Care Quality Commission

Bupa Care Homes (CFHCare) Limited

Manor Court Nursing Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on 19 May 2015 and was unannounced. We last inspected the service on 13 May 2014 and found there were no breaches of Regulation.

Manor Court Nursing Home is owned and managed by Bupa Care Homes (CFHCare) Limited (BUPA). The home is registered to provide accommodation, personal and nursing care to up to 120 people. The home is divided into four units, each unit catering for people with different needs. Larch unit is for older people who have dementia; Willow unit caters for older people, some who are receiving palliative care. Sycamore unit is for younger adults (people under 65 years) who have a physical disability. Beech unit was opened earlier in 2015 and is commissioned by the local Clinical Commissioning Group to provide care, support and rehabilitation to people who are recovering from an injury or illness and hoping to move back home. People living on Beech unit were able to stay at the home for up to six weeks. At the time of our inspection 84 people were living at the home.

The registered manager left the service in 2014. The organisation appointed a new manager who has been in post since this time. They had not applied for registration with the Care Quality Commission. During the inspection they informed us they were leaving the service. A

Summary of findings

temporary manager had been appointed to manage the service for three months whilst a replacement was recruited. This person was at the service on the day of the 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 and associated Regulations about how the service is run.

The units of the home were managed independently of each other and catered for people with different needs. The quality of care varied between the units.

Some of the practices we observed put people at risk. In particular we observed people being supported to eat and drink in a way which meant they were at risk of choking.

People were at risk because their medicines were not always managed in a safe way.

Some people had their liberties restricted in an unlawful way. For example, through the administration of sedative and covert (without the person's knowledge) medicines.

People's capacity to make decisions about their care and treatment had not always been assessed. Their consent to care had not always been obtained.

People living on Willow unit did not always receive care which was personalised and respected their dignity. The staff were sometimes too busy to listen to people's requests and respond to these.

The provider had systems to monitor the quality of the service and these were comprehensive. Some of these had identified areas of concern. However, the risks to people's well-being and safety had not been appropriately managed.

People's recreational and social needs were not always met in the same way throughout the home. In some units people wanted more opportunities for social activities and wanted their individual choices and preferences to be taken into account. In other units people felt their social needs were met.

The provider employed enough staff but they did not always deploy these in a way so that everyone living at the home had the same experience of support and attention.

The provider had procedures to help identify abuse and the staff had been trained in these. The provider had taken appropriate action and liaised with other agencies to investigate safeguarding concerns.

The provider made appropriate checks on the suitability of staff before they started working at the service.

People's nutritional needs had been assessed and they were given the support they needed to meet these. They were offered a variety of fresh and well prepared food.

People's health, physical and nursing needs had been assessed and the staff worked with other professionals to meet these.

The staff had the support and training they needed to care for people.

Some people told us the staff were kind, caring and attentive. They had good relationships with the staff and felt the staff had time to talk to them as well as attend to their personal and healthcare needs.

People's privacy was respected.

People's health and personal care needs had been assessed and recorded. Although there was no record of some people's preferences regarding their care.

There was an appropriate complaints procedure which the provider followed.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLs). DoLS provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. The provider had sought appropriate authorisation for the deprivations of liberty which they had assessed and considered to be in people's best interest.

We identified six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

The service was not always safe.

Some of the practices we observed put people at risk. In particular we observed people being supported to eat and drink in a way which meant they were at risk of choking.

People were at risk because their medicines were not always managed in a safe way.

The provider employed enough staff but they did not always deploy these in a way so that everyone living at the home had the same experience of support and attention.

The provider had procedures to help identify abuse and the staff had been trained in these. The provider had taken appropriate action and liaised with other agencies to investigate safeguarding concerns.

The provider made appropriate checks on the suitability of staff before they started working at the service.

Is the service effective?

Requires improvement 

The service was not always effective.

Some people had their liberties restricted in an unlawful way. For example, through the administration of sedative and covert (without the person's knowledge) medicines.

People's capacity to make decisions about their care and treatment had not always been assessed. Their consent to care had not always been obtained.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLs). DoLS provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. The provider had sought appropriate authorisation for the deprivations of liberty which they had assessed and considered to be in people's best interest.

