Bafford House Residential Care Home

Bafford House

Inspection report

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Ratings

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

Overall summary

This unannounced inspection took place on 11, 12 and 13 August 2015.

Bafford House provides accommodation for up to 19 older people who require personal care. The service mainly cares for people living with dementia. The home is a detached house with accommodation on three floors. People have access to a communal lounge, two communal areas in the main hall and upper landing and a separate dining room. Some bedrooms have an en-suite facility and there is a bathroom on each floor. The gardens at the front and back were accessible for people. There were 13 people accommodated when we visited.

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

Summary of findings

People and relatives told us they thought the service was safe. Accident and incident records were not always completed and audited sufficiently to ensure people's safety. People were not always supported by sufficient staff with the appropriate skills, experience and knowledge to meet their needs. A relative told us they were concerned about insufficient staff in the evenings.

Inadequate organisation of staff left people without supervision and support in the lounge and people were not repositioned in bed. We made a recommendation staffing levels are regularly assessed and monitored to meet people needs and protect them.

People's medicines were not managed safely to ensure people received appropriate medicines. Medicines were stored safely but administration records were incomplete. Staffs medicine administration practice was monitored but the doctor's instructions were not always followed correctly.

People were not protected by the Mental Capacity Act (MCA) when consent records were incorrect and capacity assessments had not been completed. There were some 'best interest' decisions recorded for people without the capacity to make a decision but some decisions were incorrectly made by the staff.

The home was clean and free from offensive odours. Staff knew about infection control and the correct equipment to use to prevent cross infection. There was sufficient ancillary staff to maintain a clean environment and complete laundry tasks. The infection control policy required updating.

There was no choice of meals and people's dietary requirements and food preferences were not fully met for their health and well-being. Food and fluid charts were not completed accurately to record people's dietary needs were met. People told us they liked the meals and a relative told us that finger food was provided in the person's bedroom when they were unwell. Special diets were catered for to include diabetic, vegetarian and fortified meals.

People had access to healthcare professionals to promote their health and wellbeing but there was a need to improve the information recorded for healthcare professionals to review progress. We made a recommendation robust records are maintained and are accessible for the appropriate period of time. A healthcare professional told us that recent end of life care for people was managed well by the service and referrals were made to them when necessary.

People looked well cared for. Most staff treated people as individuals and interacted with them positively giving them time to make choices. Relatives told us the staff were very caring and the care was good. We saw two staff did not always treat people with compassion, dignity and respect and required additional training to improve.

Relatives told us care plans had been reviewed with them but we were unable to access any records prior to July 2015 as they had been archived. The care plans we looked at were incomplete and had some blank records. The registered manager told us they were updating all the records. Some people had a 'Journey through life' record detailing their social history and a 'This is me' plan about their likes and dislikes but not all people had this information.

There were limited activities provided and staff told us they need more time to engage with people individually. We saw people playing a ball game with staff and relatives told us they completed puzzles, played skittles and sometimes sat in the garden.

The service was not consistently well managed and information required was unavailable. Quality assurance checks had not been regularly completed to ensure people were safe. People or their relatives had not been consulted about the quality of the service so that improvements were identified and made.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and (Registration Regulation) 2009 Regulations. 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?

Requires improvement 

The service was not safe

Accident and incident records were incomplete and did not record reflective practice or identify possible preventative measures.

People's medicines were not managed safely to ensure people were receiving appropriate medicines.

People were not always safeguarded as not all staff were trained to recognise and report abuse.

There were times when the organisation of staff did not protect people and meet their assessed needs.

Is the service effective?

Inadequate 

The service was not effective.

People were not protected by the MCA as capacity assessments and best interest decisions were not always recorded when people could not consent.

People living with dementia were not effectively cared for as staff did not have adequate training.

People's dietary requirements and food preferences had not been fully met for their health and well-being.

People had access to healthcare professionals and had on going healthcare support.

Is the service caring?

Requires improvement 

The service was not consistently caring.

People were not always treated with compassion, dignity and respect.

Most staff treated people as individuals and interacted with them positively giving them time to make choices.

When people were able to make decisions about their care the staff supported them to be independent.

Is the service responsive?

Requires improvement 

The service was not consistently responsive.

People did not always receive the care and support they needed and their health and wellbeing was sometimes at risk from deterioration.

