Bramcote Nursing Home Limited

Bramcote House Nursing 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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

We inspected the service on 9 and 13 July 2015. The inspection was unannounced. Bramcote House Nursing Home is situated in Bramcote, Nottingham and is a nursing home registered to accommodate 22 people. There were 13 people using the service when we inspected.

The service did not have a registered manager in place at the time of our inspection, although the manager had applied to register and we approved this application shortly after the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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.

When we last inspected the service on 6 January 2015 we found there were improvements needed in relation to how people received care and support which met their needs, staff recruitment, staffing levels, people being protected from harm and the oversight of the quality of the service. The provider sent us an action plan telling us they would make all of these improvements by the end of March 2015. We found at this inspection that although the manager had made improvements to the care people were receiving, people were still being placed at risk as there was a lack of oversight and input from the provider.

People were placed at risk from an environment which was not safe in relation to the risks of fire, unsafe water systems and a lack of testing of electrical systems.

People felt safe in the service and the manager shared information with the local authority when needed. However steps were not always put in place to learn from incidents to ensure staff were following best practice.

People were supported by staff who did not all have the knowledge and skills to provide safe and appropriate care and support, and safe recruitment processes were not always followed to ensure staff were suitable to work with the people who used the service. Staffing levels were not matched to the needs of people who used the service to ensure they received care and support when they needed it.

Medicines were managed safely and people lived in a clean environment. Risks to people in relation to the care and support they received from staff had improved since we last inspected.

The Care Quality Commission (CQC) monitors the use of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). We found this legislation was not always being used correctly to protect people who were not able to make their own decisions about the care they received.

People were supported to eat enough to keep them healthy and their health needs were monitored and responded to. Referrals were made to health care professionals for additional support or guidance if people's health deteriorated. However, when people's care and support needs changed, these were not always recorded in their care plans to ensure staff knew about the changes.

People were treated with dignity and respect and had their choices acted on. We saw staff were kind and caring when supporting people. People enjoyed the activities which had been implemented. People knew who to speak with if they had any concerns they wished to raise and they felt these would be taken seriously.

People were placed at risk due to a lack of systems in place to monitor health and safety requirements in the service. The manager had implemented audits which had led to improvements in relation to care delivery, however the provider did not have systems in place which would protect people from the risk of harm. We referred our concerns to the fire safety officer and the Health and Safety executive who both also had concerns in relation to the environment when they visited.

People were involved in giving their views on how the service was run through the systems used to monitor the quality of the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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.

People were placed at risk from an environment which was not safe in relation to the risks of fire, unsafe water systems and a lack of testing of electrical systems.

People felt safe and the manager and staff had the knowledge needed to recognise and respond to allegations or incidents in the service, however steps were not always put in place to monitor and develop staff when allegations were made.

People were supported by staff who had not all had the required checks needed to ensure they were suitable to work with people who used the service. Staffing levels were not matched to the needs of people and this posed a risk people would not receive care and support when they needed it.

Medicines were managed safely and people lived in a clean environment. Risks to people in relation to the care and support they received from staff had improved.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported by staff who had not all received appropriate training.

People made decisions in relation to their care and support. However where people lacked the capacity to make certain decisions, their rights were not always protected.

People were supported to maintain their hydration and nutrition. Their health was monitored and staff responded when health needs changed.

Is the service caring?

Good

The service was caring.

People were treated with kindness, compassion and respect by staff.

People were encouraged to make choices about the way they lived and supported to be independent.

Is the service responsive?

Requires Improvement

The service was not always responsive.

When people's care and support needs changed, these were not always recorded in people's care plans to ensure staff knew about the changes.

Summary of findings

People enjoyed the activities provided. People knew who to speak with if they had any concerns they wished to raise and they felt these would be taken seriously.

Is the service well-led?

Inadequate 

The service was not well led.

People were placed at risk of harm due to the provider failing to put systems in place to assess, respond to and improve health and safety requirements in the service.

The manager had implemented some improvements and audits in relation to the care people received. However there was a lack of practical support for the manager from the provider in putting in place the systems to achieve all of the improvements needed and the provider failed to fulfil their responsibilities.

Bramcote House Nursing 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.