People's nutritional needs had been assessed and they were given the support they needed to meet these. They were offered a variety of fresh and well prepared food.

People's health, physical and nursing needs had been assessed and the staff worked with other professionals to meet these.

The staff had the support and training they needed to care for people.

Summary of findings

Is the service caring?

Requires improvement

The service was not always caring.

People living on Willow unit did not always receive care which was personalised and respected their dignity. The staff were sometimes too busy to listen to people's requests and respond to these.

However, people living on the other units told us the staff were kind, caring and attentive. They had good relationships with the staff and felt the staff had time to talk to them as well as attend to their personal and healthcare needs.

People's privacy was respected.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's recreational and social needs were not always met in the same way throughout the home. In some units people wanted more opportunities for social activities and wanted their individual choices and preferences to be taken into account. In other units people felt their social needs were met.

People's health and personal care needs had been assessed and recorded. Although there was no record of some people's preferences regarding their care.

There was an appropriate complaints procedure which the provider followed.

Is the service well-led?

Requires improvement

The service was not always well-led.

The permanent manager was due to leave the home shortly after our inspection and there had been no registered manager in post since August 2014.

The provider had systems to monitor the quality of the service and these were comprehensive. Some of these had identified areas of concern. However, the risks to people's well-being and safety had not been appropriately managed.

Manor Court 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 checked 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 took place on 19 May 2015 and was unannounced.

The inspection team consisted of two inspectors, a pharmacy inspector, a dietitian who was a specialist advisor for CQC looking specifically at how the nutritional needs of people were being met 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. The expert on this inspection had personal experience of caring for an older relative and using health and social care services.

Before the inspection we gathered as much information as we could about the provider. We asked them to complete a Provider Information Return. This is a document where the provider tells us key facts about the service and also explains how they believe they are meeting the Regulations. We looked at notifications of significant events, including safeguarding alerts and complaints which we had received about the service.

During the inspection we spoke with 21 people who used the service, 13 visitors and 20 members of staff, including the manager, care assistants and senior carers, nurses, an activities officer, the physiotherapist, the chef and catering staff and other administrative and maintenance staff.

We used different methods to obtain information about the service. This included talking with people using the service and their relatives and meeting with staff. As some people were not able to contribute their views to this inspection, we carried out a Short Observational Framework Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We looked at the environment where people were being cared for. We looked at the way people were supported with their medicines, including how these were stored and recorded. We looked at care records for 11 people living at the home. We looked at how the nutritional needs were assessed, recorded, monitored and met, including records of this for four people. We looked at the staffing records for five members of staff, including how they were recruited. We looked at the staff training and supervision records. We looked at how medicines were managed for 52 people. We also looked at how the provider monitored the quality of the service, including audits and checks, how accidents, incidents and complaints were recorded and minutes of meetings within the home.

Inadequate

Is the service safe?

Our findings

During our inspection we witnessed a number of incidents where people were put at risk because the staff did not follow their care plans or good practice guidance. We observed the staff using approved thickeners to change the consistency of drinks for one person. The staff did not use the correct amount of thickener and therefore the person's drink was not at the correct consistency for their assessed need. This could have put the person at risk of choking. The staff did not demonstrate a good understanding of the different consistencies of food people required and in some cases information had been wrongly recorded. This meant people were at risk of choking because they may have been given the wrong consistency of food and drink. We observed the staff offering one person pureed food which they refused. The person told us they were not supposed to have a pureed diet. The staff then gave the person a scrambled egg and tomatoes and offered them a biscuit. The care plan for this person was not clear and some information stated they required a soft diet whilst another record stated the person required a pureed diet, a third record did not record the need for any special diet. The staff were not able to tell us what the assessed consistency of food for this person was. They could not explain why they had offered the person food with different textures and consistencies and the risks associated with this. The staff, including catering staff, were not aware of the National Descriptors used to indicate the different consistencies of soft and pureed food and referred to all soft diets as ''softies''. The National Descriptors describe a number of different consistencies of soft diets according to individual need. There was no evidence that the textures and consistencies of soft food reflected individual needs and this meant people could be at risk of choking. During lunch on Willow unit the staff supported people in a rushed way not allowing them enough time to swallow. This caused a risk of choking. The staff were not positioned correctly to offer support as they sat to the side and a little behind the people they were supporting, again presenting a risk to the people who they were supporting.

