Bupa Care Homes (ANS) Limited

Druid Stoke Care Home

Inspection report

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Date of inspection visit:
04 October 2016
07 October 2016

Date of publication:
03 November 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

During August and September 2016, we received a number of concerns about the care provision at Druid Stoke Care Home. This information of concern was received from people, friends and family, and from health and social care professionals. As a result of this information, we undertook an unannounced inspection of Druid Stoke Care Home on 4 and 7 October 2016.

When the service was last inspected in April 2016 there was one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified. We found staffing levels were not sufficient to meet people needs safely and in a person centred way. The provider wrote to us in July 2016 and told us how they would achieve compliance with this regulation and this was followed up as part of this inspection. You can read the report from our last comprehensive inspection, by selecting the 'All reports' link for Druid Stoke Care Home, on our website at www.cqc.org.uk

Druid Stoke Care Home provides personal and nursing care for up to 60 older people. The home is run from two buildings on the same site. One building provides residential care and the other nursing care. At the time of our inspection there were 44 people living at the home.

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

The home was not always safe as we found recruitment procedures were not robust. This meant that people unsuitable for the role could be employed. When an accident or incident occurred there was a procedure in place for reporting. However, we found this was not always used and therefore incidents may not get investigated thoroughly. Staffing levels had improved since out last inspection in April 2016. However, there was mixed feedback in people's experiences of staffing levels.

Medicines were stored and administered safely by trained and competent staff. There was clear information and guidance in place for staff and regular audits and checks of medicines were completed. The home was clean and well maintained. Effective checks took place to ensure the environment and equipment was safe. People did not always receive effective care in supporting their healthcare needs.

The registered manager was aware of their responsibilities in regards to (DoLS). DoLS is a framework to assess if the deprivation of liberty for a person when they lack the capacity to consent to care or treatment or need protecting from harm is required. However, information recorded about DoLS was not always clear and meant staff did not have a clear understanding of who had an authorised DoLS.

People and relatives told us that staff were kind and caring. We observed positive interactions and relationships between staff and people living at the home. People told us staff respected their privacy and

maintained their dignity.

People enjoyed the activities on offer at the home. People were involved with how the home was run through regular meetings, which sought people's views and opinions. We saw that the home responded to the feedback received. Care plans gave information about people's background and personal preferences. Staff were knowledgeable about how people liked their care and support delivered. We observed staff being responsive to people's daily support needs.

The home was not always well-led. Notifications had not always been sent to the Commission, which is a legal requirement. Audits were in place to assess and monitor the quality of care. Whilst some were effective they were not always consistently completed. Staff could contribute their feedback and ideas through meetings. People and relatives had access to the home's complaint procedure. However, we found the documentation and recording of complaints was not always consistent or accurate. This meant that complaints may not always get thoroughly investigated or ensure clear actions were taken.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In addition, a breach of the Care Quality Commission (Registration) Regulations 2009 was also identified. You can see what action we told the provider to take at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The home was not always safe. Safe recruitment procedures were not always followed.

Staffing levels were at the planned level. Mixed feedback was received about staffing from people, staff and relatives.

A procedure was in place for reporting accident and incidents. However, this was not consistently used.

People's medicines were managed and administered safely.

Staff knew how to identify and report safeguarding concerns.

Effective infection control systems were in place.

Is the service effective?

Requires Improvement

The home was not always effective.

The Deprivation of Liberty Safeguards (DoLS) were being met. However, staff's knowledge and information recorded about DoLS was not always clear.

Staff understood the principles of the Mental Capacity Act 2005. However, there were inconsistencies in assessing people's capacity and gaining people's consent.

People's healthcare needs were not always fully supported.

Staff were not always supported as they did not always receive regular supervision.

Staff received an induction and regular training.

Is the service caring?

Good

The home was caring.

We observed positive relationships between staff and people living at the home. Staff spoke to people with consideration and kindness.

Staff supported people in a way that respected their privacy.

People's visitors were welcomed at the home.

Is the service responsive?

Good

The home was responsive.

