Bupa Care Homes (ANS) Limited

Lynton Hall Nursing Centre

Inspection report

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Ratings

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

Overall summary

This unannounced inspection took place on 15 and 16 December 2014. Lynton Hall Nursing Centre provides accommodation and nursing care for up to 57 older people. There were 43 people living at the home when we visited. The home was based on two floors, the ground floor for people with nursing care needs and the first floor for people living with dementia. There were bedrooms, bathrooms and communal rooms on both floors. Each person has their own room with en-suite toilet and some have a bath or shower.

The last inspection on 9 and 22 January 2014 was part of a themed inspection programme specifically looking at the quality of care provided to support people living with dementia to maintain their physical and mental health and wellbeing. We found the service was meeting the regulations we looked at.

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

Summary of findings

People were not safe at the home because the provider did not have suitable arrangements to ensure there were adequate staffing levels in the home. People and relatives' feedback suggested that this was more evident during weekends.

We saw that the provider did not always ensure the safe storage of chemicals and medicines. We found that cupboards used for their storage were left unlocked. This meant that people's health and wellbeing were put at risk. We observed a medicines administration round and the practices used were safe.

Communal bathrooms we looked at were dirty and there were other areas that we found where the standard of cleanliness was not good. Some bathrooms were used to store equipment, including hoists, walking frames, laundry bins and wheelchair parts. Emergency pull cords were not within reach and in some cases tied up. This made it difficult for people to use the bathrooms safely and independently.

The provider had taken appropriate steps to protect people from abuse, neglect or harm. Training records showed that the majority of staff had received recent training in safeguarding adults at risk. Regular checks of maintenance and service records were conducted.

Although the provider ensured there was training for staff, people did not feel that staff had the skills and knowledge to know their needs and preferences. The home had a dementia champion; they had received training on dementia awareness and were responsible for training the other staff on this subject.

Records showed that supervision of staff was conducted every three months. But staff we spoke with said that one to one supervision was not occurring frequently. One staff member said they had not had supervision for more than nine months, another said not recently and another staff member that they had never had supervision. We were unable to look at staff supervision files, so could not verify what staff were telling us.

The provider ensured that people received a variety of meals to meet their needs and choices. People especially liked their breakfast

Some people and their relatives were pleased with the care but other people did not think they were always looked after by staff who were caring. We observed a number of staff engagements with people that were not positive.

People's needs were assessed prior to admission to the home. The care plans overall were to a variable standard. We found few that were comprehensive and had considered who the person was and how they would like to be cared for. Other care plans did not have this detail of information. Some of the care plans we looked at were more than a year old and had not been reviewed monthly as per the provider's policy on reviewing care plans.

There were two part time activities co-ordinators and a programme of activities, including arts and crafts, board games and outings so that people had a range of occupational activities to choose from.

The service was led by a registered manager; they were supported by a deputy manager. The manager had not submitted notifications to the CQC as they are required by law. They had not notified CQC of any Deprivation of Liberty Safeguards (DoLS) applications and the decisions taken. These safeguards ensure that a service only deprives someone of their liberty in a safe and correct way, when it was in their best interests and there was no other way to look after them.

People and relatives were aware of the complaints procedure and those who have raised concerns felt that these had been listened to and things had improved. The provider Bupa Care Homes (ANS) Ltd conducted monthly reviews of the service; we saw that recommendations made had not been actioned. The provider's monitoring systems were therefore not effective.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond to the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The actions we have asked the provider to take can be found at the back of this 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?

Inadequate

The service was not safe. Hazardous chemicals were not stored securely. The majority of medicines were not stored safely, some areas of the home were dirty This meant that people's health and wellbeing were put at risk.

There was insufficient staff to support people.

Individual risks assessments for people were not updated as required to reflect people's changing needs.

The provider had taken appropriate steps to protect people from abuse, neglect or harm.

Regular checks of maintenance and service records were conducted.

Is the service effective?

Inadequate

The service was not effective. Some staff did not always have the skills and knowledge to know people's needs and preferences.