Staff knew people well and their preferences.

Summary of findings

People took part in some activities. However there was insufficient staff to fully engage with everyone.

Is the service well-led?

Requires improvement

The service was not consistently well led.

The service was not consistently well managed and information required was unavailable. Regulations were not met with regard to informing CQC about incidents.

Quality assurance checks had not been regularly completed to ensure people were safe.

People or their relatives had not been consulted about the quality of the service so that improvements were identified.

Bafford House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 11, 12 and 13 August 2015 and was unannounced. The inspection team consisted of one adult social care inspector and a specialist dementia care adviser.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We also had information from health and social care professionals. We did not have a Provider Information Return (PIR) this time. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to assess how the service was performing and to ensure we addressed any potential areas of concern.

We spoke with the registered manager, the provider, the deputy manager, five care staff, a domestic/maintenance person and the cook. We spoke with five people who use the service, three relatives, a community mental health nurse and a nursing care assistant. We looked at information in six care records, three recruitment records, the staff duty roster and staff training information sent to us. We checked some procedures which included medicines and safeguarding adults. We also contacted a GP practice and four healthcare professionals that visited the service to obtain their view of the service.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe and relatives said people were safe and well looked after. One person told us they felt safe there as they had, "No bills to pay" and they "Liked the meals". Another person described the home as, "A safe haven from the outside world".

Accident and incident records were incomplete and did not include reflective practice or identify any preventative actions. There were blank records where cuts and bruises should be reported on a body chart. In January 2015, there was an incident where one person hit another with their walking frame. The person who was hit sustained an injury. The incident was not included on the monthly audit for January 2015 completed by the registered manager. There were examples where bruising was not adequately recorded or an explanations as to how the injuries had happened. The local authority safeguarding team and CQC had not been informed of the possible safeguarding incidents. There was a safeguarding policy and procedure in place and there were contact details for the local safeguarding team. However, the information was not displayed in a prominent place for staff to easily access.

Most staff were able to describe what safeguarding people from abuse was and what they would do if they were concerned people were at risk from abuse. There was a 'whistle blowing' policy which staff told us about. One member of staff told us they had not completed safeguarding training. A new member of staff told us they had completed safeguarding training during their induction but they were unable to describe what this meant and what types of abuse they would look for. A member of staff told us that staff completed safeguarding training annually. The training information the provider sent to us indicated that three staff did not require a safeguarding training update until 2017 which was inconsistent with the previous information.

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

We observed part of a medicine administration round which was completed safely and medicines were stored safely. Most medicines were signed as given on the charts. However a person's administration record for two prescribed creams, to be applied twice daily, had one entry when a cream was applied once in August 2015 when we visited on 11 August 2015. The registered manager had no explanation for these omissions.

We were told that medicines prescribed as 'when required' were routinely offered to people. A protocol for one person's 'when required' medicine for break through pain required updating as it did not correspond with the latest instructions from the GP to reduce the dose. We noted that prescribed complimentary liquid food drinks given were not recorded on a fluid chart or the medicines administration record. The registered manager told us they thought there was an individual chart to record complimentary food drinks in people's room but there wasn't any.

Medicines given covertly to one person had an undated and unsigned mental capacity assessment with regard to medicines in the persons care plan. The record stated the GP had agreed the person could have covert administration of medicine if on occasion they refused them and the person's relative had agreed. However the person's relative told us they had not been involved in any 'best interest' decisions. Staff were unable to explain the regular administration of covert medicines and agreed to refer this to the GP for review.

Staff were observed completing medicine administration to assess their competency and additional training was identified when required. One member of staff told us they had two planned medicine observations completed in the previous year.

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

There were 13 people accommodated and the rotas we looked at indicated there were usually only two staff from 8.00 to 10.00 when most people needed help to get up and have their breakfast. A third member of staff was available after 10am. People were accommodated over three floors. Inadequate organisation of staff left people without supervision and support in the lounge and people were not repositioned in bed.

People's needs were varied and complex and sufficient staff at all times was crucial to their safety and wellbeing. There were times in the evenings and weekends when only two staff were available according to the staff rotas. One relative

Is the service safe?

was concerned there was insufficient staff during the evenings. There was no dependency assessment tool to provide information that sufficient staff were available to meet people's assessed needs.

