raising concerns with outside agencies such as the local authority if they felt their concerns had been ignored. Staff knew and understood what was expected of their roles and responsibilities.

Risk assessments were in place to support people to be as independent as possible whilst protecting them from harm. Care plans we looked at contained risk assessments on how staff should keep people safe, including for example, moving and handling risk assessments. Records showed which type of hoist and which size sling should be used when moving people safely. Staff we spoke with knew which sling and hoist different people needed. During the second day of our inspection we observed two members of staff moving one person from a wheelchair to an armchair in one of the lounges. They were using the hoist as indicated within the person's care plan. During the procedure, the person knocked their leg against the hoist and called out in pain. Staff were very quick to check that the person was not hurt and checked the area for any sign of injury. One of the staff members involved in the incident then completed an incident form, talking us through the process. When we checked the care plan, staff had identified within the past seven days that an external referral to an occupational therapist was needed because of the difficulties staff had noted when moving the person. The staff member told us "It's important to keep people safe when we move them obviously but it's also important that we (staff) do everything to protect ourselves too. We have a manual handling trainer who is really good at teaching us how to do this properly". We saw that the incident was reported at the time of the event and documented in the person's care record. We also overheard staff discussing the incident and informing staff to check the person's leg later in the shift in case a bruise developed. Records showed that monthly reviews of risk assessments were undertaken which included moving and handling, people falling and weight loss.

During our previous inspection it was noted that people who use the service were not protected against the risk of unlawful or excessive control or restraint as low tables were put in front of people when staff left the room. We did not observe this practice during our two days of inspection. When we spoke with staff about their understanding of restraint they used the example of putting low tables in front of people. Staff assured us this was something they would no longer do. The provider had a restraint policy in place which staff were aware of. They said there would be guidance put in place before they could use any form of restraint.

People were protected against the risks associated with medicines because the provider had appropriate

Good

Is the service safe?

arrangements in place for the safe management of medicines. Most medicines were supplied by a local pharmacist in sealed dossette form. Where tablets were not supplied in dossette form, people had individual boxes of medicines stored within a locked trolley. All of the boxes and bottles had been dated and signed when opened and we saw that staff documented the number of tablets remaining. The re-ordering system was explained to us which was in line with the provider's procedure. Expired or no longer needed medicines were disposed of safely in line with the provider's procedure. We saw and reviewed the destruction of medicines book on two of the units. On both occasions these had been fully completed by two members of staff.

During our previous inspection we had noted some people had been given PRN (as required) medicines inappropriately. During this inspection we saw one person had been prescribed a sedative for agitation "as required". Staff had recorded several times on the Medication Administration Record (MAR) chart that the medication was not required and therefore not administered. On one occasion when it had been given, we saw staff had documented alternative steps they had taken to try reduce the person's agitation first. When these steps did not help, the medicine was given. Staff had also documented that the person's family and GP had been informed.

We spoke with a visiting GP during our inspection about medicines management at Bloomfield. They told us generally communication was very good between the nurses and the surgery;

We observed parts of two medicine rounds. Both of these were undertaken by registered nurses and we were told at present only nurses administered medicines. Both nurses were knowledgeable about the medicines they were giving to people and knew why they had been prescribed. They followed the provider's procedure for administering medicines. For example, they asked consent from people before giving any medicines, did not rush anybody, checked the medicines were swallowed, offered drinks and signed to indicate the medicines had been given as prescribed. People who were able to take their tablets independently were observed taking them before the nurses signed the MAR chart. When people required assistance, the nurses took time to sit with people and gave assistance as needed.

During our observations, staff were occasionally interrupted by other staff within the home, or by people living there. On one occasion during our inspection we observed one nurse wearing a red tabard informing people not to disturb them when giving medicines.

Staffing levels were determined according to the dependency levels of the people who used the service. This was currently being reviewed by senior management on the days of our inspection to identify if staffing levels were sufficient. We looked at the home's rota which indicated there was a consistent level of staff each day.

Effective recruitment procedures where in place to ensure people were supported by staff with the appropriate experience and character. We looked at staff files and saw people were protected by a safe recruitment system. This included the provider undertaking a Disclosure and Barring Service (DBS) check before staff started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults. All staff were subject to a formal interview in line with the provider's recruitment policy. The provider also contacted previous employees about the applicants past performance.