We inspected the service on 9 and 13 July 2015. This was an unannounced inspection. The inspection team consisted of three inspectors and specialist advisor who was a general nurse.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We contacted commissioners (who fund the care for some people) of the service and asked them for their views. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

During the visit we spoke with six people who used the service, three relatives, five members of care staff, a nurse and the manager. We observed care and support in communal areas. We looked at the care records of six people who used the service, the medicine administration records for nine people and staff training records, as well as a range of records relating to the running of the service including audits carried out by the manager.

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.

Inadequate

Is the service safe?

Our findings

During this inspection we found significant risks in relation to people's safety due to the environment they were living in. Prior to our inspection we received information of concern that the main boiler in the service had failed and there was no hot water or heating in the service during the winter months. The provider had notified us of the failure of the boiler, however this took longer to repair than had been anticipated and the provider did not notify us of the delay. Staff had placed portable heaters in the service and were transporting hot water from the kitchen into people's rooms so they had hot water to wash. It was a concern that people were without hot water and heating for almost three weeks during cold weather.

We found that checks on electrical appliances had not been carried out since 2013 and this posed a risk of fire in the service. We also found risks in relation to the safety of people should a fire break out. We found concerns with the suitability and accessibility of fire exits and we saw the required monthly checks of the fire exits had not been carried out since October 2014. We found a means of escape if there should be a fire was not safe. The manager confirmed this route was still in use but we found the door to the escape was difficult to navigate, the exit was blocked with boxes and the door would not open. This meant if a fire were to break out there was a risk people would not be able to exit the building safely.

We discussed this with the fire officer and they visited the service and agreed there was a risk and instructed the maintenance person to carry out some interim measures to minimise the risk to people. When we returned to the service on 13 July 2015 we found the maintenance person had not carried out all of the fire officers instructions and had also left the external fire exit door unsecured, meaning the service was left at risk of intruders over the weekend.

Additionally we found a fire exit door which led into the car park and out into the main road, which was previously alarmed was no longer connected to the alarm system. This posed a risk if a person who lived with a dementia type illness was to exit the door. This risk had not been recognised when the new call alarm had been installed.

We found the water systems were not being tested to ensure people who used the service, staff and visitors were protected from the risks of legionella. The service had a number of vacant and unused rooms. Additionally the plumbing system included a number of obvious 'dead legs' (pipes that were not connected to taps or drainage and allowed water to stagnate). This would increase the risk of legionella bacteria forming in the system and therefore increase the risk of residents, staff and visitors coming into contact with the legionella bacteria. There were no systems in place to monitor the temperature of the water to ensure it was stored at the recommended temperature to kill bacteria and to protect people who used the service from scalding themselves.

This was an ongoing 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.

During our inspection the main lighting on the ground floor of the service failed. The electrician visited and a decision was made that new lighting would need to be sourced. We saw that the only lighting available was a dimly lit uplighter and we discussed this with the manager and told her she would need to place further lighting in the area to promote people's safety.

The last time we visited the service we had concerns about staff being recruited without the required safety checks being made to ensure they were suitable and safe to work with people who used the service. We also had concerns about registered nurses personal identification numbers (PIN) being checked to ensure their registrations were up to date and appropriate. We asked the provider to send us a plan informing us how they would make improvements to this and when they would do so.

During this inspection we looked at the recruitment files of eight members of staff, including registered nurses, health care assistants (HCA's) and bank staff. Bank staff are those employed by the service to cover shifts as required rather than on a regular basis. We noted that the files were kept in a lockable drawer but found that the drawer was unlocked on both days of our inspection. This meant that sensitive personal and financial information of staff was not stored securely.

The provider had effective recruitment systems in place; however these were not always implemented. We found that two members of staff did not have DBS checks in place. The DBS enables organisations to make safer

Inadequate

Is the service safe?

recruitment decisions by identifying candidates who may be unsuitable for certain work, especially that involve children or adults. Records showed that both these staff had worked several shifts at Bramcote House. Additionally, one of these files did not contain relevant references from previous employment or photographic proof of identification.

We also found that the PIN numbers of the registered nurses employed had not been checked to ensure they were valid and up to date. This meant systems in place to ensure staff were recruited safely were not being followed.