The registered manager told us they were there every day and we observed them helping to support a person eat their lunch in the dining room on the lower ground floor. When the registered manager was part of the care team this was not clearly indicated on the rotas.

On the first day of our inspection the staff told us one night staff had stayed until 10.00 which meant there was three staff until 10.00 and then reduced to two staff until 12.00 when another care staff member arrived. Staff told us there was a shortage of staff but other staff were completing additional shifts to make up for this. This meant that staff were working very long hours each week some staff almost 50 hours and they found this hard work even though they told us enjoyed their role.

Activities were unplanned and there was no appointed activity person to coordinate them. We observed staff playing a ball game with people on two days. Staff told us when additional people were admitted they would need more staff but with 13 people accommodated they were managing. We have made a recommendation staffing levels are regularly assessed and monitored.

The registered manager told us the service was continually advertising for new staff and had recruited new staff recently. Five staff had left the service for various reasons in the last 12 months. One recruitment record was incomplete as there was only one reference. Interview assessments were not recorded in all three records we looked at. This meant that any gaps in employment may not have been explored. Identity and health checks had been completed. All records had Disclosure and Barring Service (DBS) checks completed. A DBS check is for employers to check whether the applicant has any past convictions that may prevent them from working with vulnerable people.

Peoples individual risk assessments identified what actions needed to be taken to minimise risk. One person had ten areas of risk for living with dementia which included behaviours that challenged staff and personal care. All areas were assessed as a low risk. Another person had a falls risk assessment and had sustained seven falls in July 2015. There were no reviews of the recorded risk assessments we looked at. We asked the registered manager what action was taken and they told us they would inform the GP when they next visited. Some care plans had blank records for example; risk assessments for skin pressure damage and mental capacity assessments.

There was a fire risk assessment and each person had a detailed Personal Emergency Evacuation Plan (PEEP). These were placed where staff could see what to do for each person in the event of a fire. The PEEPs clearly outlined the method to be used in the event of an emergency evacuation of the home and the support the person needed. There was a business continuity plan for staff to know what to do and whom to contact in an emergency situation.

All areas of the home looked clean and there were two staff employed six days a week to complete maintenance issues, clean all areas and manage the laundry. We spoke with the domestic/maintenance person who told us the registered manager and deputy manager informed them of maintenance issues to be completed each week. They told us the communal room carpets were regularly cleaned. There was a cleaning schedule for the kitchen and record of maintenance issues completed there. When cleaning products were not in use they were safely stored in a locked cupboard.

A member of the care staff described infection control with regard to personal protective equipment (PPE) used by staff for personal care. Disposable plastic gloves and aprons were available for staff to use. Individual washable aprons were also used by staff for each person's personal care and washed at a high temperature after each shift. There was no written procedure for the use of PPE. There was an infection control policy which was out of date and not relevant to the service, this need to be addressed.

The provider gave us a list of various maintenance issues completed which mainly involved repairs to the passenger lift over previous years, the last entry in October 2014 was a lift repair. There was no overall health and safety risk assessment completed to identify areas where improvements could be made but the provider told us they regularly checked all areas of the home and informed the maintenance person when repairs were required. An old oven stored in the laundry room was due to be removed to maintain a clean environment there. There were records of regular passenger lift services.

Requires improvement

Is the service safe?

We recommend that staffing levels are regularly assessed and monitored using a recognised method to ensure there is flexibility to meet people's individual needs and keep them safe.

Inadequate

Is the service effective?

Our findings

There was inconsistency in completing mental capacity assessments and best interest records. The records indicated there was confusion around the meaning of consent and who can give it. Staff had some simple guidance about the Mental Capacity Act 2005 (MCA) to refer to but no guidance about how to assess capacity or complete a best interest record. A senior staff member and the deputy manager told us they had completed MCA and Deprivation of Liberty safeguards (DoLS) training. Consent records for care, medicines and photography had been signed by staff or relatives. There was no mental capacity assessment and best interest record in three of the care plans we looked at to support these decisions and people were not protected by the MCA. The MCA is legislation that provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make certain decisions.

