St Philips Care Limited

Bowburn Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 14 and 15 March 2016 and was unannounced. This meant the staff and the provider did not know we would be visiting.

Bowburn Care Centre provides accommodation and personal care for up to 80 older people. The home is set in its own grounds in a residential area near to public transport routes, shops and local facilities.

On the day of our inspection there were 60 people using the service. Accommodation is provided across two floors within four separate areas. Facilities included several lounges, dining rooms and kitchenettes, a hair salon and an enclosed garden area.

We saw that entry to the premises was controlled by key-pad entry. All visitors were required to sign in. This meant the provider had appropriate security measures in place to ensure the safety of the people who used the service.

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. At the time of the inspection there was a registered manager who had been in their present post at this home for over two years.

The registered provider had in place a safeguarding policy. However we found one person to be at risk of harm because details in their care plan had not been followed in practice. We made a referral to the local safeguarding authority to ensure this person was protected from the risk of harm.

People living at the home were at risk of inappropriate use of sedation medicines because there was incomplete information in their care plan about the reasons and thresholds where they should or should not be given. The provider could not demonstrate if pain relief patches were actually removed or not, potentially placing the people at risk of overdose.

The registered manager carried out a monthly analysis of accidents and incidents to check for patterns and trends and see if there were any ways of preventing future accidents. But we found instances where people were put at increased risk of accidental injury from insecure bedroom furniture, fire protection doors being held open and broken or disengaged window restrictors.

There were odour control issues in some parts of the home and steps to ensure that the home is kept clean and the people living and working there were protected from risk of infection were not effective.

There was a staff training plan in place. However staff had been required to carry out physical restraint without any training having taken place to ensure this was safe. This meant that staff had not been provided

with the necessary skills to safely meet the needs of the people in their care.

People were not always treated with dignity and respect. Not all staff spoke with the people they were supporting in a respectful manner and one person's property checklist had been written on a piece of hand towel paper.

We saw that people's nutritional needs were assessed and plans of care drawn up if they were at risk of malnutrition or choking. The cook demonstrated that she had an extensive knowledge of people's likes and dislikes and prepared a wide selection of wholesome and popular meals to cater for people's tastes.

Arrangements for the assessment planning and review of peoples' needs were not consistently in place. Staff and vulnerable people living at the home were at risk where the needs of people with complex mental health requirements were not known, understood or well planned.

There was member of staff employed by the provider whose role it was to prepare activities for people living in the home and staff had found out about some peoples' past histories and provided activities to meet their needs.

The provider did not take steps to promote a calm relaxed therapeutic atmosphere at mealtimes nor ensure sufficient staff were deployed in a timely manner to make sure people were not at risk: Checks to make sure the continued use of antipsychotic medication was appropriate for some people, had not taken place: Measures to reduce the risk of skin pressure damage were not implemented in a safe way for some people. The provider's systems to assess monitor and improve the quality and safety of the home had not been successful in these areas.

CQC monitors the operation of the Deprivation of Liberty Safeguards [DoLS] which applies to care homes. The Deprivation of Liberty Safeguards are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We found the provider was following legal requirements in the DoLS.

We found the provider had recruitment procedures in place to make sure only those suitable to work with vulnerable people are employed. However the provider had failed to fully explore some staffs previous work history so their suitability could not be assured.

The service had a complaints policy which provided people who used the service and their representatives with information about how to raise any concerns and how they would be managed.

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

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Procedures to safeguard people using services were not robust.

Arrangements for the administration of medication did not always protect people from risk.

Actions to ensure the control of infections were not effective.

Is the service effective?

Requires Improvement

The service was not always effective.

The physical environment throughout the home did not reflect best practice in Dementia care.

Staff did not always receive suitable training and development to ensure they were sufficiently knowledgeable and competent to meet the needs of people they supported.

Is the service caring?

Requires Improvement

The service was not always caring.

Not all staff spoke with the people they were supporting in a respectful manner.

Some people's records did not demonstrate that they or their belongings were valued by the provider or that they were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Arrangements for the assessment planning and review of peoples' needs were not consistently in place.

