Bupa Care Homes (ANS) Limited

Wilton Manor Nursing Centre

Inspection report

Wilton Avenue, Southampton
SO15 2HA
Tel: 02380 230555
Website: www.bupa.co.uk

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Ratings

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

Overall summary

This inspection took place on 20, 24 and 25 November 2014 and was unannounced. The home provides accommodation for a maximum of 69 people and provides care to older people with mental health illness and those living with dementia. There were 51 people living at the home when we carried out our inspection.

Following our last inspection on 4 and 7 July 2014, we issued a warning notice for a breach of Regulation 10 this related to a failure to identify shortfalls and take action related to the environment. Compliance actions were also set for breaches of Regulation 9, care and welfare of service users and Regulation 22, staffing.

At this inspection we found improvements had been made, such as the carpets in some bedrooms had been renewed. The ground floor refurbishment had been completed to a good standard and soft furnishings had been replaced. The ground floor dining room allows level access to the enclosed and secure garden which people could safely access. However we identified different shortfalls that require action.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

The infection control practices in one area of the home were inadequate and put people at risk of cross infection. The provider had not taken adequate precautions to ensure infection control practices were safe and measures put in place to minimise the spread and control of infection.

Staff had not completed updates in health and safety and safeguarding as per the provider's policy. Staff were not appropriately supported through regular supervision, and training was not up to date which may impact on care people receive. The home relied on agency staff but efforts were being made to recruit permanent staff. There was a training programme which included induction which staff completed.

Medicines were not always managed safely. On one night people had not received their medicines as the staff had not communicated with each other effectively to make sure people got the medicines they needed. People who had diabetes did not all have' rescue medicines' prescribed in the event of having low blood sugar which would impact on their health and welfare.

Assessments of people's needs were completed which included any risks and care plans had been developed to identify care and support and how these would be met. People's healthcare needs were managed appropriately and specialist advice sought to ensure people received the care and treatment they needed. However, people were at risk as where it had been identified that they needed their drinks thickened to a safe consistency this had not been done.

People were treated with privacy and dignity and were respected when receiving care. Healthcare advice was sought promptly when needed and staff kept relatives informed of any changes.

There were systems for monitoring the quality of service provision and regular audits were completed which included health and safety, care plans, medicines, accidents and incidents. However these were not always effective and did not identify risks and the shortfalls we found during the inspection.

There were systems for responding to complaints. A complaint log was maintained for recording complaints which included details of investigations and feedback.

We have made a number of recommendations for the provider to consider when providing care to people.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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 always safe.

People did not always receive their medicines and prescribed fluids safely.

Infection control practices did not protect people from the risk of cross infection.

People's needs were assessed and care plans were developed and measures put in place to manage people's needs. Accidents and incidents were followed up and action plans developed to maintain safety.

There were enough staff employed; however staff were not always deployed effectively with care at times being task-led.

Safeguarding procedures were in place and training in safeguarding was completed by staff. They understood their role in protecting people from harm and abuse.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective. People were offered choices with meals. There was inconsistency in supporting people living with dementia in relation to preventing malnutrition.

Staff were not appropriately supported through regular supervision, training updates were not up to date and may impact on care people receive.

Food and fluids charts were not appropriately maintained and people may be put at risk of malnutrition as their needs were not always met consistently and effectively.

People were supported to access appropriate healthcare support and advice from healthcare professionals as required.

Is the service caring?

Good

The service was caring. Staff treated people with kindness and respected their privacy and dignity.

Staff were caring and respectful when attending to people and they used people's preferred names.

People were supported to maintain relationships with family and friends. There were no restrictions on visiting the home and relatives were always made to feel welcome and kept informed of changes.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs. People who were transferred in wheelchairs were not always helped to sit in the comfortable chairs.

Assessments were undertaken and care plans developed and these were updated and reviewed to reflect changes.

Advice was sought from healthcare professionals and acted upon.