The service had not taken the correct actions to ensure that the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were followed.

There was an annual staff training programme in place but we did not always see this training put into practice.

The supervision of staff did not place on a regular basis.

Where a person may have subjected to restrictions of their liberty we did not see that they had given their consent.

Is the service caring?

Inadequate

The service was not always caring. People were not always looked after by staff who were caring and respectful. Their independence was not always promoted.

Call bells were not always within reach of people.

Staff did not have arrangements to support people and where appropriate relatives in making decisions about their care.

Staff did not always respect people's privacy and dignity

Is the service responsive?

Requires Improvement

The service was not responsive.

Whilst people's needs were assessed prior to admission to the home, care plans were not comprehensive and had not considered who the person was and the care they would like to receive.

Summary of findings

Some of the care plans we looked had not been reviewed often enough to ensure these appropriately reflected people's needs.

There were two part time activities co-ordinators and a programme of activities to ensure people had enough activities to choose from and to keep occupied.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems used by the provider to assess the quality of service were not effective and actions arising from these assessments were not being followed through so the necessary improvements were made.

Staff and relatives felt the manager and deputy were approachable. This was also confirmed by staff.

Lynton Hall Nursing Centre

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 December 2014 and was unannounced. It was carried out by an inspector and a specialist advisor who was a qualified nurse. Before the inspection, we reviewed information we had about the service such as notifications the service were required to send to the Care Quality Commission (CQC).

During this inspection, we spoke with 11 people living at the home, 10 relatives, two nurses, five care staff, the dementia champion, the activities co-ordinator, the registered manager and deputy manager. We also spoke with the senior nurse from the local nursing impact team who was visiting the home. We observed care and support in communal areas. To do this we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care records for 10 people and pathway tracked three of these people. We reviewed 11 people's medicines records. We also looked at other records that related to how the home was managed including the quality assurance audits that the registered manager and provider, Bupa Care Homes Ltd completed. We also reviewed the training and staff supervision records for all staff employed at the home.

Inadequate

Is the service safe?

Our findings

The provider did not always ensure that the premises were safe. The communal bathrooms we looked at were congested with equipment, including hoists, walking frames, laundry bins and wheelchair parts. Emergency pull cords were not within reach and in some cases tied up. This meant that people could not use the bathrooms independently and safely. This was a breach of Regulation 15 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have suitable arrangements to protect people against the risks associated with medicines. We found that not all medicines were stored safely. A cupboard that was used to store oxygen cylinders and unused or out of date medicines waiting to be returned to the pharmacy was unlocked and accessible to people. This was pointed out to staff who told us the door would be locked. On the second day of our inspection the door was still unlocked. The locked medicines trolley was stored in an unlocked office area used by staff and accessible to visitors and people who lived at the home. The medicines trolley was not secured to the wall. One cupboard containing medicines could not be locked and the medicines fridge was also unlocked. We asked staff to lock the fridge and they did. We observed a medicines administration round and the practices used were safe. But the lack of care over the storage of medicines meant that people's health and wellbeing were put at risk. There was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not ensure that the premises were cleaned to an adequate standard to ensure people were protected from the risks of the spread of infection. All the communal bathrooms we looked at were dirty; many of the rubbish bins for soiled personal items were full. Sinks for washing hands and faces or shaving did not have plugs in them, which could make it difficult for people to effectively manage their own care and hygiene. In one bathroom the toilet paper was not within reach of the toilet. There was an odour in these rooms and the adjoining corridors. The kitchen area and heated food trolleys were seen to be dirty.

We looked at the cleaning schedule for the kitchen and saw that cleaning had not taken place on the previous three days to our visit. We saw that kitchen staff stored their coats and bags in a cupboard containing dry food goods, such as flour and sugar and that care staff entered the kitchen without putting on protective clothing. This lack of attention to safety, cleanliness and infection control could put people's health at risk. This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider carried out risk assessments, included health and safety risk assessments in relation to the premises. During the inspection, we saw that the door to the sluice room on the first floor was unlocked and open, inside was an open cupboard that contained cleaning fluids. This meant that the risks of people accessing these areas had not been mitigated by keeping the sluices locked.