This was an ongoing breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The last time we visited the service we had concerns about the staffing levels and how long people had to wait to receive assistance from staff. We asked the provider to send us a plan detailing how they would improve this and when the improvements would be made by.

The provider submitted a written plan to us informing us that they would complete a 'staffing grid' by 9 March 2015 which would assess how many staff were needed and to ensure there were enough staff to meet the needs of people, as occupancy in the service grew. We were told this had not been completed in line with the action plan. This meant that as people were admitted to the service, the provider could not be satisfied that there were enough staff deployed to meet the needs of these people.

The staff rota showed that there were only two staff were on duty during the night with one of these being the nurse. Whilst the nurse gave out medicines and dealt with people's nursing needs, there was only one member of staff to support other people with their needs. Staff worked a 12 hour shift at night and so would need to take a break and during that time there would be one staff left to support people. Ten of the 13 people living in the service required two staff to support them with personal care and so both staff would be needed to support these people, which left other people without any staff, should they need care or support.

This was an ongoing breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Additionally the manager had been covering nursing shifts in the service and this had resulted in her not being able to sustain care plan reviews and to assess the quality of the service. This had been escalated to the provider and the manager was in the process of accessing nursing cover to enable her to concentrate on the management of the service.

During this inspection we found that although the staffing levels had not been increased, there were less people living in the service and so staff were able to meet their needs in a more timely way during the day. People felt there were enough staff working in the service to meet their needs and told us that if they needed help then staff were quick to respond. Relatives also said they felt there were enough staff to give their relation the care they needed. One relative said, "There are more carers for less people." We observed during our inspection, during the day, that people did not have to wait for staff to give them care and support when they needed it. Staff had the time to sit with people and engage with them and call bells were answered promptly. The day staff we spoke with told us they felt there were enough of them to provide the care and support people needed during the day.

The last time we visited the service we had concerns about a lack of knowledge of safeguarding processes in the service and we saw that incidents had occurred where the information had not been shared with the local authority. We asked the provider to send us a plan informing us how they would make improvements to this and when they would do so.

Prior to and during this inspection we found that some improvements had been made and staff we spoke with knew how to keep people safe from abuse and information was being shared with the local authority when required. People told us they felt safe in the service. One person said, "I feel safe here, the staff are nice they help with my care." Relatives also told us they felt their relations were safe in the service. One relative said, "I feel [Relation] is safe here." Staff we spoke with knew the processes for escalating any concerns they had about people who were at risk of harm.

Inadequate

Is the service safe?

However we saw there had been an allegation of abuse, which had been investigated by the police. Following the allegation the provider did not take the appropriate action to ensure the member of staff was given appropriate support and supervision to ensure they were following safe practice in future. We also saw from records that only seven of the 29 staff employed at the service had received training in how to keep people safe from abuse. This posed a risk that some staff may not recognise abuse or know how to respond to incidents or allegations of abuse.

The last time we visited the service we had concerns about staff practice in relation to supporting people with poor mobility. We asked the provider to send us a plan detailing how they would improve this and when they would make the improvements.

During this inspection we saw improvements had been made and staff had been given the training and guidance in how to use equipment safely. We observed people had been assessed in relation to their mobility and where people needed support to move around the service using equipment such as a hoist, there was guidance in place informing staff how they should do this safely. We observed staff supporting people with mobility impairments using the hoist. They followed safe practices and clearly knew how to use the hoist effectively.

The last time we visited the service we had concerns about the lack of risk assessments and safety checks for people who had bed rails fitted to their beds to prevent them from falling out of bed. We asked the provider to send us a plan detailing how they would improve this and when the improvements would be made by.

During this inspection we found improvements had been made. The bedrails had been replaced by more appropriate beds which were safer and regular checks were being made to assess ongoing safety and minimise the risk of harm.

The manager had implemented systems to assess and identify other risks to people such as risks around their mobility and where risks were identified there were plans in place guiding staff on how to monitor this and reduce any impact on people's health and wellbeing.