The provider had a policy in place to promote good infection control and cleanliness within the home. There were processes in place to maintain standards of cleanliness and hygiene. For example, there was a cleaning schedule which all housekeeping staff followed to ensure all areas of the home were appropriately cleaned. We spoke with the head of housekeeping who showed us the procedures for cleaning spillages and dealing with infectious outbreaks. This information was available to all housekeeping staff, who were knowledgeable about the processes they would need to follow to minimise the potential spread of infection. All staff told us they had access to personal protective equipment (PPE) such as disposable gloves and aprons. Staff were knowledgeable about the home's infection control process and were able to explain the procedures required when dealing with people's washing. Training records showed staff had received appropriate training to support this. We found the home was clean and guidance was available for people regarding good hand hygiene to minimise the spread of infections.

Good

Is the service effective?

Our findings

People had access to food and drink throughout the day and staff supported them when required. People told us they enjoyed the food provided by the home and were able to choose meals they liked. Comments included, "If I don't like what is on the menu I can choose something different." "I really like fish so the chef will do it for me even if it's not on the menu." "The food is good" and "It's very nice".

We observed the lunchtime meal on both days of our inspection. We saw the menu for the day was displayed on tables, and staff told us people ordered from a choice in the morning. People chose to either sit with others at the dining tables, in the lounge areas or they ate in their rooms. Lunch in the dining areas ran reasonably smoothly. However, we noted that when people sat together they were not always served together. This meant one person was eating alone while their table companions sat and watched. Where required people were helped by staff to make a choice on which meal they would prefer by being shown the meal choices. Staff told us if people changed their mind about their previous choice of food, they could have the alternative or something else. We observed this several times, and each time people were offered the alternative with no fuss. One person told staff they weren't hungry, and the chef arrived and spoke to the person suggesting a lighter meal or snack could be prepared. Although the person declined, the chef told them to ask if they got hungry later. We saw people were provided with soft texture diets, thickened drinks and fortified food and that their weight was monitored by staff.

We observed a lot of positive staff interaction with people during the lunchtime meal. However there was not always enough staff to assist those people that required one to one support or encouragement to eat their meal. Some people had to wait for assistance until staff had finished helping other people. The atmosphere on this unit felt quite chaotic and busy during the lunchtime meal due to ther not being enough staff to assist everyone at the same time. .

On some units people were offered drinks, including wine with their meals. Staff asked people if they needed help cutting their food up and we saw one member of staff serving soup and then replacing the person's dessert spoon with a soup spoon. We observed staff assisting people where required. However, this was not a consistently positive experience. For example, on one unit we saw one member of staff feeding one person, but talking to the person on the other side of the table and not engaging the person they were helping. This demonstrated a lack of respect for the person they were helping and took away some of the "social" element of lunchtime.

One person on the nursing unit who had complex needs in relation to their eating and drinking. Their care plan contained a completed malnutrition universal screening assessment and they had been identified as being "high risk". We saw a referral had been made to the local SALT (Speech and Language therapy team) because of concerns about the risk of choking due to their condition. The person was receiving a liquidised diet. We saw the SALT team had attended and assessed the person and an action plan had been put in place. We observed the person being assisted with liquidised food in accordance with the plan. However, despite staff weighing the person and noting in the care plan "(person's name) is losing weight every month", the entry was not dated. This meant it was not possible to know exactly when staff had recorded their concerns. Although a referral to the GP was made, again it was not dated. The record did state when the GP had reviewed the person and detailed the outcome of this review. We read that staff were to continue to administer a fortified diet, and to weigh the person weekly. When we asked how staff were monitoring the food intake, we were told it was not recorded. However, the provider's guidance stated that people at high risk should have their food intake monitored. Staff did implement a food chart for this person and other people living at the home during our inspection.

