Advinia Health Care Limited

Cloisters Care Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on the 20 January, 22 January and 26 January 2015 and was unannounced.

Cloisters Care Home is registered to provide accommodation and nursing care for up to 58 older people. The ground floor caters for people living with the experience of dementia. At the time of our inspection there were 46 people using the service.

The service had a registered manager. 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 and associated Regulations about how the service is run.

The provider did not meet all of the regulations we inspected against at our last inspection on 16 June and 17 June 2014. During the June 2014 inspection we found the provider was not meeting the legal requirements in relation to people's views not being taken into account in relation to how the care was provided, their end of life wishes were not identified and staff did not receive training and support to provide appropriate care.

Summary of findings

During this inspection we saw the processes used when recruiting staff were not completely effective. We saw references and employment histories of applicants were not always checked during the recruitment process. We have made a recommendation about the recruitment process.

We saw the provider was gradually introducing a new care plan format which was more focused on the individuals wishes and needs. They were also contacting relatives to be involved in the on-going review of these plans. We have made a recommendation about the implementation of the new care plans.

We saw there was a clear process and procedure in place for the storage, receipt and disposal of medicines that had been prescribed to people using the service. We saw the majority of Medicines Administration Record (MAR) charts were completed accurately but we did see the records for one person were not clearly recorded.

Emergency evacuation plans were developed for each person using the service and were kept in each person's room.

Staff received training, supervision and support to ensure they were providing appropriate and effective care for people using the service.

Assessments of people's needs were carried out before they moved into the home which were used to develop care plans and risk assessment. Staff completed daily records describing the care provided to each person.

Staff felt they were supported in their work and there was a good team atmosphere within the home.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These related to management of risk, implementing the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, communication, involving people in decisions about their care, activities and monitoring the quality of the service. You can see what action we told the provider to take at the back of the full version of this report. In regard to the breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009, a Warning Notice was issued however the provider has now demonstrated they are meeting the requirements of the regulation.

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

Some aspects of the service were not safe. People were unable to reach the call bells in their room to alert staff they required assistance.

Where risk assessments had been carried out and issues identified it was not clear what action had been taken to minimise the risk to the person.

Staff understood the principle of safeguarding. They had a good understanding of the types of abuse and how to prevent them.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective. Procedures were not in place in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) to ensure the service only deprived a person of their liberty in a safe and correct way.

Staff received regular supervision from their line manager and had completed a range of training courses.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring. People felt staff respected their privacy and dignity while providing care and spoke to people in a kindly and supportive manner. We did see that three photographs providing guidance on how to position a person in bed were displayed in their bedroom which did not maintain the person's dignity.

Staff supported people to maintain their independence by ensuring they received the appropriate level of support.

People's wishes in relation to their end of life care had been identified and recorded in their care plan.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive. People using the service were not supported to be involved in decisions relating to how their care was provided.

Activities provided by the home were not meaningful and engaging for people using the service.

People using the service and their relatives completed a questionnaire to feedback their views on the care and support provided.

Is the service well-led?

Inadequate

Some aspects of the service were not well led. When people using the service died between August and December 2014 the registered manager did not notify the Care Quality Commission.

Summary of findings

The provider had various audits in place to monitor the quality of the care provided. Some of these had not been completed at the required intervals whilst others did not identify the issues we found during our inspection which required managerial attention and action.

Staff told us they felt they received appropriate support to carry out their role from the manager and senior staff.

Cloisters Care Home

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 over three days. The inspection on the 20 January was unannounced. The inspection on the 22 January 2015 was carried out at 2 am and was unannounced. Our visit on the 26 January 2015 was announced.

The inspection was carried out by two inspectors on the 20 January and 22 January and by one inspector on the 26 January 2015.

During the inspection we spoke with six people using the service, 10 relatives and visitors and 14 staff members. We reviewed the care plans and risk assessments for 10 people using the service, 10 daily records and the Medicine Administration Record (MAR) charts for 16 people. We looked at the records for four staff members. Other records we looked at included 15 accident and incident reporting forms and various audits. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also carried out general observations around the home during breakfast, lunch and throughout the day in the lounge areas.

Inadequate

Is the service safe?