The complaints process was followed and people were able to raise their concerns which were responded to.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

There were quality assurance systems in place and a number of audits were completed. However, the audit system did not identify the issues with infection control, medicines and food and fluid records.

Incidents and accidents were recorded and an action plan developed.

People's views were sought and included service users' meetings.

Staff did not feel empowered in driving changes.

Wilton Manor Nursing Centre

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 20, 24 and 25 November 2014 and was unannounced. The inspection team consisted of two inspectors 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 and in dementia care.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a document for the provider to provide some key information about the service, what the service does well and how improvements could be made. We reviewed the PIR and previous inspection reports. We reviewed other information sent to us by the provider and spoke with three social and healthcare professionals and members of the Clinical Commissioning Group to obtain their views on the service and the quality of care people were receiving.

We spoke with eight people who lived at the home, observed care and support people received in the communal lounges and dining rooms. We also spoke with nine visitors, 12 staff and two healthcare professionals. We reviewed eight care plans and associated records as part of pathway tracking. We looked at records relating to the management of the service, staff training records, duty rota, some of the home's policies and procedures, minutes of meetings and quality assurance audits. We also spent time observing the lunchtime meals and the support people received. We observed medicines management and administration.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in July 2014, the provider was in breach of Regulation 22 as there were not adequate registered nurses to manage the care of people accommodated. We set a compliance action with regards to staffing. The provider sent us an action plan and detailed the action they had taken to become compliant by the end of July 2014. This was implemented and the registered nurses were increased to a minimum of two on all shifts.

The infection control process was not adequate and put people at risk to their health and welfare. Equipment such as mattresses were not cleaned and some of these were soiled with brown stains. The cushion cover on a wheelchair which was in use was torn; the internal padding was brown and smelt of urine. The cushion could not be cleaned effectively. Wheelchairs had dried up food on the seats and the footplates and hoists were not clean. Another wheelchair had a damaged right armrest, the covering was off and bare foam was visible and would not be able to be cleaned. Other wheelchairs, used communally, were dirty with brown matters and other residues which a staff member said was "unacceptable".

The staff were failing to follow safe infection control practices. Soiled clothing with faecal matter was discarded on the bathroom floor. Staff used personal protective equipment (PPE). However, they did not follow guidance on the safe disposal of PPE. These were found in approximately nine bedrooms where used gloves and aprons had been discarded in open bins in people's bedrooms. Soiled and infected laundry was not managed safely as staff did not always use the special bags provided. There were broken and missing tiles in the communal bathroom which posed an infection control risk as they could not cleaned effectively.

As part of infection control process, registered persons are required to take account of the Department of Health's publication, 'Code of Practice on the prevention and control of infections'. This provides guidance about control measures in order to reduce the spread of infection. We found these measures had not been followed regarding the provision of a clean and safe environment, equipment in use and the staff practices.

People and their relatives said they were satisfied with the cleanliness of the bedrooms. A person told us the staff are good and "keep the place tidy". A relative commented "I am impressed with the housekeeping" as their relative's room was kept clean and tidy.

The laundry room was well-equipped. Laundry staff were suitably trained and followed safe working practices. Sometimes soiled and infected linen was not always delivered to the laundry in separate bags. Staff told us they would then follow their process and wash all the items as infected laundry.

The examples above meant people were living in unclean conditions which increased their risk of acquiring infections or of infections being spread. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Two people did not receive their night time medicines. This included a person who was prescribed two types of antibiotics and a sedative which they had not received. The registered manager told us this was due to a breakdown in communication between staff and action plan had been put in place in relation to handover.

The medicines round took up to three hours to complete. There were some medicines which were time specific. Although, staff confirmed people who had diabetes did receive their insulin in a timely manner. People who required pain control or other medicines, the specific time was not recorded and there is a potential risk of them receiving their medicines close together.