We visited the kitchen and spoke with the chef. They were proud of the fact they, "Cook everything from fresh." They told us they always had enough fresh and store cupboard ingredients to enable them to make meals and the kitchen contained all the equipment they needed. The chef was aware of how to meet people's differing nutritional needs. For example, they told us how they met the nutritional needs of people with diabetes and how they increased the calorie content of food for people who were frail or had small appetites. They were also knowledgeable about the differing cultural and religious needs of people. The chef told us and we saw that there was a choice of two main meals that had been created from set recipes to give people a balanced diet.

Good

Is the service effective?

Staff had regular contact with visiting health professionals to ensure people were able to access specialist advice and treatment as required. The home contacted relevant health professionals GPs, district nurses and physiotherapists if they had concerns over people's health needs. Records showed people had regular access to healthcare professionals and attended regular appointments about their health needs. At the end of each shift nursing staff shared information about the person's well-being and any changes to their health. This included any updates from GP visits or medical appointments. This information would then be shared with all of the care staff.

We found staff were knowledgeable about people's individual care and support needs. They were able to describe people as individuals. Staff knew about people' likes, dislikes and preferences. People who we spoke with told us they believed that the staff who cared and supported them had the right skills to do so. One person told us "The girls are all marvellous, very helpful." Another person said "They are all very good. They always check its ok to help me before they do anything."

Staff told us about the range of training they had completed to make sure that they had the skills to provide the individual care and support people needed. Some people living at Bloomfield needed support to move safely. We reviewed the providers training matrix and found that all the members of staff requiring this training had received it within the past 12 months. Moving and handling was covered within the provider's induction and by additional courses. The provider's training matrix showed that staff had received a range of training courses relevant to supporting people living with dementia which included, safeguarding of vulnerable adults, infection control, fire safety and food hygiene. Staff told us that most training was completed on the computer, although external trainers were used for some. For example, one nurse told us "If for example, we needed some palliative care training, we can access that at a local hospice, we just have to ask". We discussed competence with one qualified nurse who told us ""I wouldn't do anything if I hadn't received the training and felt competent" and "I feel able to ask for extra training if I need it".

Staff told us they were supported by receiving regular supervisions. We spoke with staff and the manager about staff supervision and appraisal. We found only some staff had received an annual appraisal. The manager said some supervisions and appraisals were outside of the providers expected timescale of every eight weeks and said this was an area they and other members of the management team were working on. We reviewed the supervision matrix which confirmed the information provided by the manager. Staff spoken with during our inspection told us senior members of staff were supportive and they could approach them should they feel they needed supervision, support or guidance.

CQC is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The Mental Capacity Act 2005 sets out what must be done to make sure that the rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care or treatment. This includes decisions about depriving people of their liberty so that they get the care and treatment they need where there is no less restrictive way of achieving this. DoLS require providers to submit applications to a 'Supervisory Body', the appropriate local authority, for authority to do so.

We spoke with the operations manager about the Mental Capacity Act 2005 (MCA) and changes to guidance in the Deprivation of Liberty Safeguards (DoLS). We found they were aware that they needed to safeguard the rights of people living at the home who were assessed as being unable to make their own decisions. We saw evidence of communication with the supervisory body (local authority) to understand and work in line with the current guidelines regarding the appropriate and lawful deprivation of people's liberty. All necessary DoLS applications either had been, or were in the process of being submitted, by the provider.

Whilst not all staff had received specific training in MCA and DoLS, they still understood the importance of providing people with choices and responding to their preference. We saw staff consistently asked people before they did anything. For example, we saw staff asking people before they did anything from assisting with lunch or when moving them.

Good

Is the service caring?

Our findings

During our last inspection we found people's privacy, dignity and independence were not consistently respected. During this inspection we found staff supported people with dignity and sensitivity, ensuring they respected people's privacy when supporting them with care. One relative we spoke with felt there had been a lot of "positive change" in the last year.

People and their relatives spoke positively about the care and support they or their relative received. Comments included "They are all very helpful and talk to me nicely", "They are all lovely and friendly. They always shout hello as they pass my door", "The care here is very good. The girls are all marvellous." Comments from visiting relative included "They are very caring, considerate staff." "I love the way the carers are with him, he is always clean and happy. I'm very happy with the care he receives." "(Name of relative) gets on well with the staff, they make a fuss of her and she enjoys that."