This is a breach of Regulation 12(1) and (2)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at medicines management in three of the units at the home, including how medicines were stored, recorded and administered. Some people were at risk because their medicines had not been managed appropriately.

A number of people were prescribed PRN (as required) pain relieving medicines. The staff had not carried out assessments of their pain and there were no protocols to tell staff when and how to administer pain relieving medicines. This meant the staff were not always aware of how people communicated and experienced their pain and when medicines were necessary. On Willow unit there were two people who had not been given pain relief medicines since 29 April 2015. Another person did not have pain relief from 29 April 2015 to 8 May 2015 as supplies of their pain relief medicine had run out. The unit manager told us that these people had not needed this pain relief, but no pain assessments were being carried out for people prescribed pain relief. Therefore the provider was unable to demonstrate they were assessing and managing people's pain.

The records of temperature checks for the medicines refrigerator on Willow unit stated that for a number of days each month since February 2015 the temperature had been 0◦C. Insulin had been stored in this refrigerator. The storage instructions for this medicine are that it must be stored between 2◦C and 8◦C and must not be frozen. The medicine properties would have been altered or damaged at lower temperatures and therefore people prescribed this medicine were at risk.

The amount of spare stock medicines held was not clearly recorded and this made it difficult to audit. We looked at the stock medicines for six people. Four of these had been wrongly recorded. The staff had altered the prescription labels on some people's medicines to include bedroom numbers. This was not good practice and the staff should use the details provided by the pharmacist to identify who medicines belong to, rather than rely on room numbers, which may change.

The staff were not able to locate a protocol for the administration of homely remedies (non prescribed medicines).

This was a breach of Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

Records of medicines administration had been completed accurately. Where healthcare professionals had changed the dose of people's medicines the staff had accurately recorded this. On Willow unit four people's allergies had not been recorded on their medicines administration record. The staff added this information during the inspection when we alerted them to this. However on the other two units where we looked at medicines management, people's allergies had been recorded and in one case the staff had queried a person's prescription because it included a medicine they were allergic too. The doctor then changed this medicine. This demonstrated the staff were aware of people's medicine needs and felt able to challenge health care professionals where they identified risks.

Controlled drugs were appropriately stored and recorded. The staff monitored these daily and made accurate weekly stock checks of all controlled drugs.

Some people were prescribed PRN (as required) medicines. There was guidance and protocols for the administration of some, but not all, of these. The staff did not always record the reason why they had administered sedative PRN medicines.

We observed the staff administering medicines. They followed the provider's procedures, and took their time to make sure people were happy to take their medicines.

The people on Willow unit told us they did not think there were enough staff to care for them safely. One person said, ''I think they've got a problem, they've got so much to do, they are very busy.'' Another person told us, ''I hear them say I've only got one pair of hands''.'' They went on to say, ''They're trying to cope the best they can but sometimes there's no-one to take people to the toilet, others shout for a nurse and it's quite a long time sometimes before anyone comes; If anything happened I dread to think if no-one (staff) is around.'' Other things people told us were, ''They do what they can but they're too busy. I came back from the hairdressers and they put me in a chair over there, I was so uncomfortable, in pain. It took two hours before anyone came'', ''if I want their attention I have to shout, I have to do a lot of shouting and they don't always come'', ''even at night, and there's a lot of pressure on the staff, the staff are too busy, I don't always get something to eat, there's more important things than making a coffee and sandwich for me.'' and ''I can't hold it when I need the toilet I sit here for a couple of hours sometimes because they're too busy.'' A relative told us, ''They could do with more (staff) during the day because a lot of people need two staff to help wash them, there aren't enough staff for anything else.''

However, people on the other units told us there were enough staff both day and night. One person said, ''Of course there's enough staff.'' We observed staff attending to people's needs in both the communal areas and their own rooms. People on Beech unit told us the unit was well staffed and they had the support and attention they needed.

The staff told us there was a high reliance on agency and temporary workers. They said that where possible they requested the same temporary workers for continuity but that there was not the same level of consistency there would be with permanent staff.

We recommend the provider follows best practice guidance to make sure staff are deployed so that people throughout the home receive the same level of staff support and attention.