Two people we spoke with told us they felt the home was kept clean. One relative told us, "There is a cleaner in the home every day, and the home seems clean"

We looked at the systems in place for cleanliness and hygiene and we saw the service was clean and there were no unpleasant odours. We spoke to one of the cleaning staff who told us they used the colour coded cleaning systems to minimise the risk of the spread of infection. Cleaning staff told us that the cleaning hours had been increased and this had made a difference to their ability to keep the home clean. We observed the cleaning staff followed safe practice in relation to infection control.

People did not manage their own medicines and relied on staff to administer these to them. We observed a member of staff administering medicines to a person and saw they followed safe practices. Staff received training in the safe handling and administration of medicines and had their competency assessed. There were systems in place to ensure medicines were stored and managed safely. The manager was undertaking regular medicines audits and these were identifying any shortfalls. We saw the manager was taking action when any shortfalls were identified minimise the risk of any future shortfalls. We found the systems were being managed well by the manager and people received their medicines as prescribed.

Is the service effective?

Our findings

The last time we visited we had concerns about the lack of training and supervision given to staff to ensure they knew how to care for people safely. We found there had been some improvement in relation to the training given to staff, and staff now received formal supervision from the manager. However staff were still not being given all of the training they needed.

People told us they felt staff were given the training they needed to do their job. One person told us, "Yes they (staff) know what they are doing." One relative told us "There have been lots of changes of staff and this has had a positive impact on residents, but I was happy with the care before anyway." Another relative told us, "The staff are trained to do their jobs."

However we asked the home manager to provide evidence of training undertaken by staff at Bramcote House Nursing Home and this showed that staff were not given all of the training they needed to guide them in doing their job safely. This record showed that there were staff working in the service without any training in areas of care delivery such as food safety and Health and Safety training.

In addition we spoke with staff about recent training they had been given in relation to the Mental Capacity Act 2005(MCA) and two staff told us they had not fully understood the training as the course content was not relevant to the work they carried out. This showed that staff did not always have access to appropriate training that would enable them to further develop skills and deliver care to the best of their ability.

This was an ongoing breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that since our last inspection in January 2015, all staff had received an individual supervision meeting with the manager. We saw the manager had discussed the concerns we found at the inspection in January with staff to outline to them what improvements staff needed to make. We found this was effective and that staff had learned from the supervision and were providing care which was more responsive to people's needs.

Staff we spoke with told us they felt supported by the manager. Registered nursing staff we spoke with also told us they received clinical supervision and their performance was monitored. They told us they could raise issues with and received support from the manager.

People felt they were supported to make decisions about their care and support and make decisions about how they spent their day. We observed staff seeking people's permission and explain what they were going to do prior to delivering care and support. For example one person declined support from staff and they respected this decision and went back later to ask the person again and the support was accepted.

The manager had an understanding of the Mental Capacity Act 2005 (MCA); however we found this was not always being adhered to in practice. We saw that an attempt had been made to incorporate the MCA into care planning, however this was not decision specific as this legislation requires. There was a lack of assessments taking place where people had difficulty in making specific decisions. For example a decision had been made that one person would not be able to return home after a short stay in the service. The manager had taken the appropriate steps of involving a range of people involved in the person's care and support to make the decision. However we found a formal assessment of the person's capacity to make that decision had not been completed and there was no record of why this had been deemed as being in the person's best interests. This person also had bedrails in place and their capacity to understand why these were being used had not been assessed or recorded to ensure the bedrails were being used in their best interest. The MCA is in place to protect people who lack capacity to make certain decisions because of illness or disability.

This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager displayed a good understanding of the Deprivation of Liberty Safeguarding (DoLS) and we saw that she had begun to make the applications where she felt people may be restricted in their freedom. DoLS protects the rights of people by ensuring that if there are restrictions on their freedom these are assessed by professionals who are trained to decide if the restriction is needed.

Is the service effective?

People we spoke to told us the food was good and there was a choice. One person who had chosen to eat meals in their room told us, "The chef comes in to tell you what (food) it is." One relative told us, "The food is good [here] and I am able to have my lunch here with [relation.]"

We observed lunch and we saw people were provided with a choice of meal and the meal looked appetising and nutritious. We saw people were offered frequent drinks and support was given to drink these where needed. One person was known to have a poor appetite and to frequently refuse to eat. We observed staff gave frequent prompts and encouragement to this person during lunch and this had a positive impact with the person eating most of their meal. We saw staff kept a record of what this person ate and monitored their weight.