Another person had a mental capacity assessment completed with regards to the administration of medicines but no required 'best interest' record. The assessment was undated and unsigned, but stated a named relative had given their consent for the administration of medicines. The person was given a pureed diet with no capacity assessment, best interest record or involvement of a healthcare professional to agree the consistency and reason for the diet. The relative that visited regularly told us they had not been consulted.

One person had a record of a 'best interest' meeting with healthcare professionals about their ability and motivation to eat. A psychologist and dietician were involved in the meeting in June 2015. This best interest decision had been reviewed regularly by the GP and the action taken had improved the person's nutrition. Another person had mental capacity assessments for five areas and a best interest record which recorded clearly the actions taken in their best interests. The registered manager had signed the record.

Two people had Deprivation of Liberty Safeguards (DoLS) in place and an annual review by the supervisory body had recently been completed. A standard DoLS application had been made for one person in 2014 and the service was waiting for an assessment of the application. The care plan had action for staff to follow to assist the person with personal care which recorded holding their hands, a form of restraint. An urgent application had not been made to protect the person.

A DoLS application had not been applied for when another person had their hands held during personal care to prevent them hurting themselves and staff. There was a best interest decision that stated it was permissible to do this. The best interest record had not been signed or discussed with the relative.

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

There were six day care staff, two night care staff and three ancillary staff employed. The registered manager was unable to find any staff training records when we visited. A senior care staff member had helped to train new staff with their induction and planned completion of the Care Certificate training for staff. They told us the staff without English as their first language asked for help when needed but this was not a big problem as they had time to help them. The deputy manager told us they checked staff training records and most staff required fire and moving and handling training updates. The training record provided after the inspection identified several staffs training required updating.

Two staff told us they had completed induction training based on the Skills for Care induction programme. New staff said they had shadowed more experienced staff when they started and felt well supported. Two staff had completed NVQ level 2 in health and social care training and two staff were in the process of completing NVQ 2 and 3 respectively. The deputy manager had completed NVQ level 3 and Leadership and Management in Care level 4.

Staff told us senior care staff had provided some dementia care training with regard to dealing with some people's behaviours that challenged staff. The deputy manager told us they completed formal dementia care training in 2001 and 2009. Subsequently we found that two staff had completed dementia training in 2013 to include the deputy manager and senior care staff member. The registered manager told us they had not completed any recent training but relied upon the CQC website for information.

Inadequate

Is the service effective?

There seemed to be little or no formal dementia training for staff to help them support people living with dementia. Dementia care training had not been provided for all staff and would increase and maintain standards of care.

The deputy manager told us they were part of a Dementia Link group but could not get to the regular meetings to keep up to date. They had implemented some dementia friendly environmental changes with two en-suite toilets painted a different colour and most toilet seats were a different colour to assist peoples vision and recognition.

We spoke with five of the day care staff and one of the night care staff. Three staff told us they did not have individual supervisions. The registered manager told us handovers between staff at the beginning of shifts was a time that group supervision was completed and information was shared. The information we received after the inspection indicated four staff had supervision completed since the inspection and all staff had supervision planned. Formal supervision would identify where staff training shortfalls were, give both parties time to assess the member of staff's performance and plan any improvements.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told by the registered manager two people given a pureed diet had difficulty swallowing. On admission one person was assessed in 2012 with no difficulty swallowing solids. Both people had not been assessed by a speech and language therapist to ensure their food was the correct consistency for them. There were no risk assessments for choking in their care plans.

One person's food and fluid charts had not been completed and according to the chart they had not eaten all day. Fluid charts did not have a record of the amount of fluid taken and one person needed oral care or increased fluids as they had a very dry mouth which may lead to oral infections.

One person had a risk assessment for nutrition as they had lost weight and had to be weighed monthly. There was a record of their weight for June and July 2015 but previous weights were not recorded as the weighing scales had not been functional since October 2014. We were unable to see the impact of this as the registered manager could not find the previous care plans and weight records for the person. We recommended that records are maintained and accessible.

We observed people having their lunch in the dining room and being supported to eat in the lounge and their bedrooms. There were no pictorial menus that people had chosen from and they were not offered any choice of food. When people were served staff did not tell them what the food was. When people did not eat their meal there was no alternative offered. Two people had assistance with their meal in the dining room. People were not offered a choice of hot drinks after their meal, only tea was offered.