There were individual risks assessments in place to ensure the safety of people using the service; however these have not always been updated as required to reflect people's changing needs. In the daily records of another person, there were entries relating to their behaviour, describing it as 'agitated' and 'shouting' on several occasions, yet the behaviour recording form was blank and there were no plans or actions about how to support the person when they behaved in this way. The record of falls in another person's care records showed they had sustained six falls since March 2014. Their risk assessment had limited details and there was no management plan in place to help reduce the number of falls occurring. The above show there was a breach of Regulation 10 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.

Two relatives told us "Staff are desperately short at the weekends". Another relative told us that it could take up to 30 minutes for a call bell to be answered. A third told us their relative had not been able to hold themselves as they had waited so long for help to use the toilet. We looked at the staff rotas which showed a full team of staff were on duty in the evenings and weekends, however some staff told us that staff sometimes just didn't turn up and this left them short. We could not evidence this with the written

Inadequate

Is the service safe?

information we looked at, although we did see that staff were very busy and there were staff shortages at certain times of the day, such as lunch breaks or where people require the assistance of two staff to help them.

There were policies and procedures available to staff which set out how they should protect people from abuse, neglect or harm. Training records showed that the majority of staff had received recent training in safeguarding adults at risk. However when we spoke with seven staff members and asked them about safeguarding and reporting of such matters although they understood the main themes to safeguarding and would report these to the manager they lacked the knowledge of reporting concerns to external bodies. We saw that more training was planned for 2015. Where there had been safeguarding concerns about a person, the manager had dealt with these appropriately. The manager had worked with the safeguarding team from the local authority to investigate any allegations thoroughly and taken action to address the issues raised.

There were arrangements to deal with fire risks. Unannounced fire drills were taking place four times a year both at night and during the day time. The last fire drill was on the 4 September 2014 and it was noted that not all staff came to the assembly point and that staff appeared confused as to what actions to take. The provider had arranged for all staff to have refresher training in fire safety and we saw this had taken place for the majority of staff.

Regular checks of maintenance and service records were conducted. We saw that up to date checks had been made of fire equipment, emergency lighting, some of the gas fed equipment, audio monitors, portable electrical appliances, water temperatures and food safety and hygiene. We did not see a current certificate for legionella water testing although we saw written evidence that the system had been tested. The gas boiler had been tested in May 2014 and was passed as fit for use but a landlord's gas safety certificate was not available to see. The maintenance person said they would ensure certificates were obtained from the testing company. These checks helped to ensure the home and any equipment used was safe.

Inadequate

Is the service effective?

Our findings

People told us that generally the care they received was good, but that some staff did not always have the skills and knowledge to know their needs and how to meet them. Records showed there was an annual training programme in place. We reviewed these records and saw that the majority of staff had attended the required training relevant to their role, but we did not always see this training put into practice. The manager was aware of the need to implement a follow up to the training programme to ensure the training was put into practice but had not been able to implement this at the time of our inspection.

We saw that the majority of staff, (61 out of 76 staff) had attended care of a person with dementia training and all bar one member of staff had attended managing behaviours that challenge training but we did not see that this training was put into practice. We saw one person shouting and pacing in the lounge and hallways, staff appeared unable to manage this behaviour and wanted the person to sit down, this insistence made the person more distressed. Staff had also not considered or taken action where some aspects of the surroundings were not conducive to the care of people who might be disorientated to time and place. On the first floor of Lynton Hall where the majority of people had a diagnosis of dementia we saw that some orientation and directional signs were not in place, most of the clocks on the first floor had stopped and in one bedroom the calendar was showing November 2014 and not December 2014. The one menu in the dining area was for Sunday, although it was Monday and there was no pictorial menu available only a written one. We spoke to the manager about this who said they would review how staff applied their learning when caring for people in the home.

The home had a dementia champion. They had received training on dementia awareness and were responsible for training the other staff on this subject and observing practices and engagement with residents during their daily job. But we saw that there was not always sufficient time for them to observe staff and engage with people who had dementia.