Our findings

People were not able to easily alert staff if they required assistance when in their bedrooms to ensure their safety and welfare. During our visit on the 20 January we saw the call bells in 11 rooms were positioned out of reach of the person. The call bells were located under people's beds, on the floor at the end of the bed and wrapped around the handles of a bedside cabinet. We informed the staff on 20 January that the call bells were out of reach during the inspection. We checked the bedrooms during the night visit on the 22 January and saw the call bells were still out of reach in all these rooms. This meant that people were unable to easily alert staff that they required assistance or support. We informed the manager that we saw the call bells were still out of reach during the night visit and she confirmed all rooms would be checked and call bells placed in reach of people. The call bells were in reach when we inspected the home on the 26 January 2015.

We looked at the care files of three people. We saw that each person's risks had been assessed on admission and these were regularly reviewed. For example each person was assessed for risk of pressure sores and malnutrition and their dependency level was monitored monthly. We saw that assessment of these risks informed care plans but it was not clear whether actions needed to minimise risks were always taken.

We found that the registered person had not protected people against the risk of unsafe care. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that another person's care plan stated that a daily visual skin check was required to monitor the risk of pressure sores. The monitoring record in the person's room showed that over the last month this had been done intermittently with up to 4 days between records. The person's daily log of the care received gave no indication as to whether daily creams had been applied as set out in the risk plan and the care plan evaluation gave no indication of effectiveness.

The provider had a process in place for the recording and investigation of any incident and accidents but not all the information was recorded on the forms. The record forms were completed with a brief description of the incident or accident and who was involved but lacked information about any action taken or outcomes. The forms we looked at that related to someone having a fall included the description of 'observed' under actions taken but no information relating to what was observed, for how long and the result of the observation was not recorded. Another form we looked at in relation to a person with diabetes stated 'refer to GP' but there was no record if the referral had been made, by whom and any outcomes. By not recording accurate information in relation to the actions taken and any outcomes staff could not identify if a possible risk had been reduced so people received appropriate and safe care.

We found that the registered person did not have a system in place to check that records were accurate and up to date to ensure people received appropriate and safe care. This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with six members of staff about how people were protected from avoidable harm and abuse. Most had a good understanding the types of abuse people might experience including neglect, harassment, physical harm, financial abuse, bullying and, through treating people with a lack of respect, psychological abuse. The staff said they had received training on safeguarding. Most staff were able to describe what they would do if they had a concern about a person's wellbeing. This included keeping good notes and checking records, raising matters with their line manager and being prepared to take matters higher if they felt their concerns were not adequately addressed. Most of the staff we spoke to were aware of the external agencies they should contact if they had a concern which has not been dealt with by the provider. A number of staff pointed out information on the noticeboard in the office which included details about who they should contact. Two members of staff including one who had just completed induction were unaware of the term whistleblowing and seemed uncertain as to the provider's policy on this matter. The new staff member was also not clear about the providers safeguarding policy.

The majority of the people living at the home we spoke with were unable to clearly tell us or indicate whether or

Inadequate

Is the service safe?

not they felt safe at the home or how they might raise concerns. Most of the relatives we spoke to said they had not been given specific information about safeguarding or how to raise concerns although they all said they felt able to approach the manager if they did have a concern and anticipated that matters would be addressed.

The recruitment process in place was not always completed effectively. We looked at the records for five members of staff. We saw references and employment histories had not been checked for two staff recruited during 2014. One person had provided copies of their references from an overseas employer but the provider had not checked with that employer to see if they had written them. In the recruitment file for another member of staff we saw that a reference had been provided but the relationship of the person to the applicant had not been noted. We saw criminal record checks had been carried out for staff.

The professional registrations for nurses working at the home were up to date. We saw copies of the registration certificates for all the nurses and the monitoring system used by the home to ensure that staff renewed their registrations when required.

A relative told us "We are pleased to see that they have put the nurse back on duty at night. A few months ago there was only one nurse on at night across both floors. This was very worrying because there's a lot of people here who are very dependent." During our inspection we saw the staff rota was displayed in a notice board in each unit. We saw there was nurse working in each unit with four care staff on the morning shift and three in the afternoon. One of the care staff took on the role of senior for each shift. At night there were two care staff and a nurse on duty on each unit. We did note that there were a number of relatives who spent long periods at the home each day providing care in addition to that provided by the staff. A relative told us "I am here two or three times a day to help but this is still easier for me than when he was at home." Relatives we spoke with raised concerns about the level of agency staff working at the home and their lack of knowledge of people's care needs. One relative said "I am here each afternoon the day staff are very good. They couldn't do more but the agency staff don't know him."