There was a list in the kitchen of special diets catered for which included vegetarian, diabetic and fortified food for people at risk from weight loss. The cook showed us a menu with small pictures of each meal which people or the relatives did not see. There was no menu displayed in the home.

People had fried salmon, vegetables and either creamed potatoes or chips and dessert was apple sponge pudding and custard. Two people had a thickened soup, and several people had a pureed meal. The cook told us they knew peoples likes and dislikes and recorded them to help plan the menus. We saw two people being offered their food slowly with small spoonful's they could manage. The staff talked to people and encouraged them to eat their lunch.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to health and social care professionals and their visits were recorded. Community nurses and care assistants visited the service to check people's healthcare, for example diabetic blood tests and wound care. We spoke to a healthcare professional at the service who had reviewed a new person's progress and they were satisfied with their improved mental health. The GP visited regularly and supported people with healthcare needs. A health professional told us the staff had recently supported a person really well at the end of their life.

A healthcare professional told us the care was good and issues were raised with them when necessary. Another

Inadequate

Is the service effective?

healthcare professional told us the service had referred people to them who required specific dementia care with behaviours that challenged the staff and for medicine reviews.

We contacted other healthcare professionals after the inspection and several concerns were raised with us. They were concerned about staff whose first language was not English being unable to communicate effectively, incomplete care records and a lack of food choice for people.

We recommend that robust records are maintained and are accessible for the appropriate period of time.

Requires improvement

Is the service caring?

Our findings

People were mostly treated with dignity and respect. We observed the staff talking to people and relatives in a kind and friendly way. People told us the staff were kind and helpful. Many people were unable to tell us what it was like to live there. One person told us they liked my watch and told me the time. They also said they liked flowers and jewellery and were wearing pretty ear rings and clothes. People looked well cared for and were wearing clean clothes that fitted them. Staff told us some people helped to choose which clothes they wore each day. A relative told us that staff helped the person to wear facial make up which they had always liked to do and the relative felt this kept their personal identity.

We observed care staff helping people with their lunch in one of the communal areas. Staff took their time offering food and spoke to people to encourage them in a reassuring manner. People were asked regularly if they wanted to use the toilet and staff gently guided them there. When activities took place people were not forced to join in and some seemed to enjoy watching others.

There were no planned activities for care staff to follow and staff told us there was little time to spend talking to people individually.

We observed a person in their bedroom was happy and content. They engaged positively with the visiting health care assistant who smiled and laughed with them while they examined the person's feet. However the same person had a poor engagement with one of the care staff who moved the person's arms roughly to look at their elbows. This clearly caused the person distress and they resisted. This person had another negative experience with a different member of staff. The staff moved their feet without warning to sit near them. There was no explanation from the staff that they were starting to help the person eat their lunch. The person was offered pureed food at some speed without giving the person time to see what was coming or open their mouth ready before the spoon was pressing their lips. The person withdrew their head as far back as possible. Instead of withdrawing the spoon the care staff member continued to prise open the person's lips and the person became defensive and pushed the spoon away and shouted, "No get out". We fed back this information to the registered manager and asked them to take appropriate action. The person refused all food and drink offered and according to the food chart at the end of the day this person had not eaten anything.

The record for a person with a history of anxiety was unprofessional and judgemental. The terminology used indicated that staff required additional training with their perception of and attitude to people with mental health needs.

Two healthcare professionals we spoke with told us the staff were respectful and approached people in a nice manner. We observed staff knocked on bedroom doors before entering. Some people had a keypad to their bedroom door to prevent other people from entering their bedroom. Staff told us this meant people felt safe from intrusion and their belongings were safe.

A relative told us the staff were very good and as it was small home they got to know people well. They said the staff were "kind and respectful" and always spoke to them. They said the staff without English as their first language did things slowly to help make sure people understood them. The relative gave an example where a member of staff gave their relative, "kindly contact" to help diffuse a difficult situation. A relative described how staff retreated when people's behaviour challenged them and returned later when people were calmer. Another relative told us, "The staff are very caring" and said "I think the care is great".

A relative described how a person had been moved to the ground floor to provide them with easier access to their bedroom. Their bedroom door had a picture on it to enable the person to recognise their own room. Several bedroom doors had pictures for recognition but were quite small for people to see. Bedrooms were personalised with some of peoples own pictures and photographs.