The home employed two part time activity co-ordinators, we spoke with one of them and they stated they had not received any training for their role and felt they would benefit from specific activities training for people with dementia care needs. The manager was aware of this and said that suitable training would be organised.

Staff we spoke with and records showed that they had received an induction to the home. Staff stated it covered the basic requirements dealing with health and safety, equality and inclusion and effective communication. The supervision of staff was conducted by the registered manager, deputy manager and senior nurses and was scheduled to take place every three months. We were unable to see the minutes of these meetings and a central record of supervision was not kept and so we could not clarify if they had taken place. Some staff stated that one to one supervision was not occurring frequently. One staff member stated they had only received one supervision session in the last 10 months, another stated they had never had supervision and another saying “not recently “. We were told that annual appraisals were conducted in January of each year although some staff stated they had not received an appraisal. The current manager was not in post in January 2014 and could not tell us if the appraisals had taken place. We discussed this with the manager who told us they would ensure that the dates for supervision are annually diarised and that each member of staff would receive a documented annual appraisal.

We found that the provider had not taken the correct actions to ensure that the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were met. These safeguards ensure that a service only deprives someone of their liberty in a safe and correct way, when it was in their best interests and there was no other way to look after them. The manager had not notified CQC of any Deprivation of Liberty Safeguards (DoLS) applications and the decisions taken.

The provider had policies and procedures for staff which provided them with clear guidance about their duties in relation to the MCA and DoLS. We observed that the internal doors to access the stairs between floors, the lifts and the external doors of the home were all key pad coded. On looking at the provider’s records and people’s care plans, we were unable to establish if the provider had considered that these restrictions could amount to a deprivation of liberty so they could make the necessary referral to the local authority for authorisation under DoLS.

Inadequate

Is the service effective?

We found that where people might have been subjected to restrictions on their liberty, that consent had not always been sought. In cases where they were unable to make these decisions we did not see that capacity assessments had been carried out and their relatives had been involved in these decisions. For example we saw that bed rails were in use for several people. We reviewed those people's care plans but could not find details of a risk assessment for the use of bed rails or of a best interest decision regarding their use. The issues summarised above were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed the breakfast service on two mornings and the lunch service on the first day of our visit. People told us, "Breakfast is good here; you get a choice of hot or cold and juice." Two other people told us they had a cooked breakfast each day and 'it was lovely'. The temperature of cooked food was monitored to ensure these were served appropriately to people. The food we saw served in the two dining rooms appeared hot where appropriate and looked appetising and was colourful. There was a choice of meals.

Two relatives of one person and another relative commented that they visited at meal times to ensure their relative has a meal because they said staff were rushed with the amount of residents they have to help. We also saw that staff did not always support people appropriately with their meals.

Lunches on both floors of Lynton Hall were served either in the dining rooms or in people's bedrooms. We saw that meals were taken to a person's room but not always put within reach of the person or that the person was helped to sit in a position where they could reach their meal. Food then went cold before staff returned to help the person.

We observed several incidents where food had been left in a room and staff walked away even though the person needed help to eat. We saw a member of staff take a plate of melon to one person and picked the melon up with their hands and placed it on the table in front of them. There was no communication between staff and the person observed. We observed at one point that many of the staff had gone on their own lunch break leaving only one staff member in the dining and sitting room on the ground floor. We spoke to the manager and staff about this at the time and where food had gone cold it was changed and help was given.

When issues had been identified such as weight loss this was not always reflected in the care plans so staff had clear guidance about how to monitor and support people with their meals. One weight chart had no records since 16 November 2014, yet weekly weighing was indicated. In another care plan weekly weights had not been recorded since 9 November 2014, even though a weight loss of almost two kilos was recorded on 2 November14. One record showed the weight of one person had not been recorded for five months, during which time the person had lost six kilos. The care plan did indicate the person was overweight but there was no explanation as to why there was a gap in recording of the person's weight. The above show that there was a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that people were able to access GP services and other healthcare professionals when needed. We saw one person asked to see the GP because of a reoccurring condition and staff called the GP surgery to make an appointment for the GP to visit. A family member told us their relative was seen by the GP on a regular basis. Staff told us and care records confirmed that the local nursing impact team called at the home on a regular basis to assist staff with wound management and training. The occupational therapist also gave training on moving and handling of people and use of equipment.