Medicines, including controlled drugs were stored securely and safely in two parts of the home. However, medicines on the middle floor were not stored safely and the staff told us this was due to lack of storage facility. The cabinet for stock medicines was overcrowded and staff had difficulty in locating medicines. Staff may not find medicines they need to give people in time.

Some people who had diabetes were prescribed "rescue medicines" for the treatment of low blood sugar. Staff told us everyone who was diabetic should have this prescribed. However this was not consistent for all the people with diabetes. Staff were unsure about where these medicines were located and the nurse in charge confirmed not all people with diabetes had the 'rescue medicines'

prescribed for them. This had not been followed up with the GP in order for them to be prescribed. The registered manager assured us this would be addressed as they were not aware of this and immediate action would be taken.

A number of people were prescribed a thickening agent to be added to their drinks as they were at risk of choking on thin fluids. We found some people had been given thickening agent which had been prescribed to other people. For one person a staff member told us they had run out of their own thickener and they were using another person's, but for other people staff could provide no explanation.

On two consecutive days a person was provided with the wrong consistency of fluids. Their care plan contained details of the consistency of fluids they should be receiving. On the second day of the inspection, this person was provided with a drink of juice in a beaker which did not have adequate thickening agent added. This was brought to the attention of a team leader, who confirmed the fluid was not the correct consistency, as the correct amount of thickener had not been added. Further checks on the third day found this person's drink was too thin. We again raised this with a senior care staff who made up a new drink to the correct consistency which was much thicker. As this person was assessed as at a high risk of choking this was not safe and put this person at risk.

One person was receiving continuous oxygen. According to the risk assessment, the volume of oxygen administered should be recorded on the medicine administration record (MAR) chart. The nurse in charge confirmed this was not recorded on the current MAR chart as required. There was a procedure for the filter on the oxygen equipment to be washed weekly. The records showed this had not been changed and the nurse confirmed this was overdue and may impact on their welfare.

The examples above show that medicines had not been stored, obtained, administered or recorded safely and this failure put people at risk. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The safeguarding procedures were available to the staff and they were confident to raise their concerns with external agencies. Some staff would speak with the Care Quality Commission about their concerns if needed. They were able to describe the different types of abuse and how they might relate to the people they were supporting. Comments included, "If I saw anything concerning, I would make sure the person was safe and report it to the manager. If I thought that nothing had been done about it I would go further". There is a private phone downstairs that you can use to raise concerns". Training in safeguarding adults was delivered to the staff on induction.

There was a procedure for the staff to follow in reporting safeguarding concerns and incidents which affected the welfare of people. Following an incident where people had not received their night time medicines, this had not been reported to the adult safeguarding team as required. Following this a system to record safeguarding alerts had been put into place. Currently the arrangements for reviewing safeguarding concerns were not fully developed in order to enable trends to be identified and lessons learnt. The staff were aware of the home's whistleblowing policy and who to contact to raise any concerns.

The arrangement for a person's credit card was not robust to ensure they were able to access this at all time. The registered manager confirmed a clear procedure would be developed to include records and audit in order to safeguard the person's interests.

We received differing views about whether there were sufficient staff to provide safe care. Staff told us they were aware that the provider was recruiting and they had "a lot of agency staff". Staff said the provider was recruiting for more ancillary staff but said " it's been like it for a while". The registered manager confirmed there were enough domestic staff. Care and nursing staff commented they were always "very busy". Although they said there were enough staff to support people this included when two staff were needed to assist a person to move using equipment. The service was highly dependent on agency staff, in particular registered nurses. The duty roster indicated the majority of the shifts on night duty were covered by agency staff, although the provider tried to use the same staff members for continuity in care.

Relatives said "the staff do their best", but they were very busy and did not have time to devote to people as "so much needs doing". Another relative commented the care staff team was more consistent and they provided good support for people. The nurses were mostly from an agency and relatives had raised with management at previous relatives' meetings. A staff member told us, "We really do care for the people living here but sometimes we are so

Requires Improvement

Is the service safe?

busy it feels like they are just the number on the door". The registered manager confirmed there were adequate number of staff to meet people's needs. They used the service users' dependency level tool to adjust their staffing. The issues related to the way staff worked and the leadership in the unit and task-led practices at times. We observed there were staff available and call bells were responded to.