Care records detailed people's preferences and staff were knowledgeable of these.

People were involved in deciding the activities on offer.

Meetings were held to gain people's views and opinions

People and relatives had access to the home's complaint procedure and knew how to raise a complaint if necessary.

Is the service well-led?

Requires Improvement

The home was not consistently well-led.

Systems were in place to monitor the quality of care and support but these were not consistently completed.

Notifications had not always been submitted to the Commission as required.

Information was not always consistently recorded.

People and staff spoke positively about the registered manager.

Druid Stoke 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.

The inspection was carried out by three inspectors, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed previous inspection reports and other information we had received about the home, including notifications. Notifications are information about specific important events that the home is legally required to send to us.

Some people at the home were not able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the home. As part of our observations we used the Short Observational Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the needs of people who could not talk with us.

During the inspection we spoke with 16 people living at the home, four relatives and thirteen staff members, this included the registered manager and the regional director. We looked at 16 people's care and support records and five staff files. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies, audits and complaints.

Requires Improvement

Is the service safe?

Our findings

People were not always kept safe as safe recruitment procedures were not always followed. We reviewed five staff files. Staff completed an application form prior to their employment and provided information about their employment history. Proof of the person's identity and an enhanced Disclosure and Barring Service (DBS) check was completed. A DBS check helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with certain groups of people. However, we found that references for two people had not been satisfactorily obtained, as they had recently worked with vulnerable adults. When people have worked previously in health and social care or with children or vulnerable adults it is a regulatory requirement that satisfactory evidence of their conduct in this role is sought. In addition to this, the references that were held on file for these two people were not clear as to whom the references had been given by, their relationship to the person or their employment position. We found that the references given by the applicant on their application form had not always been contacted or documented why a reference had not been able to be provided from them. We also found for one other person, further investigations were needed into their employment history. However this had not been documented and so it was unclear if this had been satisfactorily explored.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in April 2016 we found that staffing levels were not sufficient to meet people's needs safely. The provider had taken action to improve staffing levels by recruiting and filling vacant positions. There was now only one full time post vacant and recruitment was in progress for this. Calculations were made into the amount of staff needed based on the people's needs at the home. We reviewed the staffing rotas from the previous four weeks and the number of staff was consistent with the planned staffing levels for the current occupancy of the home.

However, despite the improvements we did receive mixed feedback from people, staff and relatives about staffing levels. Some comments were positive that staffing levels were sufficient and others were contrary to this. One staff member said, "Staffing levels are fine." Whereas another member of staff said, "Staffing levels could be improved." One relative said, "There are insufficient staff here."

We found that some people's experiences when they requested care and support via their call bell system in their room was without delay. One person said, "They do come promptly when I call for them. "Another person said, "When I ring my call bell I have never been left the staff are quite responsive." However, in the care plans we reviewed, several stated that two carers were required. With the current staffing levels people and relatives told us that people had to sometimes wait until two staff members were available. One person said, "Routinely I have to wait 30 minutes, five if I'm lucky to get a response from my call bell. Longer if staff have to go and find a colleague free to help them." One relative said, "[Name of person] often has to wait 40 minutes to get help, that is routine." When people, staff and relatives commented on lack of staffing we found this related more to the nursing side of the home. Positive comments about staffing were related to

the residential side of the home. We found that people's needs were met on the day of our inspection but we ensured the registered manager was aware of the mixed feedback we had received.

Accidents and incidents were recorded. An accident form was completed detailing what had occurred and the immediate action taken. This was then given to the manager to review at a daily meeting. Monthly summaries were completed to analyse the recent accident and incidents and to identify any trends or concerns. However, we found that not all incidents that occurred were then reported using this system. In addition to this not all accident and incident forms were fully completed. This meant that actions to prevent re-occurrence may not be fully effective as information was incomplete. For example, we found an incident involving the police in September 2016 had been recorded in the person's daily notes but not recorded on an incident form. This meant that thorough follow through was not immediately actioned. It also meant that information was potentially not passed to other agencies as it should have been for example, the local safeguarding authority and the Commission.