People were treated with dignity and respect by staff and they were supported in a caring way. Staff talked with people and involved them with whatever it was they were doing. Staff spoke kindly with people and we heard them regularly offering reassurance to people they were supporting. For example, when staff were encouraging people to take drinks or eat their meal, we heard staff saying "It's lovely to see you smile, where shall I put your tea" and "Can I move this now, what would you like to eat now? Would you like some more (food)?"

Staff members knew the people very well and explained how they used their knowledge of people to support communication and aid discussions. For example one person who was being supported to eat their meal needed time to respond to questions being asked. The staff member asked if the person wanted anymore to eat and waited for their response. When the person said "No" the staff member waited and asked again before taking the meal away.

We saw staff offering people a choice of meals in a variety of ways to help ensure they could make a meaningful choice. We regularly heard staff giving people options for other areas of their lives such as where they would like to sit or if they wanted to join in an activity. The care plans showed people got up and went to bed at different times.

One person's care record said they got up early and this was confirmed when we asked the person, who said "Oh yes. I've always been an early bird." Whilst another care plan said the person wanted to stay in bed until midday. The care records showed staff went into the person's room to check they still wanted to remain in bed and advised staff how to approach the person without upsetting them. On both days we visited the person remained in bed until after lunch and the care records showed that staff had been offering them drinks.

People who use the service had good relationships with staff members and those who were able did not hesitate to frequently ask for help. People recognised care staff and at times responded to them with smiles or conversation which showed they felt comfortable with them.

We asked staff how they support people to meet their cultural or religious beliefs or to express their sexuality. One staff member explained it was important to support people in a dignified way, especially with their sexuality. They said they would not be embarrassed by a person's need to express these needs and would make sure they did not embarrass the person when supporting them.

We saw staff knocked before entering people's rooms and that personal care was delivered behind closed doors. One member of staff told us "We always close people's doors when we deliver personal care to make sure their privacy and dignity is maintained. It's important to tell people what you're doing before you do it, and do it slowly, step by step. Caring for somebody with dementia means you have to take your time". Another staff member said "I will always speak to the person and tell them what I am doing. I'll check that everything is ok for them."

Staff told us that people were encouraged to be as independent as they could be, in the things they choose to do each day, such as what to wear, what they liked to eat and staying in contact with their family. People's bedrooms were personalised and contained photographs, pictures ornaments and the things each person wanted in their bedroom.

People and relatives we spoke with told us they were able to be involved in making decisions relating to the care and support they received. One relative said they had been involved in their husband's care plan and attended regular review meetings. They said "I am kept up to date if things change." Another relative told us they were invited to a

Good

Is the service caring?

monthly meeting to discuss their mother's care. They also said the nurse in charge would speak to them if there were any changes or concerns regarding their mothers care. People and their relatives we spoke with felt they could talk to staff or management and that they would be listened to and actions taken where required.

Where people's end of life wishes had been discussed with them, we saw the GP, staff and relatives had also been involved. The home was also supported by a local hospice to ensure nurses had received end of life training and that appropriate care and support plans were put in place for people.

Relatives had unrestricted visiting times. There were small lounges on each unit if people did not wish to meet with their relative in their bedrooms. One relative said that they would often join their family member for meals.

Requires improvement

Is the service responsive?

Our findings

During our previous inspection we found people were not protected from the risks of unsafe or inappropriate treatment because accurate and appropriate records were not maintained. Whilst we found this had improved on some of the units we found some people's care plans did not always reflect what care, support or treatment people required for staff to be responsive to their needs. We reviewed 20 people's care and support records. Whilst these had been reviewed monthly we found information contained in some files was incorrect or did not clearly identify the support required. In one person's care plan, in the mobility and moving section, it noted the person could shave and clean their teeth independently. This was dated October 2014. In the personal care section which had been written in May 2014 it stated the person now needed support in these areas. It also noted the person needed support to continue to attend dental appointments which was dated 2013. We could find no evidence in the person's care plan of any dental appointments attended.

In another person's care plan, in the mobility section, it stated the person required a 'bucket sling' and full body hoist when being supported to move. In the falls section of the care plan it stated the person only required the use of a full body hoist. Another person's care plan stated the person required a referral to the dentist for an assessment of their dental needs. Whilst the nurse in charge was able to explain what actions they had taken this had not been recorded.