The provider had a robust process for recruiting staff. All necessary checks including disclosure and barring service (DBS) checks were completed prior to employment. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Risk assessments such as falls, pressure ulcer, nutrition and choking risks were completed and care plans developed to inform the staff's practices. Care plans for people who had been identified as at risk of falling contained measures to minimise the risks such as appropriate footwear and pressure alarm mats. Staff had followed the care plans and equipment such as a pressure mat was seen in a service user's bedroom as identified in their care plan. Accidents and incidents were reviewed and action plan developed to prevent reoccurrence.

Equipment was provided and maintained appropriately such as regular servicing to help ensure people's safety. Safety checks were carried out on lifting equipment such as hoists, bath hoists. An emergency plan had been developed including safe evacuation procedures if needed.

Requires Improvement

Is the service effective?

Our findings

There was a training plan and staff completed induction training before they commenced work. The training record showed that 32 staff were out of date with moving and handling updates. There were 21 staff were out of date with fire safety training and 23 staff members requiring updates in safeguarding training according to the provider's training records. The registered manager confirmed all staff should have yearly updates in the above and this was not occurring and people may be at risk through outdated practices.

Although a staff's supervision programme had been started, the staff's supervisions were not up to date. A number of annual appraisals had been completed but these were also not in place for all staff. Senior care used to be supervised by the nurses but staff members told us they had not received supervision "for some time." Staff were not able to tell us the frequency of supervision and most of the staff could not remember when they last had supervision. There was no process for supervising the agency staff.

The nurses discussed issues at their "10at10" meeting but had no supervision and clinical support in order to carry out their roles. The lack of staff supervision and engagement meant opportunity for identifying learning and development was missed. The lack of training updates may impact on the delivery of care to meet the needs of people safely and effectively.

The examples above show staff were not appropriately supported, training updates were not up to date and may impact on care people receive. These matters were a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Five people were having their food and fluids intake monitored. However, the monitoring charts had not been fully completed. In all records but one, there was no record of what was offered in the afternoon or following supper. The staff could identify people who were at risk of malnutrition and provided extra support. The kitchen staff had a list of people who required extra support such as snacks. The registered manager was unable to demonstrate what support people received at times outside the set meal time hours.

In one unit people ate very little of the main meals at lunchtime, as the deployment of staff was not effective to ensure they were prompted and supported to eat. On one occasion meal was taken away uneaten. Two people had their lunch served in the lounge, but did not touch them for half an hour as there were no staff present to encourage them to eat.

In another unit we found the staff were kind and supportive in their approach; they did not rush people and interacted with them during the meal. One person had not eaten their main meal and staff offered them soup and a sandwich which they ate. The menu plans offered a range of healthy options for people, presented in a way suitable to their needs. Some people's record showed where they needed soft diets and this was provided for them. We have made a recommendation regarding this.

One person had been assessed as needing fortified food due to weight loss. Although they receiving treatment the staff had failed to correctly measure their accurate weight loss. We informed the nurse in charge who assured this would be corrected. This could impact on the action and treatment this person may require in the future if action to accurately taken to accurately monitored their weight.

People were positive about the meals and choices available. A person told us "The food is very nice. I'm a bit faddy but it's very good. I don't like tomatoes and have told the staff". Another person told us "you can have what you like". Relatives told us people were asked about their likes and dislikes when they first moved in and the staff knew their relative's preferences. A relative said people had drinks in their rooms although this was not always within reach. A visitor told us they had helped their relative with a snack which they had enjoyed.

People were supported to eat in their rooms and there were a number of people who remained in bed. Staff provided support to these people in a calm and compassionate way and encouraged people to eat. Staff used pictorial menus and 'sample plates' for the meals on offer in order to support people in making choices. People and their relatives spoke positively about their experience and care they received. They were confident they staff would call out their doctor if they were unwell.