The ordering, retention and administration of people's medicines were safe. Medicines were signed onto people's Medicine Administration Records (MAR). MARs had a picture of the person, and information about any known allergies. A list of sample staff initials used for signing MARs was available in the folder. Medicines were stored securely in a trolley or fridge. Medicines that required storage in accordance with legal requirements had been identified and stored appropriately. Registers of these medicines matched the stock numbers held. The temperatures of the medicines refrigerator were recorded daily to ensure medicines were stored correctly. Topical medicines included clear pictorial instructions to guide staff.

We reviewed a sample of people's MAR and no recording omissions were identified. There was a clear protocol in place for each 'as required' medicine a person was prescribed. This explained when a person may need these medicines and the potential dosage. There was complete information about homely remedies available for people. Additional information staff may need to be aware of was also detailed. For example, if the person had any swallowing difficulties when taking their medicines or any specific needs. One person received their medicines covertly. This is when a person's medicines are administered by disguising them, usually in food or drink. This means that the person takes their medicines unknowingly. This decision had been made in line with the Mental Capacity Act (MCA) 2005 and there was a clear record of the best interest decision made. It was detailed both within the care plan and on the MAR of how this was to be undertaken. We saw one person who required medicines at very specific times that were outside of the usual administration times. These were always accurately given. We saw effective checks and audits were in place of the medicines system and stock.

Individual risk assessments identified potential risks to people for example in falls, mobility and finances. Guidance was in place to inform staff how to support people safely. For example, how to move around the home safely and any mobility equipment used. This detailed the level of support required.

The provider had policies and procedures in place for safeguarding adults. This contained guidance on what staff should do in response to any concerns identified. From the training records we reviewed we saw staff received training in safeguarding adults. Staff were knowledgeable about the types of abuse that can occur and ways these could be identified. One staff member said, "I would report to a senior or a manager straight away." The provider had records of when concerns had been reported to the local authority safeguarding team.

We reviewed records which showed that appropriate checking and testing of equipment and the environment had been conducted. This ensured equipment was maintained and safe for the intended purpose. This included safety testing of electrical equipment and lift and mobility equipment. Which we

viewed taking place on the day of our inspection. There were also certificates to show testing of fire safety equipment and gas servicing had been completed. Regular health and safety checks were completed of the environment, these identified any areas which were in need of repair or maintenance. For example, a new number on a person's door. Records were kept of what action had been taken.

Staff had training in fire safety. Systems were in place to regularly test fire safety equipment such as emergency lighting, alarms and extinguishers. Regular practice fire drills had been undertaken and any actions identified had been clearly recorded. An emergency plan was in place that had been reviewed in July 2016. This contained protocols to deal with unforeseen circumstances such as a flood or gas leak. An evacuation overview was updated weekly and available in the emergency folder. This detailed the level of support each person required to be able to leave the building safely in an emergency situation.

There were members of staff on shift during our inspection with a responsibility for keeping the home clean. These staff wore appropriate personal protective equipment to help prevent the spread of infection. We checked bathrooms and toilets throughout the home and saw that they were cleaned and well maintained. On occasion when we saw that toilets were soiled, these were promptly cleaned. We also noted that in one of the bathrooms, there was an unlined open bin. When we returned later in the day, this had been addressed. This showed that cleaning systems were effective. There were systems in place to manage laundry, with colour coded bins in place to keep soiled laundry separate from other items. Consideration had been given to hand hygiene. There were sanitising gels available throughout the home and signs were on display with instructions on how to clean hands effectively. Gloves were available in the toilets and bathrooms for staff to use when assisting with personal care.

We also checked the kitchen on the lower floor of the nursing unit. We saw see that the hob and grill shelf above the hob appeared quite old, with some staining apparent. Staff in the kitchen told us that a deep clean was undertaken once yearly with staff also cleaning on a daily basis. We also saw that there were some areas of the floor that required further attention.

Requires Improvement

Is the service effective?