Nutritional assessments were carried out on people and where a risk was identified staff were taking the appropriate action. We saw staff had identified one person had lost weight and were monitoring this closely and providing them with a diet which was high in calories and prompted them to eat more.

People were supported with their ongoing healthcare. We spoke to one person who told us that they had been supported to have their own doctor to provide health care and treatment and had a check-up recently. Relatives we spoke to told us the staff were quick to respond if people needed to see a doctor. One relative told us, "They tend to be able to get a doctor here quicker than I could at home." This relative told us their relation's health had improved since coming to the home.

We saw from care records that staff sought advice from a range of external professionals such as dieticians, occupational therapists and the community nursing team to support people with their health care. The manager told us she had worked hard to develop a relationship with other health professionals and that this had been achieved and a variety of health professionals were involved in supporting people with their health needs. One person had recently developed diabetes and we saw staff had implemented appropriate care plans and systems for monitoring their blood sugar. We examined the care plan for a person who had significant dental problems. The care plan showed the person had been referred to the community dental team, and had been referred to the local hospital for treatment.

Is the service caring?

Our findings

When we inspected the service in January 2015 we had concerns about the way people were being cared for. We asked the provider to send us a written plan detailing what improvements they would make and by when. During this inspection we found the required improvements had been made.

People felt that staff were caring. One person told us, "Yes, I have not been here long and the staff cannot be faulted they are kind and caring." Another said, "The staff are very kind here." A relative told us, "Things have improved. The carer's attitude is better."

We observed staff practice and approach had improved since our last inspection. We saw staff supported people to move using equipment such as a hoist. We saw staff were kind and patient whilst supporting people and offered reassurance. We observed a member of staff support a person to walk with a walking aid and they were patient and gave the person time to walk at their own pace, offering gentle encouragement. Staff told us they felt the care people received had improved since our last inspection. One member of staff told us, "There have been improvements. The home is moving in the right direction. The atmosphere is better, it is more homely.

We saw the improvements in the way people were supported and cared for had resulted in a positive impact for people. For example we saw one person, who we were concerned about at our last visit, looked healthy, happy and settled. At our last visit they had been withdrawn and their emotional needs were not being met. We saw they were now engaging positively with staff and staff were supporting the person to maintain relationships outside of the service and take part in activities they enjoyed. The person told us, "I would rather be at home but I am safer here and I am quite happy."

We saw some good interactions between staff and people who used the service. Staff were caring when talking to people and noticed when people appeared to be in discomfort. One person was feeling unwell on the first day of our visit and we saw staff were aware of this and gave the person more support and reassurance than they would usually need. They prompted the person to drink plenty of fluids and showed compassion and kindness.

People were supported with their independence and their abilities were detailed in their care plan. For example one person had a care plan in place detailing that they were to be given adapted cutlery and crockery to enable them to eat independently. We observed this was given at lunchtime on both days we visited and the person ate a good amount of food.

People were also supported to make choices about their care and support. People were able to give us examples such as if they had specified a certain gender of staff deliver their personal care, this was respected. They told us they were given a choice of what to eat each day and that they decided what time to get up and go to bed each day. We observed people's choices were respected during our visit, for example, one person requested an ice cream straight after breakfast and staff provided the person with what they had asked for.

We saw relatives were welcome to visit the service at any time and we saw one relative who visited on a daily basis got involved with tasks such as handing out biscuits. Another relative ate a meal with their relation and other people who used the service. This showed relatives were supported to be involved in the service and felt relaxed enough to do so.

The manager told us that there was information available for people if they wished to use an advocate but that there was no one who was currently using one. We saw this information on display in the service. Advocates are trained professionals who support, enable and empower people to speak up.

People we spoke with told us that staff were polite and treated them with dignity and respect and our observations supported what we had been told.

We observed staff respecting people's privacy and dignity when supporting them. For example speaking to people discreetly about matters of a personal nature and knocking on bedroom doors and waiting for an answer prior to entering. We spoke with two members of staff about how they would respect people's privacy and dignity and both showed they knew the appropriate values in relation to this.

Requires Improvement

Is the service responsive?