The majority of people accommodated at the home were living with dementia. Not all areas of the building met the

Requires Improvement

Is the service effective?

needs of people living with dementia. We have made a recommendation related to this. The doors were similar and toilets and bathrooms were not clearly identified by appropriate signage.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards, which apply to care homes. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards. These require providers to submit applications to a 'supervisory body' for authority to deprive someone of their liberty. The registered manager confirmed there was no one subject to a Deprivation of Liberty Safeguards (DoLS).

The registered manager and staff were aware of their responsibilities under the Mental Capacity Act 2005 and (DoLS). Staff had undertaken training in MCA and DoLS. Applications had been made for the use of keypad locks on doors around the home to ensure this is managed.

Some people had signed their care plans. Where people were unable to be fully participate in their care planning due to their mental frailty, their family had been consulted. Care plans had do not attempt resuscitation (DNAR) forms completed which showed the person's had been consulted to gain information. Other records contained 'advisory notes' following decisions taken by the G.P and family about not admitting to hospital. Some but not all the care plans contained mental capacity assessments and it was not always clear how best interests' decisions were taken to ensure decisions and care provided met the needs of people. This was brought to the attention of the registered manager.

People had access to healthcare professionals. People and their relatives told us staff supported them to access healthcare as needed. A relative said "the staff are very good at getting the doctor in" when required. Where necessary other professionals were involved in people's care, such as speech and language therapists (SALT). District nurses also visited the home regularly to provide help and advice such as pressure ulcer management. Staff were following advice such as wound care management and care plans were amended following advice received.

We recommend the provider researches and follow good practice for supporting people living with dementia in relation to preventing malnutrition.

We recommend that the provider considers current guidance on enhancing the environment for people living with dementia.

Good

Is the service caring?

Our findings

People and their relatives told us that staff were caring, treated them 'with kindness' and respected their privacy and dignity. Two people told us they were supported to access their local community and went out shopping regularly. Relatives told us they were kept informed about their family member's health and any changes. When asked about the staff a person said "They are lovely girls". They said the staff were "Very good and did their best", although they were always very busy. Comments included "I am generally very pleased with the care". Relatives said when they had made any comment this was acted upon. Another relative said the staff were "Always kind and caring including the housekeeping team".

Observations during the two days showed that although staff were kind and caring, there was little time to spend in the company of service users in order to provide mental stimulation and interest for people.

The majority of people accommodated were not able to participate in their care due to their mental frailty. A nurse said they always called the relatives if there were any changes to ensure they were kept up to date and they could visit if they wished. Relatives told us there were no restrictions for visiting the service and they were made welcome. A visitor told us they came in at lunchtime to assist their relative with their meal and this worked well for them.

Staff were aware of people's preferred form of address and were respectful when providing support to them. Staff were caring and had a good understanding of people's needs and provided care in a caring and compassionate way. One person became distressed at which point a staff member sat with them and tried to calm this person. The staff member supported the person from their room to the dining room and was much calmer. The person had become distressed about a family member and the staff had taken the person to show them a photograph of that family member which then settled them. They responded appropriately to people who became distressed.

The service had appropriate policies in place to ensure people's privacy and dignity were respected. Staff described how they did this in practice, for example by making sure doors were closed when people received personal care. Staff knocked on people's doors and waited before entering. Doors were always closed when people were receiving personal care. Staff ensured people were not exposed when they were helped to move using the hoist and were respectful of their dignity. The staff were kind and caring in their approach and had a good rapport with the people they were supporting. We observed people were comfortable with staff and interacted with them positively.