Staff and vulnerable people living at the home were at risk where the needs of people with complex mental health requirements were unclear.

Is the service well-led?

Requires Improvement

The service was not always well led.

The management systems which should have ensured the service was well-led were ineffective.

The management team did not have had effective systems in place to assess, monitor and drive the quality and safety of the service.

Actions to assess, monitor and mitigate risks to health and safety were not always effective.

Bowburn Care 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 checked whether the registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection of Bowburn Care Centre took place on 14 and 15 March 2016 and was unannounced inspection. This meant that the provider was not aware of our visit prior to it taking place.

The inspection team consisted of one adult social care inspector and two specialist advisors. The specialist advisors had a background in working with people with dementia and of providing nursing care respectively. During our inspection we spoke with fifteen people who used the service and four relatives / visitors. We spoke with the registered manager, the deputy manager, senior and care staff, housekeeping, maintenance and kitchen staff.

We carried out observations of care practices at the home and visited most areas. We also spent time looking at records, which included six people's care records, and records relating to the management of the service.

Before the inspection, the registered provider completed a Provider Information Return [PIR]. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We used the content of the PIR to inform our inspection and to ask questions of the registered provider.

Before the inspection we reviewed all the information we held about the service. We reviewed any notifications that we had received from the service and information from people who had contacted us about the service since the last inspection. For example, people who wished to compliment or had information that they thought would be useful.

Before the inspection we reviewed information from the local safeguarding teams, local authority and health services commissioners in which the provider operated. Prior to the inspection we also contacted the

local Healthwatch. Healthwatch is the local consumer champion for health and social care services. They give consumers a voice by collecting their views, concerns and compliments through their engagement work. Information given by these public bodies were used to inform the inspection process.

Requires Improvement

Is the service safe?

Our findings

People we spoke with said they felt safe. One person told us, "They do lots for me as I'm a bit unsteady on my feet but I know they're always there when I press the buzzer [nurse-call]." Another person told us, "The staff look out for people who can't do it themselves." Relatives told us they, 'had no concerns about safety' and 'weren't worried' about their relative's well-being. One relative told us, "I'm not worried about the care [their relative] received when I'm not here; I could tell if something isn't right when I visit."

We saw the registered provider had in place a safeguarding policy. Prior to the inspection we reviewed the safeguarding incidents notified to us by the home. We found there were a number of incidents between people who used the service. The registered provider told us about actions they were going to take to keep people safe. However in the care records for one person we found an assessment from an NHS Foundation Trust dated October 2015. In this assessment it had been recorded that the person had suicidal thoughts and had talked of how they would take their own life. We saw that the provider had written a risk assessment describing specific actions the staff needed to take to keep this person safe from harm. During the inspection we found that the actions which were described in the assessment had not been carried out placing them at risk of harm. We drew this to the attention of the registered manager who agreed that the risk reduction measures had not been carried out. We made a referral to the local safeguarding authority to ensure this person was protected from the risk of harm.

We examined the medication administration records [MAR] and practice in detail on the 'Brockwell' are of the home where people with nursing care needs were residing. We found that records were organised and a policy and procedure for the administration of medication was available to guide staff's practice. Areas of good practice such as a homely medications protocol [those that are not required to be prescribed by a doctor] and a policy for administering medication covertly [in the person's best interests] were in place.

We also found that staff were responsible for administering sedative medication should they become anxious or stressed. However for some people there was incomplete information in their care plan about the reasons and thresholds where medication should or should not be given, preventative actions staff should take or of any known causes which could then be avoided.

A number of people living at the home were prescribed medication for pain relief through transdermal patches [placed on skin.] We found that each person had a transdermal patch record form attached to their MAR. However we found that in some cases the form was not completed to record when the patches were removed. This showed that the provider could not demonstrate if the patches were actually removed or not, potentially placing people at risk of overdose. We drew this to the attention of the registered manager for her immediate attention.