People told us they felt safe at the home. Some of the things they said were, ''It's like a fortress, this place. Safe, yes'', ''relatively safe, yes'', ''yes, I feel okay here'' and ''safe? Of course, of course. Yes, I'm safe here.'' People told us they knew who to speak to if something was wrong, but some people said they did not want to speak up. Relatives told us they felt people were safely cared for. One person said, ''they are safe and it is peace of mind for us.'' Another person told us, ''(my relative) is very safe here.''

The provider had procedures for safeguarding vulnerable adults and whistle blowing. The staff had been trained in these and were aware of them. They were able to tell us how they would recognise abuse and what they should do to report this. We saw that safeguarding training was regularly updated for all staff. Records of safeguarding concerns showed that the provider had worked with the local authority and other agencies to investigate these.

The provider had appropriate procedures for recruiting staff and assessing their suitability. These included a formal interview, written tests, reference and criminal record checks. We looked at the recruitment files for five members of staff and found that these included all the required documents and checks.

Requires improvement

Is the service effective?

Our findings

Some of the practices at the home restricted people's liberty and freedoms.

One person had been prescribed a PRN (as required) sedative medicine. There was no protocol for this person's medicine. The person had been administered the medicine 12 times since 29 April 2015. The staff had recorded the reason for this being the person had ben restless and noisy. This is not an appropriate use this type of medicine and the person's liberty and freedom of movement had been unlawfully restricted.

The staff were covertly (without the person's knowledge) administering medicines to one person by crushing them and hiding them in their food. There was no assessment or care plan to explain why this was taking place. There was no evidence of a multidisciplinary decision to do this in the person's best interest and the unit manager on Willow told us the person had capacity. Therefore the provider was unlawfully restricting this person's liberty without their knowledge.

This is a breach of Regulation 13(4)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not always assessed people's capacity to consent to care and treatment. The systems BUPA used for assessing capacity, obtaining consent and recording what action had been taken when people did not have capacity had not always been followed by the staff. Some of the care plans we viewed did contain this information or indicated verbal consent had been given. However, some people had been assessed as requiring bedside rails to keep them safe. These rails also restricted their freedom of movement. Their agreement to the use of these had not always been obtained. There was not always evidence that the use of these had been discussed with the person's next of kin and other relevant parties. In some cases there was no record to state the reason for the decision to use these had been made in the person's best interest.

There was little or no evidence that the person or their relatives had been involved in care planning for the majority of people whose records we looked at. There was no record of their consent to the care plan. In two instances the care plan indicated the person had capacity to make decisions about their care, however there was no evidence they had been consulted about their care plan. Instead there was a record of discussions and consent given by their next of kin.

This was a breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLs). DoLS provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them.

The manager told us that applications had been made to lawfully deprive some people of their liberties. We saw that records of this action included a capacity assessment, meetings about their best interest, an application and authorisation from the local authority. The manager explained that she had worked closely with the local authority to make sure the provider was taking appropriate action and meeting the requirements of DoLS.

Most people told us they felt the staff were appropriately skilled and cared for them in a professional way, meeting their needs. One person said, ''they know what they are doing, most of them have worked here a long time.'' However, some people on Willow unit told us they did not think the staff had the right skills and knowledge to support them. One person said were, '' 'They don't understand my needs, they should be a bit more sympathetic but they're not trained.'' A visitor told us that the staff did not understand her relative's health conditions and did not always follow their care plan.

The staff told us they received the training and support they needed. They spoke positively about the management support on their units and from the home manager. They said they had regular team meetings and individual supervision and appraisals. The records of this formal staff support showed that these meetings did not always happen regularly. However, we saw that formal meetings had been held to follow up concerns about staff performance, there were daily handover meetings between staff. The staff told us they felt there was good informal support. They told us, ''we work as a team and help each

Requires improvement

Is the service effective?

other out", ''the managers are always available if we need them'' and ''I am new to this unit and the other staff really supported me and help guide me, I can ask them anything.''

All new staff completed an induction into the organisation, the home and the work they were undertaking. They told us this was thorough. We saw records of some staff inductions and these included assessments of their work and skills. The provider monitored staff training and made sure all staff received the training required for their role. This included updates in areas where annual or biannual training was required. The manager monitored this and we saw action had been taken when a staff training need had been identified.