Our findings

The home was not always effective. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The registered manager was aware of their responsibilities with regards to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

There was a 'tracker' in place to record the details of people in the home who had applications submitted to the local authority. We found that from this information it was not clear as to who had an authorised DoLS in place and whose applications were still in process. The registered manager also could not tell us who had an authorised DoLS as they needed to check the outcomes of the applications on the list. The registered manager was also not aware at this time if any authorised applications had any conditions applied to them. On the second day of our inspection this information had been clarified and one person living at the home had an authorised DoLS. We checked the conditions attached to this authorisation and found the home had clear records to show how these conditions were being met.

Staff we spoke with also could not always tell us who had an authorised DoLS in place. One staff member when asked said, "I don't know who has a DoLS." A list was available in one of the staff offices. It listed 'Yes' to four people having a DoLS, when in fact they did not have an authorised DoLS in place. This information was misleading to staff. Staff had not had it clearly communicated to them who had an authorised DoLS in place and any conditions required by this authorisation.

There was evidence that people's capacity to make decisions was considered in their care planning. There was reference made to people's ability to make decisions. This included information about the particular ways a person may indicate their lack of understanding. For example, for one person their plan described how they would look distant and not respond if they did not understand. We also noted some good practice in terms of recording that verbal consent had been given when a person was unable to physically sign a document. However, we also found in some cases, that information was unclear, conflicting or omitted. For example in one person's care file we saw that on their 'consent to access care' document, the sections for both a person with capacity and for a person who lacked capacity had been completed. For another person, they had been described as having 'full capacity' in one section of their file and 'variable capacity' in another section.

When a best interest decision was needed we saw this was inconsistently completed. For example, a best interest meeting had been held for one person moving bedrooms. It clearly recorded who was involved in this decision and the reason for the decision made. However, in another case we saw a best interest decision had been made around a person's visitors. This was not clearly recorded who had been involved in this process, why other options had been discounted and why the decision was in the person's best interest.

We found that consent for specific aspects of people's care was not always sought. Some people in the home had sensor mats or alarms in place to alert staff to their movement at night and to ensure they could be supported to stay safe. Consent had not been gained for the use of this equipment. This meant we could not be sure that the full impact on people's privacy had been considered. There is also a risk with this type of monitoring that it can potentially be used to unnecessarily restrict people's movements. Without consent or a best interests decision being made for those people lacking capacity, we could not be sure that all the potential risks associated with the equipment had been considered.

Where bed rails were in use, we saw that in some cases, they had been requested by the individual concerned and this had been recorded in their file. In another case, the person lacked capacity and a best interests decision was recorded. However, in another we saw no specific consent had been obtained.

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

People's healthcare needs were not always sufficiently supported within the nursing side of the home. People who had been identified at risk in regards to nutrition and hydration had their food and fluids levels monitored. This was completed daily. However, we found that two people's fluid records had not been totalled, despite these being signed off by a senior member of staff. It meant that when fluid intake was low, which we saw on six occasions no subsequent action had been recorded as being taken. We also viewed records for one person who had lost a significant amount of weight since January 2016. Whilst the weight loss had been monitored monthly, there was no specific action plan within the care plan. The information recorded about food intake was generalised and did not detail the specific amounts consumed daily. This could place people at risk if sufficient action is not taken in regards to low nutritional and fluid consumption.

Some people used pressure relieving mattresses. These are used to protect people who have, or are at risk of developing pressure ulcers. These mattresses require setting according to the weight of the person. We viewed information around 10 people's pressure relieving mattresses. We found that seven of these were not on the correct setting for people's current weight and position. We also found there was no written guidance for staff on how the mattress settings should be adjusted. This meant that people were at risk of not being sufficiently protected against the risks of developing pressure ulcers. We viewed two care plans for people who required repositioning. The care plans viewed did not detail how people should be repositioned, but guided staff to 'turn' or 'move' people every three hours. We found on 3 October 2016 that both people were not recorded as being repositioned for a seven hour gap.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was clear documentation in people's care records when people had seen or been referred to other healthcare professionals. For example, the dentist, chiropodist, opticians or a specialist nurse. A GP from a local surgery visited the home regularly and was at the home on the day of our visit. One person also went to the dentist on the day of our visit and they were supported by staff. However, where people had indicated

they wished relatives to be informed of their health appointments and outcomes this was not always being completed.