Medicines were stored safely and records were kept for the medicines received and disposed of. We saw medicines were kept in secure rooms on each floor and there was specific storage for controlled drugs. The fridges used for specific medications such as insulin had their temperatures checked twice a day and we saw the records indicating they were at the appropriate temperature. The pharmacy provided medicines in blister packs for each person and when it was due to be taken during the day. We saw any medicines provided by the pharmacy in separate boxes had the person's room number clearly written on the box. The date of opening was recorded on any liquid medicines and eye drops to ensure they were used by the disposal date. We saw copies of the controlled drugs policy and the procedure for medication errors in the medicine administration record (MAR) chart folder. We looked at 16 MAR charts for people using the service. The majority of Medicine Administrations Record (MAR) charts we looked at were clearly and correctly completed by staff. We saw the MAR chart for one person had not been completed fully which showed that they had not received their medicines on different days. We raised this with the manager who explained that the person often went out and sometimes did not take their medicines. The manager told us she would review how medicines were administered and recorded for this person.

We saw that each person had a personal emergency evacuation procedure form kept by the door of their room. This set out the needs of each person should evacuation be required stating for example how many staff were needed to move a person.

We recommend the provider identifies guidance related to reviewing references as part of the recruitment process.

Requires Improvement

Is the service effective?

Our findings

People were not protected from being deprived of their liberty in an unsafe or inappropriate way in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguard (DoLS). DoLS provides a process to make sure that people are only deprived 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. We saw that people were being deprived of their liberties without appropriate assessments and safeguards. We looked at the care folders for five people who we saw had the side rails of their bed in place at all times. We saw that two people had been reviewed as part of their continuing care assessment as lacking capacity to make decisions relating to their healthcare and wellbeing. Assessments had been done by the home in relation to the use of bed rails which had identified them as having capacity. We saw that another person had been assessed at the time of admission to the home as having 'cognitive impairment'. One person had been assessed by the staff as lacking capacity and a care plan had been developed with the relatives in relation to the use of bed rails. We did not see any information recorded that the relatives had formal authority through a Lasting Power of Attorney to act on the person's behalf.

In one care folder we saw a Do Not Attempt Resuscitation (DNAR) order was in place for the person which had been agreed by a doctor and relative. The order indicated that the doctor had assessed the person as not having capacity to make decisions relating to resuscitation. This had been in place for more than six months. We saw an assessment had been carried out by the staff at the home at around the same time as the DNAR which stated that the person had capacity to make decisions. We raised this with the manager who told us the person's health had improved since coming to the home and they now had capacity. The DNAR had not been reviewed and discussed with the person using the service since they moved into the home so it did not reflect the person's current wishes in relation to resuscitation.

No referrals had been made for any of these people to the local authority for best interests assessments or DoLS to ensure that, if required, they were deprived of their liberty in an appropriate manner.

The registered person did not take proper steps to ensure people were protected from being deprived of their liberty in an unsafe or inappropriate way in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguard (DoLS). This was in 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.

Four staff members we spoke to said they had received training on the Mental Health Capacity Act and were aware of the need to give people choices where they had capacity to make decisions about their care.

During our inspection on the 16 and 17 June 2014 we saw that people were cared for by staff that were not supported to deliver care and treatment safely and to an appropriate standard as they did not receive the necessary training and annual appraisals. We asked the provider to send us an action plan identifying how they would make improvements and we received this.

During our visit in January 2015 we saw that the provider was meeting the Regulation as some improvements had been made and actions implemented. The provider had taken steps to ensure staff delivered care that was safe and to an appropriate standard as they had the skills developed through suitable training. We looked at the training matrix for all the staff working at the home and we saw the majority of staff had completed the annual refresher for the training identified as mandatory by the provider. The records did indicate that seven care staff had not completed the training courses and we asked the manager what action they were taking to get the training completed. She explained that if staff continually failed to complete the training it would be dealt with through the disciplinary process which could result in the staff member being dismissed. We saw copies of letters sent to staff arranging to discuss the training as part of the disciplinary process. We asked five staff about the training they received at the home. We were told the training was a combination of online courses and there was also a trainer who came in regularly. A number of staff said that the training provided by this person was thorough and they described tests they had to do to ensure they had understood the content. Staff described the various modules they had completed including safeguarding vulnerable adults, dementia, infection control and fire safety.

All the staff we spoke to said they had regular supervision from their line manage approximately every six weeks. One

Requires Improvement

Is the service effective?

staff member said 'it's helpful; seeing how you're doing and an opportunity to raise any issues.' Records showed the manager had carried out regular supervision sessions with staff members. Staff also said they had had appraisals but it was not clear how often these took place. We saw records and the manager confirmed that 28 staff had an appraisal during 2014.