A visiting GP told us that on occasion changes they made to prescriptions were not reflected in the care delivered. As an example, they discussed one person who had been prescribed a steroid cream. On 2/2/15 they had discontinued the cream on the MAR chart, but the following week, on 9/2/15 it was noted that the care record stated that staff had continued to document that they had administered it. We checked the record for this person, and saw the GP had documented their instructions clearly in the notes, but this change had not been followed through by staff.

Care plans were regularly reviewed and any changes were filled in by staff. However, it was not always clear which part of the reviewed care plan was to be followed by staff. We saw several of the care plans had the original support guidance for staff and the updates on the same page. This could lead to confusion for new or inexperienced staff because sometimes the information was contradictory.

We found that the registered person had not protected people from the risks of unsafe or inappropriate treatment because accurate and appropriate records were not maintained. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

People had a copy of the activities programme in their bedrooms and the programme was reviewed monthly. The activities staff divided their time between group activities and one to one work. During our inspection we observed that on the nursing units that many people were sitting alone in their rooms. On the units for people living with dementia most people were sitting in communal lounges. Whilst we saw some people engaging in activities such as singing, pottery or painting people and relatives we spoke with felt there were insufficient staffing and activities to ensure that people did not become socially isolated. Relative's comments included "There is a lack of activities for (relative's name). Because they can't communicate they get frustrated if they sit in the lounge with other people, so they just stay in their room all day." "I feel more activities and stimulation would benefit my relative and other people living here." "Whilst staff are good there are just not enough of them." "Staff don't have time to chat or pop in for a minute." "It's a shame there are no activities in the rooms for people that can't get out."

A relative told us they had filled in the detailed life story for their mother but there was no sign of staff using it to support the care the person received. They said they often seem short staffed and when their relative requests help they are often met with comments from staff which include "I can't come right now" or "I'll be back as soon as I can."

Whilst people could choose to join in the activities if they wished some people we spoke with said they did not join in as they felt the activities were not appropriate for them. Comments included "They (activities) don't suit me" "I've tried the activities before but not gone back as I find they

Requires improvement

Is the service responsive?

are for the majority and not challenging enough for me." "I don't want to join in and anyway they don't ask me." When asked some people felt that they had not been consulted on the kinds of activities they would be interested in.

Each month activity staff wrote a review of activities people had taken part in. For one person January only had one activity entry which stated that the person had a cup of tea and a milky way, which was their favourite chocolate, as their activity. There was no date to say when this activity had taken place and with who. There was also no detail as to how the person had responded to this activity. Another entry for February stated that staff had sat with the person and showed them pictures which had made them smile. There was no information of what the pictures were so staff would know for future reference.

Whilst people spoke positively about staff they felt that care was very task orientated. People felt their care needs were met staff did not have the time to stop and chat to them. Comments included "They are marvellous but there's no time for chatting." "Night staff can be a bit short and impatient." "Sometimes they are a bit slow to answer the call bell, but they do always come."

Staff comments included "It's all about tasks, not enough staff to do anything nice with the residents." Another staff member said "There's not always the time to chat to people, I always pop my head in as I pass someone's room to check they are ok but sometimes that's all I have time for."

There was a system in place to manage complaints. We saw from a recent complaint the service recorded people's concerns and investigated and responded appropriately. A complaints procedure was available for people living in the home. People and their relatives felt the service was responsive if they had any queries or concerns. They said they would be comfortable raising their concerns. They were confident that any concerns would be listened to and acted upon. One relative said "I feel comfortable going to management with my concerns." People we spoke with said they had not had any reason to make a complaint but felt they could speak with staff if they had any concerns. Comments included "I've no complaints, staff are helpful." "Nothing to complain about, staff are very kind."

Requires improvement

Is the service well-led?

Our findings

During our last inspection the provider had a system in place to regularly assess and monitor the quality of service that people received but this was not consistently effective. Whilst there had been some improvements in this area we found that some of the auditing was still not robust.

At our last inspection we found that no action plan had been put in place to ensure actions identified during audits were carried out. The operations manager showed us the service action plan which included all audits that were carried out periodically throughout the year. These included safe medicines management, infection control, care plans and health and safety. The action plan identified actions required, dates for actions to be completed, when actions were completed and who was responsible.