There was no end of life care for people when we visited. Two healthcare professional told us the care staff looked after people well when their life was nearing its end and they were supported by the primary health team and palliative care specialists.

Requires improvement

Is the service responsive?

Our findings

We looked at six care plans and most were dated July 2015 and had not been reviewed. There were many blank records for example no social history, or skin pressure risk assessments. The registered manager told us they were updating care plans. However they were unable to provide us with the archived records by the end of the inspection. Many records were undated and unsigned by the staff. A member of the care staff told us they didn't know the care plans were updated but they wrote the daily records.

People were on pressure relieving mattresses but there was little evidence of risk assessment scores completed to measure the risk of developing a pressure ulcer. Two people had repositioning charts that were incomplete and incorrect which may contribute to the formation of pressure ulcers when people do not have the appropriate care. Staff reported a person had a red coloured heel which was identified in the care plan as sore heels but the information was not dated or reviewed. The person's position was not changed for most of the day and when it was the incorrect time was recorded.

There was clear advice for staff to follow to care for a person with insulin dependent diabetes. The advice included the signs and symptoms for staff to look for when the person's blood sugar was low or high. However when we looked at the records their blood glucose had been monitored in the morning only when the care plan indicated twice daily. It was also recorded the person was unaware of the symptoms when their blood glucose was low.

We observed a handover session. Handover information between staff at the start of each shift ensured that important information about people was known, acted upon where necessary and recorded to ensure people's progress was monitored. People's mood, their fluid and food intake and any activities they had joined in with were reported verbally at handover. The registered manager prompted staff at the handover to complete food and fluid charts correctly as we had identified they were incomplete.

During the handover session a person's pressure ulcer was discussed and records we looked at indicated the pressure ulcer was a grade 3 on 29 July 2015 had deteriorated to a grade 4 on 11 August 2015. The registered manager was unaware the pressure ulcer was previously grade 3. A notification form had not been sent to CQC regarding this, however one was sent after the inspection. Healthcare professionals were involved in the person's care and had been concerned the pressure ulcer was not reported to them sooner and records were not completed.

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

A relative told us that a care plan review was planned with them as changes had occurred. One relative told us six monthly care plan reviews took place and they were included when there were changes to the plans. Another relative told us care plans were reviewed with them and they signed when they read the plan. They said the registered manager kept them informed of any concerns or visits by healthcare professionals. The relative was impressed with the care the person received when they had a chest infection and did not have much appetite. Finger food was provided in their bedroom and staff spent time with them there.

Some people had a 'Journey through life' record about their life and family. There was also a 'This is me' record which included people's likes and dislikes. One record stated, 'I know I have Alzheimer's and take a memory pill'. Staff told us they use pictorial cards to try and find out what people liked. Daily records were clear for both day and night and recorded for example, people's mood, pain level where appropriate and what they did. One person had help from staff to write a letter.

People joined in with the activities provided when staff had the time to organise something. They were not planned in advance and there was no activity person to help with them. Entertainers came to sing with people and were booked in advance. One person told us, "I get bored. I never listen to music, I don't do much but watch television. There are loads of quizzes on television". There was no activity plan to follow, the activity plan on the wall was blank.

We observed staff playing the same ball game with people on consecutive days. A care staff member told us they sometimes do activities with balls, dance with people or take them out in the garden. Staff told us they sometimes had time to talk to people and do colouring in with them. A member of staff told us, "Activities could improve with more staff as we would then have more time with people". They said communication can be difficult when people are

Requires improvement

Is the service responsive?

living with dementia and they can't remember the correct word to use. Staff told us they had taken people out in the garden and sometimes to local shops. One person went to a weekly church service.

A relative told us the person had completed puzzles, sat in the garden with staff and played a skittles game. The relative said they take the person out to a local coffee shop when they visit, which the person loved to do. Another relative said, "They [people] have a quiet time after lunch but sometimes do activities such as ball games and puzzles". Activities people had joined in with were recorded in their care plan. One person had six activities recorded in July 2015 two were individual sessions where staff helped with puzzles. Another person had completed three activities in August 2015 so far which were dance and exercises. We have made a recommendation for an improvement of activities.