We spoke to one person who was a new member of staff. They told us their induction included training and shadowing over a two-week period. We saw two completed induction check lists in the records for staff that had been recruited during the previous year.

During our inspection there were enough staff on duty to support people to eat and drink effectively. We observed breakfast and lunch on one of the units and saw staff supporting people to eat in an appropriate and unhurried manner. Many people chose to eat in their rooms and we saw that food was delivered in a timely way and those needing help received it. We saw that drinks were served regularly throughout the day.

We noted that porridge was given to some of the people in the dining room without staff asking first what sort of cereal they would prefer. We asked staff about how people expressed a choice of breakfast and were told that the staff 'knew what people liked' and that some people were not able to eat other cereals. We saw that people were able to choose a cooked breakfast and where chosen this was provided.

We spoke to two relatives who had concerns about whether staff would take the time required to ensure their bedbound relative was properly fed and that sufficient liquids were given. They said "There is not enough staff. If we didn't come in her feeding and fluids might get left. I don't think staff would look after mum with a full heart." However the other relatives we spoke to were confident that the necessary level of support was given.

The care records we looked recorded people's food preferences although this was mostly stated simply as 'normal diet'. It was not at all clear what a normal diet was in view of the numbers of people from different cultures and how people were really given choice about their food. In eight of the records we looked at we saw staff had completed food and fluid charts. The charts included the type of food and drink and the quantity.

Relatives we spoke with told us people were seen by the relevant health professionals when required. The care folders we looked at showed that people were referred to other health professionals as required. We saw records of doctor's visits and that people were seen by social services, dentists and the podiatrist.

Requires Improvement

Is the service caring?

Our findings

People's personal care was carried out in the privacy of their individual rooms or in shared bathrooms. We saw that staff took care to protect people's privacy when moving people from the bathrooms to their rooms and ensuring doors were not left open when care was given. But during our inspection we saw three photographs of a person on the wall of their bedroom showing the position staff should put the person in to support their legs. The photographs were not dignified and did not protect the person's privacy. These could easily have been placed elsewhere such as the inside of a wardrobe or out of line of sight of people entering the room.

We found that the registered person had not protected people's privacy and dignity. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we visited the service on 16 and 17 June 2014 we saw that people's views and experiences were not taken into account in the way the service was provided as staff did not engage or communicate with them. We asked the provider to send us an action plan identifying what improvements they would make and we received this.

We saw the provider was meeting the Regulation as improvements had been made. We observed staff during lunch and saw they communicated with people while they were supporting them while eating. A relative told us "They are very supportive of my relative and they know how to encourage them to eat." Another relative we spoke with said 'The day staff are good with him. He can be quite aggressive and refuse food. The staff are gentle and come back to try at other times to ensure he eats and is looked after. The day staff know him and know how to best help.' We saw staff gave people a choice of drink and reminded them what food they had selected for lunch. The staff provided appropriate support with eating but did not rush the person to finish their meal and asked the person if they were happy and if they had eaten enough.

During our inspection on the 16 and 17 June 2014 we saw that end of life and resuscitation plans for people had not always been developed with the person where they had capacity to give consent. We asked the provider to send us an action plan identifying how they would make improvements and we received this.

During our visit in January 2015 we saw the provider was meeting the Regulation as care plans were in place identifying people's end of life wishes. Where people using the service had capacity and did not wish to discuss their end of life wishes it was noted in the care plan.

A person using the service we spoke with said "I am treated with respect. The carers talk to you properly not smarmy - they talk to me in an adult way. I like the privacy and the food is done how I like it. I have never been treated badly by anyone." We saw staff treating people in a caring way. Staff supported people with breakfast engaging people in conversation and we observed people expressing affection for staff. The interactions we observed throughout our visit indicated that staff treated people in a caring and respectful way. For example we observed two carers gently reassuring an agitated person in a manner which calmed a potentially difficult situation. People told us that staff were kind, pleasant and helpful.

However during a fire alarm test a staff member told people in the sitting room that the fire alarm would be activated but staff were not in the room when it went off. This upset and confused people sitting in the lounge at the time. In one lounge we saw a person was asleep and staff did not wake up the person to warn them. When the alarm test started the person was woken suddenly and was confused. There were no staff in the lounge to support the person.