It was difficult to initially obtain a clear overall picture in relation to how well staff were supervised and whether this was in line with the home's policy because the supervision tracker had not been kept up to date. There were a number of supervision records in the office, unfiled and not recorded on the tracker. A senior staff member told us that the expectation was that staff would have six supervisions during the year. We were told that this could include supervision in various formats such as 1-1 and in staff meetings when clinical matters were discussed. On the second day of the inspection, information on the tracker had been updated and it was clear from this that not all staff had received regular supervision. For example, two members of staff had only received one supervision since January 2016. This meant that there was a risk that people in the home were being cared for by staff who's performance and skills had not been appropriately monitored.

New staff completed an induction programme when they joined the organisation, this was not yet aligned with the Care Certificate. However, the documentation was in place for this to begin and the home were currently training people on how to mentor new staff appropriately through this process. All the staff we spoke with confirmed they had received an induction. The induction consisted of mandatory training, orientation to the home and people and shadowing a more experienced member of staff. One staff member said, "The induction was good. I felt confident afterwards." An induction for agency staff was in place. However, a member of agency staff on duty on the day of our inspection told us they had not received any induction. A senior member of staff said this would be addressed in the future to ensure all agency staff receive the provider's agency induction.

We reviewed the staff training records and saw that staff received on going training in areas such as moving and handling, food hygiene and fire safety. Training specific to the needs of people living at the home had been conducted for example in dementia.

Good

Is the service caring?

Our findings

People were supported people by staff who were kind and caring toward them. We observed that people had good relationships with staff members and they were happy and comfortable in their presence. One person said, "They [staff members] are all nice and polite, always patient and treat us with respect." Another person said, "I am well looked after."

People told us that staff were kind and caring to them at all times. One person said, "I like the staff, they are very good and very caring. They ask you how you are and if there is anything more they can do for you." Another person said, "The staff are what make it worthwhile here." Another person added, "The staff are all kind and thoughtful."

Due to some people's complex needs they were not able to directly tell us what they thought of the home. We spent time in the lounges and dining areas and observed how people were cared for. The staff were caring and warm in their approach towards people. Staff communicated and responded to people in a sensitive and gentle way. We observed staff communicate with people in their preferred way for example verbally, through touch or using facial expressions. We observed people laughed and joked with staff. Staff demonstrated a compassionate manner when speaking and providing support and care to people.

Staff treated people as individuals and knew people and their personal preferences well. These included what time a person wanted to get up, what activities they enjoyed, and whether they wanted to spend time with people or preferred more time alone. We observed staff ask people's consent before giving support. For example on staff member asked, "Is it OK if I push your chair a little nearer the table?" The staff member respected the person's answer and responded accordingly.

One person told us how they had to leave their pet fish behind when they moved to the home. A member of the maintenance staff kindly went and collected them. They are now in the home's pond so the person can continue to enjoy them.

The home had received 11 compliments since January 2016. One compliment read, 'Like to thank all the staff for their support.' Another compliment said, 'Thank-you for all your kindness.' One person had given the home a bunch of flowers as a token of their appreciation and had written, 'For all the good care."

Staff treated people in a respectful way and knew how to maintain their privacy. Staff told us they always knocked on people's doors before entering. One person said, "Staff never invade our privacy." We observed a member of staff sitting with a group of people in a communal area of the home. The member of staff spent time asking how people were and discussing the recent change in weather.

People told us that family and friends could visit whenever they wished. One person said, "Our families can visit at any time of the day or night and stay as long as we want them to." Relatives told us they were welcomed by staff. We had received information that sometimes people could not gain timely access to the buildings. Nobody we spoke with raised this as an issue and we observed visitors being admitted to the

building in a prompt way.