Care plans contained information such as a "map of life" which detailed the person's life, hobbies and interests. These were developed with the involvement of their family for people who were not able to contribute to these due to their cognitive impairment. This provided information for the staff in the development of care plans, getting to know people they cared for and people's likes and dislikes. However this was not always reflected in the development of individualised activity plan to inform practices and meeting needs consistently.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in July 2014, the provider was in breach of Regulation 9, we set a compliance action . There was a lack of reviews of care plans which may have put people at risk of receiving inconsistent care and not according to their current needs. We received an action plan and the provider stated they would become compliant by 30 September 2014. Action had been taken and care plans contained evidence of regular reviews where changes had been identified and these included wound care management.

Care plans contained good information about people's needs. There was evidence of regular reviews which identified changes in people's needs and the care plans were updated. Before people moved into the home an assessment of their needs was carried out to assess if the home was able to meet these. Staff tried to get people involved in the initial assessments, this was not always possible. They used information from the hospital and from care managers and relatives as appropriate.

Relatives told us they had been involved in the assessments. The assessments were used in the development of care plans. Care plans contained details of people's individual needs and the care, treatment and support needed to ensure these were met. For people who were not able to contribute to their care planning, relatives were involved to gain information about them and plan their care appropriately.

There was a lack of meaningful activities in order to meet the individual needs of people and this increased the risk that people would experience social isolation. Three family members said there could be more activities provided. Comments included, "My relative is always clean and the staff are kind but there is not a lot of stimulus for people".

There was one activity co-ordinator to provide support to people who were accommodated in different units. People were in the lounges or in their bedrooms with no stimulation or meaningful activities, which could lead to the risk of social isolation. We have made a recommendation related to this. There was a group activity carried out on the top floor during the afternoon which was interactive and people seemed to enjoy.

Two people who were able to go out in the community received good support and they were positive about the trips out and maintaining links with the community. People on the ground floor told us they enjoyed living at the home and they received one to one support to go out. A person said they went out on most days and they went shopping or for coffee. They commented it's "a very good home" and "I'm happy here". Another person told us "I get on very well" with the staff member who supported them with their activities and the local amenities. A relative told us "am generally very pleased with the care, I have only ever had to make one comment and it was acted on very quickly".

Three people were left sitting in wheelchairs for long periods of time. One person was asleep for nearly an hour in a wheelchair and others were put in wheelchairs and taken to a small lounge and not transferred into comfortable chairs. They were left in the wheelchairs for part of the morning and then taken to the dining room for lunch, which was not comfortable for people. In these instances staff had not responded to people's individual needs. The registered manager assured us immediate action would be taken and addressed with staff as they would expect people to be transferred into comfortable chairs.

The wound care plans for three people contained detailed information about their wound and leg ulcer management. These also contained regular reviews and any changes to the type of wound dressing used were recorded. Care plans were reviewed, changes in people's conditions were acted upon and advice sought. The care records for a person whose condition had deteriorated had a short term care plan developed.

People who had diabetes had their blood sugar monitored at regular intervals particularly for those who were on insulin. Staff knew each person well and staff were able to describe their needs, abilities, and the way in which their care was provided. The care records contained details of the individual's blood sugar range and action to be taken if they were too high or too low. People's dietary needs were set out in their care plan. Diabetic care plans were detailed enough for staff to deliver the appropriate care.

There were arrangements for responding to complaints. A complaint log was maintained for recording complaints which included details of investigations and feedback. Relatives said they could raise their concerns with management if needed. Information about how to raise any concerns was available at the home.

Requires Improvement

Is the service responsive?

Accidents and incidents were recorded and formed part of the provider's internal audits. These were recorded on the provider's quality monitoring system, reviewed by the quality manager and an action plan developed and monitored. The fall audit had identified an increase in falls in the evenings and the provider introduced a twilight shift, where staff worked between six in the evening and midnight to provide support and monitor people in the lounges. Sensor mats had been introduced for four people following falls which alerted the staff when people got out of bed at night and they could be supported and monitored. These examples show that accidents had been assessed and lessons learnt and appropriate actions to reduce the risk of them happening again.