Three relatives we spoke with raised concerns relating to the poor attitude of some staff members and their behaviour towards relatives and visitors. But other relatives spoke positively about the staff providing care. Five relatives raised concerns about the care provided by staff at night. Relatives said "But we don't know what goes on night. I don't think the night staff are trained to deal with difficult behaviour," and "I just don't know about the nights. My relative is awake much of the night. He gets frightened and needs calming. It's down to knowing the carers - those that know him talk to him and are very friendly." Other relatives we spoke with did not discuss the care provided at night. During our night inspection we saw that staff were

Requires Improvement

Is the service caring?

supportive to people who wanted to move around or were awake in their bedrooms. They ensured people were comfortable and we saw records were completed when hourly checks were carried out.

We saw staff supported people in maintaining their independence. All the people who were able to get up with minimal support were able to get up and dressed when they wanted to. We saw that people were able to move freely about the home and could choose whether to spend time in their room or in the other communal areas.

Requires Improvement

Is the service responsive?

Our findings

A person we spoke with said “There is nothing to do here, people don’t talk to you and the fire test is the most exciting thing that happens”, another person said “We never have music on we like just this caterwauling from the radio.” We saw that most people who were not confined to their beds spent most of their day just sitting in their room or in the communal areas. The same radio station was on in the lounges and dining rooms which played recent recently music which was not to the taste of people we spoke with. Whilst we saw from people's files that assessments included information about their interests and hobbies we saw little evidence that people were actively engaged with meaningful activities during our visit. We saw that there was an activities programme with one activity offered in the morning and afternoon of each day. The majority of activities were free but we noted that some of the activities were not open to everyone and had to be paid for. For example hairdressing was put down as an activity on one morning of our inspection but in fact the hairdresser saw only a small number of people during that time and activity was an optional extra which had to be paid for. There were no alternative activities around the home during this time and we saw people left in the lounges. In the afternoon of our visit we saw that some people had been gathered in one of the sitting rooms for an exercise session although this amounted to little more than lively music being proclaimed and staff using maracas. Some of the people we saw spent very long periods of time sitting just in one place with no meaningful engagement unless receiving a visitor. For example we monitored the movements of two people in different lounges and they were seen to remain in their chairs in the lounge from 8am to at least 4 pm. This included receiving meals in this location. We spoke with the activities worker who told us about other activities that were made available such as computer based exercise and a regular visits from pets in therapy which people and their relatives enjoyed.

We found that the registered person had not provided activities which were meaningful. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection on the 16 and 17 June 2014 we saw that people’s views and experiences were not taken into account in the way the service was provided as people using the service or their relatives were not involved in the development and review of care plans. We asked the provider to send us an action plan identifying how they would make improvements and we received this.

During our inspection in January 2015 we saw the provider had made some improvements and was now meeting the Regulation. We saw copies of a letter that had been sent to the relatives of the people using the service inviting them to attend a care plan review. This information was kept in a separate folder and it was recorded on the copy of the letter if the relative had confirmed they wished to be involved in the next review. Some relatives were aware of the care plans for their relative and had been involved in the drawing up of these. But other relatives were not aware of these care plans at all and had not been formally involved. Relatives we spoke with told us “I have not seen a care plan but there is a meeting being organised about their care but it's a time I can't make. They are changing the day”, and “We have not been involved in care plans at all but changes have been made at our request to help my relative at night. For example carers know now to leave a light on and his door open with the TV on low all-night that he will watch if he wakes up.”

Each person had a care plan folder which was kept securely in a cupboard in each unit. We saw an example of a new care plan format in the one person’s care folder. Each section of the care plan started with a statement that the person using the service was involved in reviewing the document. There was no other evidence that the person had been involved in the development or review of the care plan. The manager explained that only a few care plans had been written in the new format and the remaining plans would be changed over the next few months.

The other care plans we looked at included information relating to different aspects of the person’s support needs. Sections included personal care, diabetes management, catheter care and nutrition. The care plans identified the support required with the expected outcomes from the care but the descriptions were very task focused and did not describe how the person wished to have their care provided.

We saw staff completed daily records for each person which included any personal care provided, what the

Requires Improvement

Is the service responsive?

person had done during the day and what they ate and drank. Each unit had a communication diary that staff used any appointments people had with social workers, healthcare professional and if any reviews were scheduled by the local authority.

Assessments of a person's needs were carried out before they moved into the home to identify if appropriate care and support could be provided. We saw the completed assessments reviewed the person's individual support needs including personal care, communication, mobility, health and nutrition. The information from the assessment was used to develop the care plans and risk assessments.