Inadequate

Is the service caring?

Our findings

People were not always looked after by staff who were caring. Our use of the Short Observational Framework for Inspection (SOFI) tool found most interactions between staff and people were not positive.

A visitor told us they had heard people calling out for help and had helped a person themselves when no staff could be found. Another relative said they found their family member wet during the morning but staff had made no attempt to help the person. When asked why this had happened, day staff blamed the night staff for not helping the person even though it was nearly mid-day.

Staff were heard to speak about people in loud voices as though the person was not there. We saw and heard in the ground floor lounge staff calling out 'can we move x and don't sit x there take x to the toilet'. Another staff member was heard to shout in the lounge area "x needs to be changed". We heard on several occasions staff calling people by the wrong name and also calling out 'Who's feeding today', and 'I've done x', referring to people who needed assistance to eat.

Where people required assistance to eat their meal in the dining rooms staff did not give time to the person on an individual basis and would help two people to eat at the same time. Staff did not sit beside the person when giving help but stood beside or behind them, sometimes holding onto the back of their chair or wheelchair. We saw that help was given without speaking to the person or engaging in any eye contact. Staff would leave a person they were helping to help someone else or to speak to other staff and in some cases to leave the dining room, only to return later and continue helping a person to eat. We observed that food was often 'pushed' into a person's mouth.

We observed staff helping people to move in the lounge area. One staff member was trying to physically lift a person from their chair using the person's walking frame as an aid. Another member of staff was heard to say 'sod that', when helping a person to move. One family member told us that their relative had sustained bruises on their legs from a hoist being wrongly used.

One person who used a commode independently told us they were unable to close their door before doing so and staff often did not respond to their call bell. They said they had to cover themselves with a blanket if necessary. Another resident was seen undressed in their room with the door open but they were unable to shut the door themselves, their call bell was not within reach. We observed that call bells were not always in reach of people when they were in their bedrooms. We found call bells were located behind the bed or on the floor beside the bed. We saw no evidence that call bells were available in the communal lounges and although these were staffed most of the time there were periods when no staff were present.

There was a bathing list indicating whether a person had a weekly bath or shower, which did not take into account people's preferences and wishes in regards to how often they wanted a bath or shower, this appeared to be a fixed day with no flexibility. One person told us that in the last six weeks they had only had one bath even though they should have two baths a week. They said "A bath is lovely but there aren't enough staff to help me, so I only have strip washes."

We observed staff engagement with people on the first floor during the majority of the first day of our inspection. We noted that the TV was on continuously, on a news channel that was repeating the same news story. At around 1pm the TV was changed by staff, although people were not asked what they wanted to watch or listen to. We heard a staff member tell another person, who was calling out for help for themselves and other person "Will you please sit down", this was said several times. They did not make any attempt to find out why the person was asking for help. The above show that there was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did observe one of the registered nurses demonstrating good interactions with people and telling staff not to stop one resident from wandering but to let them do so. However, apart from the medication administration round this nurse was not in the lounge for the majority of the day and was unable to supervise care staff effectively.

Despite what we saw and found on the two days of our inspection one family describe the care given by a senior staff member to their relative as 'exceptional'. A relative said "I cannot speak highly enough of the home", my relative has gained weight and is much better off here."

Requires Improvement

Is the service responsive?

Our findings

People's records showed that their needs were assessed prior to admission to the home. Relatives and people confirmed this. The care plans were well laid out and each section clearly labelled. In addition, to assist staff the file prompted staff to what risk assessments and records may need to be included in the current section. There were additional information sheets such as the Bristol stool chart, wound care information and guidance on other risk assessments. Sections on "Who am I" and "A map of my life" were included.