People's nutritional needs were assessed and they were given the support they needed to have good nutrition. We looked at the nutritional assessments, care planning and monitoring for four people. Three people had been assessed as having dysphagia or malnutrition risk and one person used a Percutaneous Endoscopic Gastrostomy (PEG) feed. We saw that people's needs were met and they had not been put at risk, however, there were some gaps in recording which could have presented a risk for some people.

The care plans gave relevant information about people's needs and in some cases included guidance from other professionals supporting the person, for example the dietitian and speech and language therapists. However, one person's care plan identified they had swallowing difficulties but there was no evidence they had been assessed by a relevant health care professional to determine the consistency of food they required. We saw evidence that people's food and fluid intake and their weight were regularly monitored. In one case we saw that someone's weight had been incorrectly recorded and a significant change in their weight had not been assessed. Malnutrition screening tools had been used to assess the risks to people, but in one case we saw the risk had been wrongly calculated and did not fully identify the level of risk for that person. We spoke to the members of nursing staff about these concerns and they took action to address these at the time of our inspection.

The procedures to support people using PEG feeds were followed. Their care and nutrition was monitored appropriately.

Most people liked the food at the home and felt they had a choice but some people wanted more variety. Some people on Willow unit told us they had not seen a menu and were not offered a choice. Some of the things people said were, '' The food is quite good and it is enough. I am not always given a choice but if I don't like what I am given I can have something else", ''I never see the menu, I would like to", ''I am given porridge every day for breakfast I would like more choice and to be asked'' and ''in general the food is varied but we are not always offered a choice, the breakfast is just brought to me.''

BUPA implemented a four week menu at the home which changed seasonally. This menu was varied and had three main choices at each meal, including an Asian dish. There were also other foods such as salad, omelette and jacket potatoes which were available at any meal if people wanted these. The food served on the day of our visit reflected the menu. There was a photographic menu for people who required additional information to help them chose their meals. People chose their main meal the day before but the staff said that they could change their mind at the point of service. Some visitors told us they would like more variety of food and the African Caribbean diet was not catered for. Some Asian people told us they would like more variety with the Asian menu as the food was often dhal and they were not offered enough variety of vegetables. People were offered a choice of cereals, breads and fruit for breakfast and could request a cooked breakfast if they wished. We observed people were given appropriate portion sizes which met their individual needs.

On Larch unit people were offered snacks, fresh fruit and drinks throughout the day. They were able to help themselves to some food. The staff encouraged people to eat and brought them food as they asked for it. This was good practice as the people living on this unit had dementia and did not always follow the routines of set mealtimes.

The staff worked closely with other healthcare professionals to meet people's health needs. The home employed physiotherapists who offered support to people in two of the units. There was also an occupational therapist working in one unit. They assessed people's healthcare needs and we saw they had made appropriate referrals for additional professional input when people needed this. The nursing staff assessed, monitored and met people's nursing needs. Information about nursing

Requires improvement

Is the service effective?

needs had been clearly recorded. The staff reported good working relationships with the GPs and other specialist healthcare professionals. Information about people's health needs was clearly recorded. In most cases wound care had been monitored appropriately, although in one case the records relating to the treatment of one person's wound were not clear.

Two of the units were equipped to support people to regain skills and independence, for example specially adapted kitchens and a gym. People were supported to make use of these. People staying on Beech unit were there for a limited time. The majority of people were aiming to return home once they had recovered from their injury or condition. The staff on this unit had weekly multidisciplinary meetings with community professionals to help support the person's transition back home and to make sure the equipment and services they needed were in place before they left Manor Court.

Requires improvement

Is the service caring?

Our findings

Some of the people on Willow unit told us the staff were not always caring. Some of the things they said were, ''they don't pay attention'', ''they're not listening to individual choices'', ''the staff speak to me like a child'' and ''some of the staff have a sort of superior voice, they told me no-one likes me because I shout and said I must apologise''.

We observed some practices on Willow unit which did not always meet people's needs in a person centred way.. For example some people were given their breakfast at 11.30am and then given lunch at 12.30pm. They were not able to eat their lunch but then were not offered any other meals until the teatime meal. One person told us this was often the case. They said, ''by the time everyone is washed and dressed and gets in here (the lounge) its 12.30pm and time for lunch.'' In another incident we observed a person slipping down in their chair, they told us they were in pain. The staff did not noticed so we alerted a member of staff whose initial response was that they were too busy to help the person.