All of the nurses discussed the monitoring of medicine administration. We were told a new system had been implemented where another registered nurse in the building checked that all of the MARs charts had been signed and completed fully at the end of each shift. These "checks" were kept at the front of the MARs file. On the two units we looked at, we saw gaps where the checks had not always taken place. We were told this was probably because an agency nurse had been on duty. However, staff were not able to tell us how the gaps were addressed. One nurse told us it would be handed over to the next shift to inform any agency nurse to complete the checks, but nobody was able to explain what would happen if the checks were not completed.

Whilst care plans were reviewed monthly these reviews had not identified where information in care plans was contradictory, as we found in the plans we reviewed. It had also not identified where changes to people's care had been entered but had not been dated or signed to identify this was the most up to date information for staff to follow.

Each day there was a head of department meeting and a nurses meeting with the operations manager. This gave staff the opportunity to discuss what was going on in each of these areas and identify areas for improvement. We attended two daily nurse meetings where nurses shared information amongst themselves and with the operations manager. Nurses were supposed to bring the care plans of four "residents of the day" for discussion to these meetings, but this did not happen consistently and on both days staff needed to be reminded to bring them.

There was an audit of activities undertaken in January 2015. Within this audit there was an area which stated 'The range of activities for each resident reflects their choice, social, cultural and religious preference and is available at frequent regular intervals throughout the week'. This was rated as 'good'. However some people and relatives we spoke with felt activities did not meet their needs and reflect their choices. We saw people who during the course of our inspection had no social interaction or activity provided for them. Sections of this audit were rated as adequate or poor. However an action plan of how to improve these areas had not been identified.

We found that whilst the provider had a system to regularly assess and monitor the quality of service that people received but this was not consistently effective. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with said they received regular supervision with their line manager. These meetings were used to discuss progress in the work of staff members; training and development opportunities and other matters relating to the provision of care for people living in the home. During these meetings guidance was provided by the line manager in regard to work practices and opportunity was given to discuss any difficulties or concerns staff had. Staff commented on the recent management changes. Comments included "There have been lots of changes", "some of us have felt a bit wobbly with the changes but things are getting better now."

Responsibilities of different staff roles were clearly identified, with care staff referring to senior care staff who in turn reported to nurses and management. We saw all staff had been written to about what was expected of their job role. The way in which information was communicated to staff was not always effective and differed on each unit. On one unit there was a communication board in the nurse's office which communicated all the information staff needed to know about the people they would be supporting that day. This clearly identified staff's responsibilities for that day. However this system had not

Requires improvement

Is the service well-led?

been implemented in other units. When we asked staff on the other units how they organised their day and how they knew what support people required some responded by saying "We just know." At times staff on these units were seen to be rushing around trying to meet the needs of those individuals requesting support. Staff were not always aware of which staff were support which people. One staff member told us "It's chaotic, we are always rushing around." Another staff member said "It's manic. We try our best but at times, like lunch times, it is not always the peaceful experience for residents it should be."

Accidents and incidents were recorded appropriately. These were assessed by the management team to identify any trends. We saw after a recent incident with one person living in the home appropriate action had been taken. A safeguarding alert had been raised with the local authority.

Care plans had been updated to include guidance on how best to support the individual. The provider had also notified CQC which is a legal requirement of the regulations.

We saw the home had held a recent resident and relative meeting where they could discuss the service they or their family member received. They also had the opportunity to discuss ongoing recruitment issues within the home and invited families to be proactive in speaking to the manager about things that were working well or not so well.

The operations manager had a clear understanding of the changes and improvements that were required within the service. They told us that the challenges for the coming year were to ensure that new systems to monitor the quality of service that people received were embedded and were sustainable. The recruitment of a registered manager, deputy manager and permanent nurses was also a priority for the service.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance People were not protected from the risks of unsafe or inappropriate treatment because accurate and appropriate records were not maintained. (1) (2) (c)

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 Whilst the provider had a system to regularly assess and monitor the quality of service that people received but this was not consistently effective. (1) (2) (a)