However, care plans were not always detailed enough to describe how to meet a person's individual needs. These had not fully considered the person's background, life style, wishes and preferences of how they would like to be cared for. Some of the care plans we looked at were more than a year old, but we could not find any dated reviews other than "no change to care plan". There was also little evidence that people or their relatives were involved in care planning. The communication section of the care plans included a person and relatives input sheet. The manager told us this is where evidence of a person or relatives input into the care plans was noted. Whilst two relatives told us they had seen the care plans and had been involved in their development, we were unable to locate any entry relating to discussion about the care plans in the three care records we looked at. The above showed that there were risks that people might not receive the care they need according to their preferences and wishes because these have not been accounted for when the care plans were developed. There was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One care plan detailed a leg wound and there were photographs of the wound to monitor its progress. There was an undated report from the Tissue Viability Nurse (TVN) about the leg wound, which contained their advice about how to care for the wound. However, the care plan itself was general and did not detail the specific care required or refer to the TVN report. There were no further updates on the progress of this wound since November 2014.

One chart used for the recording of blood sugar levels for one person, indicated that these levels should be checked fortnightly. The last recorded check was 12 November, over a month ago. Staff could not explain why this had not happened fortnightly, despite the person's sugar levels being erratic.

There was a programme of activities and it was noted in people's daily records if they had attended. The activity co-ordinator told us they read peoples care plans to see what things they liked to do or what they had done in the past and they spoke with people and used this information to plan the activities. These included arts and crafts, manicures, board games and outings, although they did tell us that organising outings could be difficult because of the amount of paperwork to be completed and staff availability. Entertainment was also organised as were visits from local churches. On the first day of our visit the activities co-ordinator was making Christmas calendars with people on the ground floor. The co-ordinator visited people who preferred to stay in their room to chat or play games. During our time observing people on the first floor we did not see staff attempting to initiate any activities. We saw very little spontaneous engagement between staff and people. Some people would initiate contact with staff through speech or their behaviour, and generally staff would respond but would not explore the reasons for the engagement nor follow it on.

The provider responded appropriately to people's concerns and complaints. Relatives and people we spoke with said they knew how to make a complaint to the service and felt comfortable doing this. We saw that leaflets were available in the main reception area. One set of relatives said, "We have always spoken up; we have raised concerns on several occasions". They felt that their concerns had been listened to and things had improved.

We saw the service had a complaints procedure which detailed how people could make a complaint about the service. We noted all complaints received by the service were logged by the manager and the actions taken to resolve these had been documented.

Requires Improvement

Is the service well-led?

Our findings

The provider had quality assurance systems but people were not always protected against the risks of poor care and treatment because these systems were not always effective in identifying areas for improvement and for ensuring that prompt remedial action was taken to make improvements.

As part of this inspection we asked the provider to complete and send us the 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. When we asked the manager why the PIR had not been completed and returned, they said they had not had enough time to gather the information required.

The manager told us and we observed during our visit that each day either they or the deputy manager 'walked the floor'. During their walk they looked at different aspects of the home to ensure that systems were safe. All areas were looked at including the environment, service of meals, staffing levels and activities on offer. Any changes required were noted to be actioned. The manager conducted weekly, monthly and quarterly audits of complaints and compliments, falls or other accidents, health and safety and medicines. The supplying pharmacy conducted annual audits of the supplied medicines, the last audit in September 2014 was positive

The provider, Bupa Care Homes Ltd conducted monthly reviews of the service, this included quality of care, quality of life, quality of leadership and management, quality of the environment and general observation of care. The provider was looking for both positive and negative aspects of the home and these were reported back as an action plan. We saw the report dated 4 November 2014; the only section completed was for quality of care. This included a review of four care plans, errors that had occurred and actions to be taken, no other areas were reviewed or reported on. We also saw the action plan for October 2014, with recommendations to be completed by 14 November14. The recommendations included removal of unused medicines, complete care plan updates, rearrange ground floor lounge so that chairs were not all against the wall and ensure that food and fluid charts are completed. During our visit we saw that these recommendations had not been actioned.