We recommend that the provider considers current guidance such as NHS choices and Alzheimer's society on enhancing the activities available for people living with dementia.

Is the service well-led?

Our findings

Following the last inspection in July 2014, we issued the provider with a warning notice for failure to assess and monitor the environment and have a strategy in place for the renewal of carpets in some of the service users' bedrooms. Falls and incidents were not being analysed in order for appropriate actions to be taken.

At this inspection we found the provider had taken appropriate action as part of their renovation programme; a number of the bedrooms had been refurbished and the carpets were clean and in good condition. There is an on-going programme of refurbishment to ensure all parts of the home remained safe and fit for purpose.

During this inspection we identified a number of breaches under Regulations 10, 12, 13 and 23 and also made a number of recommendations for improvement.

A number of audits were completed which included health and safety and infection control. The audits covered all areas of the running of the home including health and safety, recruitment, observations of care, incidents and accidents. These were then fed into the organisation's quality matrix in order to identify trends and form learning outcomes. However the concerns found with infection control were not picked up as part of the provider's internal audit. There was a system which had been developed for the cleaning of equipment including wheelchairs, hoists. The records showed the cleaning programme had not been adhered to as the daily cleaning had not been completed. This had not been identified as part of their monitoring process. The registered manager said the staff had let her down.

There was an internal audit system. Staff audited care plans and records of food and fluids. Records of food and fluids were inadequate where gaps were found from teatime until breakfast the following day. The audit system had not identified these shortfalls so that appropriate actions could be taken. The medicines audits did not identify the shortfalls in medicines management which we raised with the registered manager during the inspection such as safe storage and medicines for people with diabetes.

Although there was an audit system, this was not always effective through lack of continuous management monitoring such as food and fluids charts, cleaning schedule completed and medicines management were robustly applied.

The examples above show the audits were not effective which may impact on people's health and welfare. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A family member told us, "They (the staff) are very good at passing on information and will always phone me if there is a problem. I can also always go to the family meetings". Relatives said they usually contacted the nurses and "very often" the care staff if they needed anything. They said the registered manager did not work in the units and could go to the office on the ground floor if needed.

There was a '10 at 10' meeting held each morning that included senior staff and nurses. This was a handover time which involved the senior team from the different areas of the home; where information was shared. The staff said this was helpful to give them an overall picture about what was happening in the different units and staffing to support people's needs. However staff felt management were not visible on the floor and communication "could be better".

Comments from the nurses were some of the team leaders were "overpowering" and did not always seek and take advice from the registered nurses. Agency staff were not confident in raising concerns as they said they would not be given shifts at the home. Care staff told us "it's about making sure people are treated with respect". None of the staff could tell us about the value and visions for the service which may not have been communicated to them. There were processes in place for managing risks and staff performance. The staff survey result was published for September to October 2014. This showed some low scores such as staff not feeling valued and involved. The registered manager said the provider would be putting together an action plan as a result and they had employed a clinical lead to support the nursing staff. We will check whether this action plan has been put into practice effectively during the next inspection.

Records showed that staff meetings had been held in March and September 2014.The registered manager told us that another had been recently held but that the minutes

Is the service well-led?

had not yet been typed up. Staff that spoke with us said that general staff meetings did not happen very often but would be "really useful". The registered manager told us that staff meetings were often poorly attended, although there was currently no strategy to improve attendance to meetings.

The provider carried out an annual service users' survey. Service users and relatives meetings were held on a quarterly basis. The last meeting was held in November 2014 where issues such as activities, staffing and call bells were discussed. An action plan was being developed to look at the issues raised.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: People were not protected for the risk of inappropriate care as the audits did not effectively identify risks to health, safety and welfare.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: Medicines were not always managed safely and according to people needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: People were not protected from the risk of receiving inappropriate care due to the lack of staff training and supervision.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control How the regulation was not being met: People were not protected from the risk of infection because the premises and equipment were not maintained to a clean and hygienic standard.