The atmosphere on Willow unit at lunch time was not friendly or relaxed. The staff were focussing on tasks and supported people in a hurried way. They did not ask people about their enjoyment of the meal or interact with people who they were supporting. The tables were not set with cutlery, mats, napkins or condiments. People were served their desserts at the same time as their main course so these went cold. People were not asked where they wanted to eat their meals and were served where the staff had seated them.

None of the people eating on Willow unit were offered drinks during their meal. One person asked for a drink of water but they were not given this. They asked a second time and the staff brought them a glass of squash.

This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However people on the other three units had a different experience. They told us they thought the staff were caring and kind. Some of the things they said were, ''They always come round at 8 o'clock and say good morning, how are you? It's the same at night ... the night staff introduce themselves. It's nice'', ''The majority are caring and they ask me if I'm alright'', ''they're nice and helpful people'', ''I am very happy, they respect my dignity and they are good, kind and caring'', ''the staff are all very approachable, kind and thoughtful'', ''I am very happy and well looked after'', ''they are all so kind and caring'' and ''they are caring, they look after you but there isn't always someone to talk to.'' The provider's own records included thank you cards and compliments about the way people had been cared for from relatives.

We observed the staff being kind, caring and attentive towards people. They approached people with a smile and greeting. We saw lots of examples of staff sharing a joke with someone, talking about the person's interests with them, playing, singing and dancing with people who wanted this and offering people choices. The staff knew about people's needs and preferences. They identified when people were not happy and cared for them in a sensitive and kind way.

The staff on Larch unit made sure everyone living there had regular time and attention from them. People who were sitting quietly were joined by staff at regular intervals to make sure they were well and happy. The staff took their drinks and had their breaks in the company of the people who lived there. There was a relaxed atmosphere and people appeared content and comfortable.

The staff were able to describe how they would maintain people's privacy and dignity. We saw them knocking on bedroom doors, explaining what they were doing when they were supporting people and reassuring them through potentially distressing procedures, such as using a hoist to move.

The staff appeared motivated and positive when they were supporting people. They spoke to people in their preferred language and using their preferred names. Relatives told us they were able to visit whenever they wanted and we saw a lot of people were joined for lunch by their relatives who ate with them. At lunch time, the staff offered people choices and showed them the food so they could make informed choices.

Requires improvement

Is the service responsive?

Our findings

People's experience of how their social and recreational needs varied. On Willow and Sycamore units people told us they would like to go out but the staff were too busy to do this and therefore it did not happened. There was a notice board advertising activities in both units, but this was not accurate and people told us the activities did not take place. The advertised activity on Sycamore unit on the day of our inspection was a trip to the London Transport Museum. This had not taken place and none of the staff or people who lived in the unit knew anything about this trip. Other advertised activities included potting plants; flower arranging; cheese and wine; walks in the garden and story reading but people told us none of these events had taken place.

On Willow unit people were helped into the lounge during the morning and were placed in seats watching the television. They were not given a choice of programmes or offered an alternative activity.

Some people on Willow and Sycamore units told us they were not happy with the activities at the home. Some of the things people said were, ''you have to set the ball rolling yourself if you want to do something, nothing is offered'', 'the staff try to get people involved in little games. I have been told there is more going on in the summer'', ''the concerts are quite good but people are not interested in the games and other activities'', ''the things on the activities board never happen, there is no staff, they haven't time to play tiddly winks with us they are helping people in their bedrooms'', ''I'd like to go out the nurses keep promising me I will, but they are always too busy, it's the same every day'', ''we just sit and watch television'' and ''things to do? There is always the television.''

This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people spoke positively about activities. For example they said, ''I like drawing and colouring and I do that every day'', ''I use the gym and I am very happy with this'' and ''some of the residents attended a mosque and enjoyed that, it's important to meet people's cultural needs''

People were happy with the support they had to access the gym on Sycamore unit. The home employed a physiotherapist who worked with each person on this unit to assess their needs and develop an individual exercise plan for them. There was also a specially adapted kitchen on the unit and the physiotherapist ran a cooking group to help people develop their skills in the kitchen. People spoke positively about this support. We saw the staff supporting people with some individual activities on Sycamore unit and people told us they enjoyed these.