We also saw a complaints procedure clearly displayed. Not all the relatives we spoke to were aware of the formal procedure for making a complaint should they wish to do so but they all said they were confident that the manager would respond appropriately to any issues they raised.

We saw that relatives and friends of people living at the home were made welcome. We met relatives who came in very regularly and spent a significant part of each day with their relative as well as friends and acquaintances of people living in the home who were welcome to pop in.

People using the service and their relatives were able to provide feedback about the quality of care provided. We saw satisfaction questionnaires were sent out in May 2014 and 15 completed forms were returned. People were asked to comment about the care their relative received including the cleanliness of the home, choice and quality of food and activities. Everyone who responded said they felt safe and 14 people said they trusted the staff. None of the people asked were able to name the staff member responsible for their care. Five people were aware of the complaints procedures and 10 people felt they were able to make suggestions about the service. There was a poster displayed on the units advertising a meeting for relatives which was one of the ways the provider obtained feedback on the services. We saw the minutes from a recent relatives meeting where issues relating to the care provided were discussed. Meetings were organised for people using the service by the activities co-ordinator. At the meetings what food people wanted on the menu, activities and issues relating to the care people received were discussed. We saw detailed minutes were taken of these meetings.

We recommend the provider identifies guidance related to developing person-centred care plans and engaging and recording involvement with people using the service and their representatives in identifying care needs.

Inadequate

Is the service well-led?

Our findings

The registered manager did not notify the Commission of the deaths of people using the service. In preparation for our inspection we noted that we had not received any notifications in relation to deaths from the service from the 1 August to the 31 December 2014. The manager was required to inform the Commission of the death of any person using the service. During our inspection the manager informed us there had been 21 deaths of people using the service during this period of time. She could not locate any notification forms related to these deaths to show these had been completed but not sent to the Commission. Subsequent to our inspection, we were sent the notifications in respect of the 21 deaths which had occurred. Following our analysis, we saw no indication that any of these deaths warranted any further analysis or investigation.

The above paragraph demonstrates a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

The provider had various audits in place to monitor the quality of the care provided but some of these had not been regularly carried out, completed in full or did not provide appropriate information to identify issues with the quality of the service.

An audit of up to five care plans was carried out monthly. Staff reviewed the contents of the care plans to ensure they were up to date and contained the relevant information. We saw the audit form had a section for staff to record any comments relating to any areas of concern but not to identify any actions that were required or timescale for completion.

As part of the incident and accident recording procedure each person had a separate form where staff should record information following each occurrence. This form enabled staff to track a person's history of incident and accidents and identify any trends or if their care and support needs had changed. When we looked at these forms we noted that they had not been completed since July 2014 therefore current information could not be analysed and any required changes made to the care provided.

We found that the registered person did not have effective systems in place to monitor the quality of the service delivery. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An audit of complaints was carried out each month which reviewed the number of complaints received, what they related to (care, food or the environment), details of the investigation and the outcome when the complaint had been resolved. We looked at complaints audits that had been completed over a three month period.

We saw copies of the service improvement plan that were completed monthly by the manager and the operational manager. This audit reviewed any actions identified in the other audits carried out by the home and any monitoring visits or inspections from external organisations including the local authority and CQC. Any areas for improvement identified in other audits were recorded with specific actions, who was responsible, timescales and what progress had been made.

All the staff we spoke to said they felt supported in their work. Staff told us there was a good team atmosphere within the home and that people had a positive and caring attitude. Two members of staff told us about how management had been supportive about their working arrangements following periods where they had had to be away from work and others mentioned the collaborative atmosphere. We saw minutes from a recent team meeting which showed the manager explaining to staff if they were not confident raising concerns directly with her they should follow the whistleblowing policy. They also discussed safeguarding, the complaints process and confidentiality with staff.

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 9 HSCA (RA) Regulations 2014 Person-centred care We found that the registered person had not protected people against the risk of unsafe care. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 We found that the registered person had not provided activities which were meaningful. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 We found that the registered person had not protected people's privacy and dignity. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

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 registered person did not take proper steps to ensure people were protected from being deprived of their liberty in an unsafe or inappropriate way in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguard (DoLS). This was in 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.

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 We found that the registered person did not have effective systems in place to monitor the quality of the service delivery. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 We found that the registered person did not have a system in place to check that records were accurate and up to date to ensure people received appropriate and safe care. This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services

The registered person did not take proper steps to ensure the Care Quality Commission was notified of the death of a person using the service without delay.

Regulation 16