There was a complaints procedure in place where people and their supporters had the information to help them make a complaint and ensure they knew what to expect. There had been no recent formal complaints. The registered manager kept a record of concerns raised, there had been three informal concerns in 2015 raised and it was recorded relatives were happy with the explanations. There was also a compliment about the service. A visitor told us if they had any concerns they would speak to the registered manager or deputy manager.

We recommend the service seeks advice and guidance from a reputable source, about supporting people with meaningful and satisfying activities that meet individual social needs.

Requires improvement

Is the service well-led?

Our findings

The registered manager had not informed CQC about safeguarding incidents to include unexplained bruising. A person sustained an injury which was a safeguarding incident and CQC was not informed. Peoples bruising had not been recorded correctly and how it happened. When the cause of bruising is not known, the local authority safeguarding team and CQC should be notified.

This is a breach of Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents.

The registered manager and provider were currently at the home every weekday. The deputy manager told us they or the senior care staff member were in charge of each shift and either of them were on duty when the registered manager was unavailable. Care staff told us that senior staff and managers were approachable and they could talk to them easily.

Staff meetings were not formally held but during daily handovers meetings between shifts the registered manager passed on information to staff and raised any concerns. The registered manager told us there was a weekly meeting between senior staff. The meeting minutes on the 29 July 2015 recorded, 'activities must be done' and 'staff were not recording in charts'. We found there were still significant shortfalls in records and activities when we visited.

People or relatives had not completed a quality survey about the service. The registered manager was unable to tell us when the last quality survey was and did not find the results. The relatives we spoke with were generally complimentary about the care provided and they told us staff responded to any concerns they raised. A relative we spoke with raised concerns with us for example; "The service does not contact me readily about any changes", "There is no choice of food" and "There is not enough stimulation" [for their relative]. We passed the information to the provider.

Some quality assurance audits had been completed to include a safety of equipment check completed in 2014 where a clear record of the action taken was seen. A comprehensive fire safety audit was completed in 2013 to include a fire risk assessment. Each person had a personal emergency evacuation plan (PEEP). Accident and incident audits completed monthly did not analyse the information to recognise themes and record any action to reduce or prevent reoccurrence.

There were medicine audits completed in September 2014 and April 2015 and the action taken was recorded. Subsequently the provider sent us copies of the monthly medicine quality assurance audits. These would help to ensure any shortfalls were quickly noticed and action taken. There were no health and safety risk assessments recorded for all areas of the service to maintain a safe environment. There were no monthly quality assurance checks recorded to ensure all areas of the home were safe.

The registered manager told us a care plan audit was completed in 2014 but they were unable to find the results and any action taken. Significant shortfalls were found in the care plans we looked at and the registered manager was unable to find archived files before July 2015.

Some outcomes for people could be improved. The registered manager had not developed the staff team to consistently display appropriate values and behaviours toward people. There was a high turnover of staff and a lack of supervision. There were shortfalls in staff training and the registered manager had not completed any recent training to remain updated.

Care staff told us the registered manager was approachable but there were no regular meetings to share their views and identify any obstacles to them fulfilling their roles and responsibilities. We were disappointed the omissions in records we identified on the first day of the inspection continued. There was a lack of accountability and the registered manager did not sufficiently monitor the quality of care provided. Records were incomplete or missing. Regulations were not met and the governance of the home required improvement.

This was a breach of regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulation 2014.

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	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: People were not protected from abuse when safeguarding procedures were not followed. Regulation 13 - (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People who use services were not protected against the risks associated with the proper and safe management of medicines. Regulation 12 - (1) (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: People who use services and lacked the capacity to consent were not protected by the MCA (2005) and DoLS. Regulation 11(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

How the regulation was not being met: Staff did not have specific training to meet the specialist needs of the people accommodated living with dementia.

Regulation 18 (1) (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met: People were at risk of not receiving adequate nutrition and hydration. Regulation 14 - (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People who use services were not protected against the risks associated with unsafe and incorrect care practices. Regulation 12 (1) (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents How the regulation was not being met: People who use services and others were not fully protected against the risks associated with abuse and allegations of abuse as The Care Quality Commission was not notified of all incidents. Regulation 18 (1) (2) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

How the regulation was not being met: The registered persons must have systems in place to assess, monitor and improve the quality and safety of the service provided

Regulation 17) (2) (a).(b) (c) (e) (f)