Some people at the home were nearing the end of their life. There was specialist seating and beds in place to minimise how often people needed to be moved while in bed .This reduced how often people needed to be disturbed and minimised the risk of discomfort to them. People who were nearing the end of their life had detailed and informative care plans to guide staff to provide sensitive care.

Good

Is the service responsive?

Our findings

People were supported so that they received care that was responsive and met their needs. We saw staff assisted people in a flexible way. For example, people had their meals where they chose to be and people ate at different times. One person said, "I am quite content here. It is a good home." Another person said, "It is very pleasant being here."

Care records were informative and contained a photograph of people and essential information. We saw that a personal life history was completed for each person. The staff said this was useful as it helped them get to know what mattered to each person. A full assessment of people's needs was conducted before people came to the home to ensure the home could meet people's needs. The information in people's care records set out what care people required and what actions were needed to support each person to meet them. For example, how people liked to be supported in personal care. People's personal preferences were described. For example, the types of food people liked or disliked. Care plans also included information such as if people had a preference for a male or female carer.

We saw that care plans were being reviewed and updated regularly. This helped show peoples' needs were reviewed and monitored. This meant staff knew how to provide the care they needed. However, we did note that people and relatives were not always involved in this review process. For example one care plan we viewed said, '[Name of person] likes to be involved in decisions over her care'. However, in the review sections of their plan it showed they had not been involved in these reviews.

A survey had taken place in response to people's comments raised about the quality of the food at the home in February 2016. There was no overall analysis of the results but ideas had been extracted about ways to improve. For example, 'more salads and fresh fruit' and how the meat could be cooked more so that it was more tender. However, we did note that 15 out of the 16 surveys completed had said they never saw or did not see the chef manager regularly. This had not been remarked upon and so did not appear to have been addressed.

People took part in a variety of social activities and events that were arranged for entertainment and stimulation. For example, we observed a musical afternoon that took place. This was well attended and we saw a group of people singing together. One person told us afterwards, "I enjoyed that." Staff told us that people from the residential or nursing side would attend social activities all together and we saw this take place. The majority of people we spoke with showed us their copy of the time table of forthcoming events and activities that were planned to take place in the home. People told us that they enjoyed the different events and activities that were arranged. One person said, "We have a lot of activities, we have quizzes and music which is lovely and really enjoyable."

We saw that people's rooms were personalised and decorated to individual's taste. Rooms contained items that were important to people and reflected their personality. For example, ornaments and photographs. One person said, "I have things in my bedroom like my TV and radio."

People received care that was responsive and met their needs. For example, we observed when a person came to have their meal they preferred something different. The person asked for soup instead. Staff responded by offering a choice of flavours. We saw staff respond to people when asked. For example, one person asked to be supported back to their room.

People and relatives told us they had been given a file with information about the services the home provided. This included a copy of the provider's complaints procedure if they felt they needed to make a complaint. The procedure was easy to follow and it fully set out how to make concerns known. One person said, "Yes, I know what to do to make a complaint." Another person said, "I know how to complain, I would go and see the manager."

Regular meetings took place for people and their relatives. We reviewed recent meeting minutes and saw that people's opinion and feedback was sought on areas such as meals, laundry, the premises and activities. Information was communicated to people. For example, any changes in the staff team. We saw from the meeting held in September 2016 that when suggestions had been made about relocating the dining room that people had unanimously voted against this. This had been respected and people's views were fed back to senior managers. Where issues had been raised we saw these were addressed and actioned. For example, the feedback that the sofas were too low for people. These were scheduled to be replaced with armchairs.

We saw cards left in the entrance hall of the home that invited people to rate the care home on an independent website that allowed people to review care homes. This helped to convey that the provider was actively seeking the views of people who used the service. No recent reviews had been left although previous comments were positive. There was also a 'You said, we did' noticeboard in the corridor. This showed details of comments people had raised and the subsequent action taken.

Requires Improvement

Is the service well-led?