The lack of updated care plans had been noted in the provider's October monthly monitoring review. This included an action for care plans to be updated. We asked the manager about this and they said that there was so much to do that priorities had to be made and so not everything got done.

The provider's monitoring systems were therefore not effective because where actions were needed to be taken they had not been and these failed actions had not been noted in the following months reviews. We spoke with the manager about this. They acknowledged this and said a lack of staff and time meant that other priorities took over and not all changes could be made.

The above issues were a breach of Regulation 10 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.

The service was led by a registered manager who had managed the home for less than a year. They were supported by a deputy manager. From our discussions with the registered manager, it was clear they had an understanding of their management role and responsibilities. Whilst they understood their legal obligations with regard to CQC requirements for submission of notifications, they had not always submitted these in a timely manner. We had not received a notification to inform us that an application for DoLS had been authorised by the local authority. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People, relatives and staff were asked for their opinion of the service through an annual survey. The staff survey sent out in September/October 2014 was a global survey for all Bupa staff and the report we saw was not broken down into individual homes, so we are not able to report on this. The people and relatives survey was sent out in November 2014 and the results were not available during our visit. We saw the results for 2013 which showed that 25 questionnaires were sent out and 11 returned. The results made comparisons between the previous survey and this one and showed if people's satisfaction with the service had changed. They showed that activities had improved and one area for improvement was food. Consistency and lack of staff and promptness of staff to attend to people's needs was also identified. Our findings during our visit showed

Requires Improvement

Is the service well-led?

that whilst we saw an improvement in the provision of activities and meals for people, there was still a lack of staff to meet people's needs. This meant that the action plan following the 2013 survey might not have been fully met.

Relatives said the service ran in an open manner and they felt able to raise issues with the manager and knew they would be addressed. Staff also said the registered manager and deputy manager were approachable and could raise any issues with them. The service had a whistleblowing procedure with which staff were familiar with. Whistleblowing is when a worker reports wrongdoing at work to their employer or someone in authority in the public interests.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People using the service, staff and others were not protected against identifiable risks of acquiring an infection by the means of the maintenance of appropriate standards of cleanliness and hygiene in relation to premises or equipment used for the purpose of carrying on the regulated activity.** Regulation 12(1)(2)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **People who use services and others were not protected against the risks associated with unsafe or unsuitable premises, by means of the proper operation of the premises.** Regulation 15(1)(c)(d)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People who use services and others were not protected against the risks associated with the unsafe use and management of medicines by means of making appropriate arrangements for the safe keeping of medicines.** Regulation 12(f)(g)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **People who use services were not protected from the risks of inadequate nutrition and dehydration, by means of the provision of support, where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs and monitoring their nutritional status.** Regulation 14(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People who use services were not protected against the risks of inappropriate care and treatment by means of the planning and delivery of care to meet the service users' individual needs and to ensure the welfare of the service user.** Regulation 9(1)(a)(b)(c)(3)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider did not have suitable arrangements in place for obtaining and acting in accordance with the consent of people who use services in relation to the care and treatment provided for them.** Regulation 11(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **Regulation 18 Care Quality Commission (Registration) Regulations 2009. Notification of other incidents.**

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not notify the Commission without delay of any requests to a supervisory body or any application made to a court in relation to depriving a service user of their liberty.

Regulation 18(1)(2)(c)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People who use services and others were not protected against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the services provided and identify, assess and manage risks relating to the health, welfare and safety of service users and others. The registered person must have regard to reports prepared by the Commission from time to time relating to the registered person's compliance with the provisions of these regulations. Regulation 10(1)(a)(b)(2)(b)(v)(3)

The enforcement action we took:
We issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Suitable arrangements were not in place for people who use the service to have their dignity, privacy and independence maintained and to enable service users to make, or participate in making, decisions relating to their care or treatment, or to be treated with consideration and respect. Regulation 17(1)(a)(b)(2)(a)

The enforcement action we took:
We issued a warning notice