We found that some people were prescribed topical creams and a chart with body maps were kept in a separate file for care staff to record applications. However we found that the forms were of such a poor quality photocopy as to be almost illegible and that the records of topical cream application was not routinely completed. In some cases these were completely blank therefore it was not possible to determine

if the prescribed creams were applied as directed or not.

We carried out a check of controlled drugs to see how these were managed at the home. Controlled drugs are drugs liable to misuse. We checked one person's controlled drugs and the stock balanced. We looked at a selection of medication and found no discrepancies when compared with the controlled drug record book. However we did find that in one instance one medication had not been signed by the second administrator to verify that the medication had been given. This was brought to the attention of the registered manager and was rectified later that day.

We spent time observing care practices in the 'Brockwell Unit" where people with advanced dementia type illness were accommodated. We saw that on two occasions the dining room was left unattended by staff with a 'hot trolley', which is used to serve meals, plugged into the wall where four people with dementia were sitting, all of whom could mobilise independently. This meant people were placed at risk of burns and scalds.

The registered manager told us that the home had procedures in place to ensure control of infections. We were shown cleaning routines which were carried out by staff and audits [checks] of their work which was carried out by senior staff. The registered manager told us she had recently received advice from the providers cleaning specialist and chemical detergents were no longer being used in the carpet cleaners at the home. We found areas where the odour control at the home had not been successful. For example, there was a strong unpleasant odour in the corridor near to the two dining areas of the 'Brockwell Unit'. We also found a strong unpleasant odour in one person's bedroom. The easy chair in this room was heavily soiled with what appeared to be old food debris. There was a brown like substance splattered on the ceiling in this bedroom. We spoke to the manager about this person's room. The manager stated that due to this person's mental health needs they would not always allow staff in to clean this area. We saw there was no plan in place to guide staff as to how to manage this situation to ensure effective infection control.

We looked at other areas of the home and found chairs in people's bedrooms which had damaged upholstery that was soiled with brown and yellow substances and could not be effectively cleaned. Several people had skin pressure relieving equipment that was soiled and stained; some of this was also damaged and could not be effectively cleaned. In one persons' room the mattress and bedframe had brown stains / deposits but clean sheets had been put on without cleaning these first. In another person's room a bed pan had been spilled under the bed and had not been cleaned up. We drew these to the attention of the registered manager for her immediate attention.

This was breach of Regulation 12 of The Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

During this inspection we looked at the recruitment records for five staff, who had been employed to work for provider since 2015. We saw gaps in two records we looked at which placed people at risk of harm. Applicants had been asked to complete a job application form. In two out of the five records we looked at the section requiring the applicant to provide an employment history was incomplete. There was no evidence that gaps in people's employment history had been explored further by the provider as part of the recruitment process. For example, in one person's file there was a gap in their employment history of two years. The only reason given by them on the application form was 'Travelling'. Similarly on a second job application, the employment history section stated they were employed in 2013 however this did not match with the dates of employment as stated on the reference, which was October 2012 – December 2015. There was no information in the file that this had been noted and followed up. For one person they had listed their previous employers in the work history section of the application form. However this person had listed a

previous employer as a referee who was not recorded in their work history. Again there was no note on the file to show that this had been noted and followed up prior to employment. This showed that checks to verify staffs employment history were not carried out diligently and had not protected vulnerable people from potentially unsuitable employees.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

The registered provider had in place an electronic analysis of accidents and incidents in the home. The registered manager carried out a monthly analysis of accidents and incidents to check for patterns and trends and see if there were any ways of preventing future accidents. The regional manager had also reviewed the accidents and made recommendations to the registered manager for example to review if a person needed a referral to the falls prevention team.

Requires Improvement

Is the service effective?

Our findings

Staff told us they were able to undertake training courses and felt they had the support from senior staff and the registered manager when they needed. One member of staff commented, "I have been working here two years. I love it." Another staff member told us, "If there is any training you would like to do we can put our names forward." And, "We have supervisions [with senior staff or managers] regularly now." Supervisions are meetings held with senior staff where workers can discuss their performance, training and any other issues which helps improve their work.