Our findings

The home was not always well-led as whilst monitoring systems were in place we found these were not always operated effectively or consistently to ensure the home was able to make improvements or delivery high quality care. There was a log of complaints and compliments received. We found not all information regarding complaints and concerns were recorded on there. For example we found a verbal complaint discussed in the June 2016 staff meeting minutes had not been logged on the complaints record and a verbal concern raised in August 2016 which later developed into a formal complaint had not been logged at the time of the initial concern. When complaints were raised we found there was not always a clear accessible record to show how the complaint had been investigated, if the complainant had been satisfied with the outcome and what had been changed or actioned as a result of the complaint. For example, we viewed one complaint which detailed a missing item. The complaint record said this had been referred to the police but there was no documentation or details that this had actually been done. Another similar incident occurred, but this had not been logged as a complaint. As two similar situations had arisen, people would have benefited from a more thorough review and consideration of how to prevent this occurring again. Where one complaint in January 2016 had been fully investigated, this information was not held in the complaints log to demonstrate the actions taken.

Systems were in place to monitor the quality of the service. This included audits of care records, medicines and accidents and incidents. We found some of the audits were detailed and effective. For example, the care records audits, which identified areas for action such as a person required an oral care assessment to be completed. However, we found some audits that had not been consistently completed. For example, audits of response times and type of call from people's call bells. We found these audits were not regularly completed. In addition, some audits had explanations and actions taken whilst others had no investigation or outcomes from the audit. Given the feedback that we received in regards to response to call bells, complete audits of this is imperative to ensure that people's needs are being met in a timely manner. Audits were also not in place to robustly monitor the areas we identified in recruitment.

We found that information was not always kept up to date or organised. This meant important information was not clearly to hand and it was sometimes difficult to know the current status of events or issues. For example, we found that the supervision tracker, the complaints log and information regarding people's DoLS applications had not been kept up to date. This meant that the registered manager did not have a clear overview of these matters. It also meant that information that needed to be communicated to staff could not be. For example, who had an authorised DoLS.

All of the above is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Notifications had not always been submitted to the Commission as required. We found that one notification in relation to a DoLS authorisation from August 2016 had not been sent to the Commission as required. In addition to this we found the Commission had not been notified of a police incident in September 2016 and a safeguarding incident in May 2016. A notification is information about important events which affect

people or the home which the home is legally obliged to submit.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

People and staff spoke positively about the registered manager. Staff told us she was, "Approachable," and "Always had an open door." One staff member said, "The manager is good. She is visible." Staff said they worked well as a team. One staff member said, "We get along quite well the staff team."

Staff attended a daily handover at the start of their shift. This was in written and verbal format. The handover sheet had recently been changed to ensure information was communicated more effectively. It covered a 24 hour period so that information flowed between the day and night shifts. It also had specific areas to be covered for example, illnesses, falls, wound care and medicines. This made sure that important information was detailed. There was also a communication book, so important messages could be shared. We viewed details of appointments for people for example with the GP. Staff we spoke with told us they felt well informed.

The registered manager organised regular team meetings. Different meetings took place with different teams. For example, kitchen, nurse, activity and care staff. One staff member said, "Staff meetings happen regularly. We can bring things up." However, meetings were not always well attended by care staff. This meant that important information could not be communicated and discussed with all staff members. We reviewed the minutes of recent meetings and saw that the team had received training from a health professional and recent audits were discussed. The registered manager said ways would be considered to try and increase participation in these meetings.

The home operated a resident of the day system. This was where a particular resident was focused on to ensure their care and support needs were met. For example, their care plan was reviewed and the maintenance team would visit to check their environment.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18(2) (c) The provider had failed to notify the Commission, as required of a notification relating to a DoLS authorisation, a police incident and a safeguarding matter.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 (1) The provider had not ensured that care and treatment met people's healthcare needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 (1) The provider had not ensured that practice to obtain consent for care and treatment was in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a)

The provider did not consistently operate effective systems to monitor and improve the quality of care provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 (3) (a) The provider had not ensured that effective recruitment procedures were maintained