Our findings

When we inspected the service in January 2015 we had concerns about the way complaints were responded to. We asked the provider to send us an action plan detailing how they would make the improvements and by when. During this inspection we could not fully assess if the improvements had been made as the manager had not received any complaints. However, people we spoke with told us they would know who to talk to if they had any complaints and felt they would be addressed. Relatives echoed this and said there was a complaints procedure for them to follow if they had any concerns. We saw this was kept in a file in the reception area. One relative raised a concern with a nurse during our visit and this was responded to and resolved straight away.

A complaint which had not been appropriately responded to when we last inspected had been re-opened and investigated and an suitable response was sent to the relation making the complaint.

We saw the manager had begun implementing new care plans and the plans we looked at gave staff information about people's needs. Although reviews of the care plans had not taken place for two months, we found that the information in people's care plan generally matched their needs and staff were following the plans in practice. For example, where people had been identified as being at risk of developing a pressure ulcer there was an appropriate care plan in place guiding staff in what to do to monitor this risk. We found staff were following this guidance in practice, such as repositioning people to alleviate the risk of a sore developing.

However when new needs were identified these were not always added to people's care plans to ensure staff knew of the change to the person's care and to give guidance on how they should provide that care. For example, one person had injured themselves and the required actions had been taken, including putting a wound management and pain relief plan into place. However the person's care had not been reviewed to identify how to prevent the person injuring themselves again.

People were involved in planning their care and support. We spoke to one person who told us that their relation had helped staff plan their care by implementing a care plan which met their needs. Another person we spoke with knew about their care plan and said staff had asked them about their preferences about how their care was provided. Two further relatives told us they had input in developing their relations' care plans.

We observed staff knew the preferences of people and saw examples of where this was respected. For example one person liked a different drink to other people and we saw staff knew about this and provided it throughout the day. People's life histories and preferences for care were being introduced to care plans and staff we spoke with had a good knowledge of the likes and dislikes of the people they were supporting.

People were given the opportunity to participate in their hobbies and interests, and activities were being implemented in the service. People told us they were able to do the activities they enjoyed and that there was now an, "Activities girl" working in the service and this had resulted in them taking part in activities which they enjoyed, such as arts and crafts. There was evidence of this with art work displayed on the walls in the dining room. One person who didn't spend much time in the communal areas told us, "I am always included and staff offer activities or spend time with me so I don't feel left out."

We observed people were provided with support to follow their individual interests. This enabled one person to play a game they enjoyed and another person to do puzzles. We observed some people had a manicure during our inspection. One relative told us, "[Relation] enjoys doing things and does art classes and does crosswords."

One person told us they liked to spend time in their bedroom watching the television and said that staff went in to talk with them throughout the day. Another person told us they were supported to go out with their relations and were doing so later that day.

On the day of our inspection the staff had planned a tea party for the afternoon, with activities for people who wanted to take part. People's relations had also been invited to the party and we saw there had been a lot of work put into making the afternoon enjoyable. People had been supported to decorate the walls into a theme for the party and there were fund raising activities.

Inadequate

Is the service well-led?

Our findings

When we inspected the service in January 2015 we had concerns about the lack of governance in the service, audits were not carried out and there were a lack of systems to assess and identify where improvements were needed in the service, particularly in relation to the safety of people who used the service. People were not being given an opportunity to have a say in how well the service was being run. We asked the provider to send us a written action plan informing us what improvements would be made and by when. We found during this inspection that the provider had not made all of the improvements they told us they would, by the dates they specified.

During the course of our inspection it was evident that the manager had worked hard to implement audits to assess and monitor the quality of the care being given and these were starting to bring about improvements in relation to care delivery. However the manager was not, at the time of the inspection, registered with the CQC and the provider of the service, who was the responsible person was not fulfilling their responsibility. The manager was not being given the practical support to bring about all of the improvements and there was a lack of provider oversight and assessment at a higher level to assess and monitor the overall safety of the service. During our inspection we identified major risks to the safety of people who used the service as a result of the lack of oversight by the provider.