We looked at the arrangements at the home to ensure staff were suitably qualified and experienced to fulfil the requirements of their posts. Staff had the opportunity to develop their skills and knowledge through the registered provider's training programme. Staff told us the training was relevant and covered what they needed to know; they had recently received training on supporting people living with dementia and end of life care.

Some of the care and nursing staff had considerable experience of working at this and other care and medical establishments. New staff spent time shadowing more experienced team members to get to know the people they would be supporting. They also completed an induction checklist to make sure they had the relevant skills and knowledge to perform their role. Plans were in place for staff to complete other relevant training such as understanding of Deprivation of Liberty Safeguards DoLS. Nursing staff told us they received clinical supervision from the manager who was also a qualified nurse and were supported to complete their continual professional development training as required.

However we saw in one person's care records an entry had been made dated 30 November 2015 'Staff had to intervene and hold onto both [Name of person] hands so [they] would release staff member.' We asked the registered manager what training staff had had in relation to safe physical intervention. She confirmed that staff were trained in responding to challenging behaviour but informed it was not the policy of the registered provider to provide training in relation to physical intervention. This meant that staff had not been provided with the necessary skills to safely meet the needs of the people in their care.

We observed the organisation of the midday meal between 12.15pm and 13.17 pm in the two dining areas on the 'Brockwell Unit.' At 12.15 pm we saw that six people were sitting in these areas. At this time care staff were busy in other areas of the unit. We saw that the hot trolley, containing the midday meal, did not arrive until 12.45 pm. Between 12.15pm and 12.45pm at least two people got up from their chairs and left the dining area. We observed one person banging on the table, pushing the table away from themselves towards another; and another person shouted out as they were becoming distressed by this noise. The fire alarms were also tested during this time at 12.24pm which contributed to the overall noisy, disruptive atmosphere. When the hot meal trolley arrived we saw staff plate food and take them to people who had chosen to have their meals in their bedrooms. Therefore it was not until 12.50pm that the first two people were given their meal in the dining rooms. They had been waiting in the dining area for 35 minutes without food or drink. We saw that one person who required assistance to eat their meal, and due to their mobility

needs was unable to leave the dining room, had sat without food or drink from 12.19pm until 13.12 pm, a total of 53 minutes, until a member of staff was free to provide them with assistance. The overall atmosphere was task orientated and reactive, with some people having to wait an exceptionally long time before receiving their meal. This is not best practice in caring for people with Dementia type illness. The failure to provide a calm relaxed therapeutic atmosphere at mealtimes and sufficient assistance from staff in a timely manner may place people at risk of injury and inadequate food and fluid intake.

This is a breach of regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] 2014.

We saw that the physical environment throughout the home did not reflect best practice in dementia care. The National Institute for Health and Care Excellence [NICE], guidelines 'Dementia: Supporting people with dementia and their carers in health and social care 2006' states, 'Built environments should be enabling and aid orientation. Specific, but not exclusive, attention should be paid to: lighting, colour schemes, floor coverings, assistive technology, signage, garden design, and the access to and safety of the external environment'.

During the inspection we spent time in the 'Brockwell Unit' where people with more advanced dementia type illnesses were accommodated. Other than the pictures of toilets and shower rooms placed on doors and memory boxes being placed beside people's bedrooms there was no further evidence of adaptations to the environment to show good practice guidelines had been put into practice. For example, there was no evidence of contrasting colours being used to aid independence, for instance on light switches, grab rails and bathroom/bedroom doors. Corridors were all similar in colour and the lighting in the corridors was poor. Although people's names had been placed on their bedroom door and a memory box, these were placed high up on the doors and walls and therefore not at a level for people to easily see. We asked the manager what model of dementia care the provider adopted, for example social, psychological, or a person centred approach to dementia care. She confirmed that no specific model of dementia care had been used in the care home to guide and inform best practice. This demonstrated that the provider had failed to follow good practice guidelines issued by NICE, the non-departmental public body with the responsibility to develop guidance and set quality standards for social care.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 [Regulated Activities] 2014.