People on Larch and Beech unit were offered individual activity support. On Larch unit we saw people using the garden, colouring, looking after dolls and toys, watching TV and pursuing other individual activities. The staff were attentive and made sure people were doing what they wanted. In Beech unit each person had a programme of individual therapy and enablement. They told us the staff supported them with this.

Each person had their needs assessed before they moved to the home. The staff created care plans based on these assessed needs. The care plans covered a range of different needs including health care, nursing needs, personal care, communication needs, skin integrity, personal safety and mental health. Care plans were reviewed and evaluated each month and this was recorded. The care plans had detailed information about how needs should be met but did not always include information on people's preferences, likes and dislikes. For example, how often people wished to have a bath or shower. Information about people's lifestyle and background varied in detail and in some cases hardly any information had been recorded. Therefore the staff could not always be sure they were meeting people's needs in a way they would want or in a way which reflected their culture and background.

The provider has a complaints procedure and people living at the service and their relatives had received a copy of these. People told us they knew how to make a complaint.

We saw records of complaints. There was evidence these had been investigated and acted upon. The complainant had receive feedback. The provider's quality assurance system monitored complaints to make sure any common areas of concern were identified and acted upon.

Requires improvement

Is the service well-led?

Our findings

There had been no registered manager in post at the home since August 2014. The provider had not made an application for a manager to be registered with the Care Quality Commission since this time.

This was a breach of Regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The records about people who lived at the service were not always completed. The provider was in the process of changing over care planning systems and some of the information had not been transferred to the new system. This could mean that staff who did not know people well may not always know about their individual needs and how to meet these.

We identified a number of areas where the service was in breach of the Regulations. of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Although the provider had systems to monitor the quality of the service and had, in some cases, identified the same areas of concern, they had not taken sufficient steps to manage the risks to people of inappropriate care and treatment. Therefore people could not feel confident that their need would always be met in a safe and person centred way.

This was a breach of Regulation 17(2)(b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of the inspection the manager had been in post since 2014, she had previously worked at the home as the deputy manager and knew the service well. She had not applied to be registered with the Care Quality Commission. On the day of the inspection she told us she was leaving the service the following week. BUPA had recruited a temporary manager who had her own consultancy business. She was experienced at managing homes. She told us she had been employed for three months whilst the provider recruited a permanent manager. The day of the inspection was her first day at the service.

The provider had developed a number of systems to monitor the quality of the service. These were detailed and included regular visits to the different units by the management team. They carried out monthly audits on all aspects of the service including how health and medicine needs were met, management of pressure sores, accidents and incidents, nutrition, healthcare input and involvement of people who used the service. The manager prepared a report and this was viewed by senior managers within the organisation. An action plan had been created where problems were identified

The provider worked alongside other agencies and the local authority. They had liaised with the London borough of Ealing about deprivation of liberties and had a good understanding of this. They adopted recognised good practice approaches for working with people who had dementia and there was a lead nurse who trained others in this good practice.

Accidents, incidents and complaints were recorded and monitored. The manager analysed these and had identified trends and patterns. There was evidence that action had been taken to reduce reoccurrence of accidents.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 7 HSCA (RA) Regulations 2014 Requirements relating to registered managers The registered person had not employed a registered manager. **Regulation 7**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person did not always provide care and treatment to service users that was appropriate, met their needs and reflected their preferences. **Regulation 9(1)**

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 Care and treatment of service users had been provided by the registered person without the consent of the relevant person. **Regulation 11(1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Action we have told the provider to take

The registered person had not provided safe care and treatment to service users because they had not assessed risks to their health and safety, done all that is reasonably practical to mitigate against such risks or managed medicines in the safe and proper way.

Regulation 12(1) and (2)(a), (b) and (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person had provided care and treatment for service users which included acts intended to control and restrain a service user. **Regulation 13(4)(b)**

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 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not effectively operate systems to assess, monitor and mitigate the risks relating to health, safety and welfare of service users and did not maintain an accurate and complete record in respect of each service user. **Regulation 17(2)(b) and (c)**