The provider informed us in their action plan following our previous inspection that 'A full redecoration throughout the home will be staggered over the next few months and will be completed 31st July (2015); this work will begin Tuesday 24th Feb (2015)'. During this inspection we saw that work had been completed on re-decorating five of the 22 rooms. However we did not see evidence that any of the communal areas had been redecorated and did not have confidence the provider would complete all work by the 31 July target they had set. We also found that the action plan had not been met in relation to staff recruitment, staffing levels, staff training and the MCA. In addition we found that the provider was still in breach of several regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found the provider had failed to carry out an assessment of the service to identify and respond to shortfalls which could pose a risk to people who used the service. We found that despite us highlighting to the provider in our inspection report in January 2015 that checks on electrical appliances had not been carried out since 2013, the provider had not taken action to remedy this. This failure posed a risk of fire in the service. We found concerns in relation to the risk of harm to people should a fire break out in the service and these risks had not been recognised by the provider due to a lack of systems in place to assess such risks.

The Health and Safety Executive (HSE) had issued an improvement notice to the provider in 2009 for failure to manage risk of legionella. We also alerted the provider of this failure in our report following our inspection in January 2015. Despite this the provider did not put systems in place to assess risks in relation to the water systems and to have the required tests in place to protect people who lived in the service, staff and visitors from the risk of contracting legionnaire's disease.

We saw there was a lack of oversight from the provider and although people told us the provider visited the service there were not any records kept of what these visits involved and whether the provider was completing any audits or assessments of the quality and safety of the service. Our evidence showed that the lack of oversight from the provider was placing people at significant risk.

This was an ongoing 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.

On the day of the inspection there was not a registered manager in post, although the manager had submitted an application to us and shortly after the inspection this was approved and the manager became registered. The manager understood her role and responsibilities and was aware of the improvements she still needed to make in relation to the care and support people received. People were clear about who the manager was and felt they could approach her if they wanted to talk to her about anything and that she would listen and make changes as a result of this. Records we looked at showed that CQC had received all the required notifications in a timely way. Providers are required by law to notify us of certain events in the service.

Inadequate

Is the service well-led?

People who used the service and their relatives told us they knew who the manager was and that she was a visible presence in the service. They told us the manager was approachable and if they had concerns they could go to her.

We observed the manager had worked to create a more open and inclusive atmosphere and staff were being given leadership and direction in their day to day work. This benefitted people who used the service as they were being supported by staff who were supported and directed by the manager to deliver a better quality of care than when we last inspected the service. Staff worked well as a team and we saw they communicated with each other to ensure people received the care and support they needed.

Staff felt supported by the manager and were attending regular meetings with her to discuss improvements made and what further improvements were needed. One member of staff told us, "She (manager) is a good leader." Another member of staff said, "[The manager] is approachable and she listens. Staff are working better as a team."

Additionally we found the manager had implemented meetings for people who used the service and their relatives to enable them to have a say in the quality of the service delivered. The meetings were used to get people's opinion of the service and to communicate what improvements were being made. There had also been a client satisfaction survey sent to people who used the service and their relatives. We saw there was positive feedback on the improvements in the service and that some people had indicated they still felt there were improvements needed. The manager told us the results of this were being analysed by the provider and that she had been told the results and an action plan would be provided to enable her to address any concerns noted, however this had not yet been actioned by the provider.

During our inspection we examined audit records completed by the manager and found these had been completed regularly up to May 2015. There were audits completed in various areas relating to the care and support people were being given, in order to identify any improvements needed in this area. We found these audits were effective with care delivery and monitoring of such having improved since our visit in January 2015. We noted that one audit established the need for a risk assessment for one person and we checked the care records and found this had been completed.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 17 HSCA (RA) Regulations 2014 Good governance People who use services and others were placed at risk as the provider did not have systems in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. Regulation 17(1)(2)(a)(b)(d)(i)

The enforcement action we took:
We cancelled the registration of the registered provider.

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 Recruitment procedures had not been established and operated effectively. Regulation 19 2(a) 4(a)(b)

The enforcement action we took:
We cancelled the registration of the registered provider.

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 Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed. Regulation 18 (1) (2)(a)

The enforcement action we took:
We cancelled the registration of the registered provider.

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 People were not protected under the MCA 2005. Regulation 11 (1)and (3)

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We cancelled the registration of the registered provider.