We found some evidence that people were supported to maintain good health. The daily 'flash' meeting with key staff from all areas of the home raised any issues, and in the notes we found evidence of professional involvement with doctors and community nursing staff regularly reviewed and treated residents. A specialist practice nurse visited the home daily to provide support which had promoted timely diagnosis and treatment.

We found evidence that those people vulnerable to weight loss or required their fluid balance monitored had care plans in place to reflect these needs. For these people their weights were regularly monitored and records of daily fluid and food intake kept in a separate file for all staff to record.

We talked with the cook who demonstrated that she had an extensive knowledge of people's likes and dislikes. They told us they visited every new service user admitted to the home in person to find out about their requirements. She told us that if people didn't want what was on the menu then there were always several alternatives available; and if anyone required specific foods to help improve or maintain a medical condition such as diabetes or those who were at risk of malnutrition, then these were always available.

The Mental Capacity Act 2005 [MCA] provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards [DoLS].

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found in care plans that necessary records of assessments of capacity and best interest decisions were in place for people who lacked capacity to decide on the care or treatment provided to them by the provider. The registered manager explained how they had arranged best interest meetings with other health and social care professionals to discuss people's on-going care, treatment and support to decide the best way forward. We saw records of these meetings and decisions undertaken.

Requires Improvement

Is the service caring?

Our findings

People who used the service made positive comments about how they felt the staff were caring and how they appreciated the service they gave. Comments from one person who used the service included, "I can't ask for more. I didn't expect to come here but now that I am I can see how I have struggled to cope at home and being here is just so much better. I get support with all the little things and I am actually more independent and healthier than I was." Another person told us, "These [staff] are just top of the class. They keep us all on our toes and make sure we are all happy and content." And, "You have to say staff are diligent, thoughtful and courteous." Relatives we spoke with were very complimentary of the staff. They said things like, "The staff show they care not just about [their relative] but about us relatives too," and "They always have a kind word and can take the time to talk to you."

Over the first day of the inspection overall we saw staff interacting with people in a caring and professional way. We spent time observing care practices in the dining areas of the first floor and other communal areas of the home. We saw that people were respected by the majority of staff and treated with kindness. We saw staff communicating well with people, understanding the gestures and body language people used and responded appropriately. We heard staff address people respectfully and explain to people the support they were providing.

We saw staff respected people's right to privacy. For example, we saw one service user, who chose to spend time in their bedroom, were supported by staff to keep their room locked from within. We saw how another person had a key to their bedroom which we saw them use to keep their personal space locked and private.

However, not all staff spoke with the people they were supporting in a respectful manner. For example during our observations of lunch we heard one member of staff repeatedly tell people to "Stand up and sit properly," "Sit down because your dinner is coming," "Sit at the table and eat your dinner" and "Sit down on that chair please." Such care practice does not promote a positive image or an understanding of the person with Dementia; neither does it reflect a person centred approach to care. [Person centred means written in a way to describe in an individualised way the best way to support each person taking into account their individual choices, preferences and life histories].

We reviewed one person's care plan record and found that their property checklist had been written on a piece of hand towel paper. The property checklist is used to record each person's possessions throughout their stay at the home and helps ensure these remain safe. Recording this persons possessions on a piece of hand towel paper did not demonstrate that this person or their belongings were valued by the registered provider or that they were treated with dignity and respect.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 [Regulated Activities] 2014.

People were given support when making decisions about their preferences for end of life care and these were recorded in their care plans. The registered manager told us, people who used the service, those who

mattered to them and appropriate professionals contributed to their plan of care so that staff knew their wishes and to make sure the person had their dignity, comfort and respect at the end of their life. This meant people's physical and emotional needs would be met, their comfort and well-being attended to and their wishes respected.

Some people at the home were subject to a 'Do Not Attempt Cardiopulmonary Resuscitation [DNACPR]' decision. These had been completed by a variety of medical professionals from the community and hospitals. The DNACPR were noted on peoples' care planning files and the homes emergency procedures. However it was unclear from the records held if these decisions had been made with the persons, or their family members knowledge; or in the persons best interests where they lacked capacity to make these decisions themselves. We asked the local health commissioners to review these decisions with the registered provider and registered manager in the light of our findings.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with told us that they were happy with the support they received at the home. They said things like, "The staff help you to stay cheerful and positive," "I know I will be able to rely on the support of people around me," and "I'm writing a book and hoping to get some help from the staff."
Relatives told us, "They [staff] are always very busy but they do what's needed." "My [relative] is content, she has her own room where she prefers to spend her time and everything she could need is there for her."

Staff said they were responsive because they 'worked closely with people' and 'could tell when people were 'under the weather' or 'if changes to their normal behaviour meant something else was wrong with them.'

When we visited the home we looked at individual's records to see how their care was planned, monitored and co-ordinated.

We spoke with staff who told us every person who lived at Bowburn Care Centre had a care plan. They described to us how people were cared for and showed us how this was written in their care plans. We looked at five peoples' care plans in detail. We saw each person's needs had been assessed and a plan of care written to describe how these were to be supported. However we found that some important details were missing or needed to be more detailed. For example there was some evidence that people's likes and dislikes were recorded, but these were generally contained within the pre-admission assessment and for some people there was an absence of well documented profiles or life history documentation that could give a clear all round history of the person.

However the provider did not demonstrate that they were able to meet the needs of all people who had been admitted to the home. For example some people had been subject to periods of serious mental ill health which required hospital in-patient treatment. The registered manager and staff remained unclear about all of their assessed needs and previous, or present history of mental ill health. For some people, their mental ill health had led to periods of time where serious incidents of behaviour which challenged staff had taken place. Staff were not sufficiently informed of these persons' needs. Guidelines about how staff should respond and de-escalate incidents or of the strategies to support them and protect others were not sufficiently detailed. We found that staff and vulnerable people living at the home were at risk where the needs of people with complex mental health requirements were unclear. We made a referral to the local safeguarding authority to ensure people were protected from the risk of harm.

This is a breach of regulation 9 of the Health and Social Care Act 2008 [Regulated Activities] 2014.

Although the service has some dementia friendly aspects such as memory boxes and signage on doors and names on bedroom doors, overall the service did not subscribe to a particular model of dementia care, applying only general principles. This meant that people may not experience a consistent approach to their dementia care needs.

We saw evidence that people living at the home had access to other health care professionals. For example;

district nurses were visiting some service users on the day of the inspection and we saw that a chiropodist had visited one person over the weekend. People had access to other specialist health care professionals if required, for example, community psychiatric nurses.

We saw that people's nutritional needs were assessed and plans of care drawn up if they were at risk of malnutrition or choking. We saw strategies were successful for example people had been discharged from the dietician services as they had gained weight and were no longer at risk of malnutrition. Records also showed the effective use of the support from the speech and language team [SALT] assessment where for example peoples' risk of choking had increased which required a change in diet. This was recorded in care plans to guide staffs practice and promote safety.

We saw there was a member of staff employed by the provider whose role it was to prepare activities for people living in the home. We saw how staff had found out about some peoples' past histories and provided activities to meet their needs. For example: the staff described one person whose previous role in life was to care for rescue dogs. In order to meet her needs staff had brought into the care home a dog, which belonged to a member of staff. This person was described as gaining great enjoyment from walking this dog. We also saw preparations were under way to provide activities for Easter with an egg decoration competition. Preparations were also underway for outdoor activities with the provision of a greenhouse. Staff discussed how one person was going to shop for a selection of plants which they could tend to.

We checked complaints records. This showed that procedures were in place and could be followed if complaints were made. The complaints policy was seen on file and the registered manager when asked, could explain the process. The policy provided people who used the service and their representatives with information about how to raise any concerns and how they would be managed. People who lived at the home and visitors said things like, "I would have no hesitation in complaining – you can just have a word or you can make it more official," and "I can go into the [managers] office at any time and I know I will get things sorted out." The deputy manager described to us how they listened to people and took their concerns seriously. She described to us how it was her intention to meet with a service user that day to discuss their concerns about mealtimes.

Requires Improvement

Is the service well-led?

Our findings

Staff were complimentary about the registered manager. They said the home was well led because, "We meet regularly, we have flash meetings where everything that is going on in the home is shared so the manager can make decisions about things that crop up during the day." Other staff said, "Since taking up her post she has improved the home to what it is now and we will improve more." Relatives said things like, "She's a straight forward talker," "Very approachable," and "I have no problem approaching the manager or anyone in the office – I know I'll get a hearing."

We looked for evidence that monitoring of the service took place in order to assess the quality and safety of the home and make improvements when required. The registered manager showed us how the provider had a system of collecting important information which was then reviewed by senior managers when they visited the home. The registered manager showed us how she and senior staff carried out regular checks to make sure people's needs were being effectively met. We saw that the manager and senior staff had a daily 'flash meeting' where changes to people's care needs were discussed and monitored as well as two handovers each day involving all staff. We saw there were audits used to identify areas of success and when improvements were needed. The audits covered aspects of care. For example, the environment, health and safety issues and how infection control was managed. Audits also included checks on care plans, equipment to make sure it was safe, and administration of medication.

However we found that peoples care plans were not always reviewed as planned on a monthly basis and some people's care plans were out of date. Staff had recorded this on the care plan itself. We were informed by the registered manager that they were fully aware of this situation and were in the process of trying to update these care plans. This showed that measures to ensure care plans were accurate, complete and contemporaneous had not been completed.

We found records which showed that four people who lived at the home, all of whom had a diagnosis of dementia type illness, were prescribed antipsychotic medication. However we could not find special notes of justification for these prescriptions or evidence that reviews of their effectiveness had taken place. This meant that checks to make sure the continued use of antipsychotic medication was appropriate, had not taken place putting them at risk of inappropriate medication.

We found measures to reduce the risk of skin pressure damage were not implemented in a safe way for some people. We found three examples where pressure relieving mattresses were set by staff at a pressure which was too high. This meant that the mattress were too hard and did not reduce the risk of skin pressure damage.

We found that measures to ensure quality and safety at mealtimes were unsuccessful. People did not experience a therapeutic and supportive mealtime. People with Dementia type illness had to wait in a noisy and disruptive atmosphere for excessively long periods of time without sufficient staff to support them. This meant that people were at risk of injury and inadequate food and fluid intake.

We spoke with the registered manager who demonstrated that the home had a formula in place which was meant to ensure that the correct levels of staffing were in place at the home. She demonstrated that at times additional staff had been brought in to support some people's specific needs. However the registered provider had failed to ensure that sufficient staffing were in place at lunchtime to support people with Dementia care needs who lived in the Brockwell Unit. The registered manager told us there was an unusual amount of activity and the deployment of existing staff had not been successful at that part of the home.

We looked at how the provider checked to make sure that staff were suitable to work with vulnerable people. We found that checks to verify their employment history had not been carried out diligently and people living at the home had not been protected from potentially unsuitable employees.

The provider's governance systems had failed to ensure that risks to the health and safety of people living at the home were minimised.

This was breach of Regulations 17 of The Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

At the time of our inspection visit, the manager had been registered at the home for over two years. 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.

The registered manager had notified the Care Quality Commission of all significant events which had occurred in line with their legal responsibilities and had also reported outcomes to significant events.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's individual needs were not appropriately identified and assessed. Care planning arrangements did not reflect their individual requirements.

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 RA Regulations 2014 Dignity and respect People and their possessions were not always treated with dignity and respect.

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 The provider did not ensure that people received care and treatment that was safe and in an environment that protected their safety.

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 The physical environment throughout the home did not reflect best practice in Dementia care.

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 RA Regulations 2014 Good governance Governance systems had failed to ensure that risks to the health and safety of people living at the home were minimised.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Checks to verify staffs employment history were not carried out diligently.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not been provided with the necessary skills to safely meet the needs of the people and their deployment in the home was ineffective.