Bupa Care Homes (ANS) Limited

Regency Court Nursing Centre

Inspection report

18-20 South Terrace
Littlehampton
West Sussex
BN17 5NZ
Tel: 01903 715214

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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

Regency Court Nursing Centre provides both long term and respite nursing care and accomodation for up to 45 older people, including people living with dementia. At the time of this inspection, there were 44 people living at the home, 43 of whom required nursing care.

A registered manager was in post when we visited. 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.

The majority of people and their relatives told us that they were happy with care they received. We heard staff speaking kindly to people and they were able to explain how they developed positive caring relationships with

Summary of findings

people. One person told us, "I am very pleased with the service. I am well looked after!" However, those people who were more dependant due to their needs were not receiving a consistently good service.

Staffing levels were insufficient to meet the needs of people who were nursed in bed or required staff support for their mobility.

People and their relatives said that the food at the home was good. Where necessary, people were given help to eat their meal safely and with dignity. There was insufficient evidence in care records to demonstrate that, where people were identified as being at risk of weight loss and malnutrition, there had been appropriate interventions to reduce the risk. People who were nursed in bed did not have access to fluids throughout the day to reduce their risk of dehydration.

A programme of activities had been provided for people to enjoy. However, it was not clear how they provided for the needs of people who stayed in their rooms. This meant that they were at risk of isolation and withdrawal.

Care plans did not include sufficient information about individual needs and preferences to ensure the care delivered was person centred.

Staff understood their role in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. Staff confirmed they had received training in these areas. Where people did not have the capacity to make decisions for themselves, the registered manager acted in accordance with the Mental Capacity Act 2005(MCA). Where appropriate, DoLS applications had been made on behalf of people. Staff had been provided with appropriate training to ensure they were able to deliver care to people with complex needs.

A quality assurance system was in place to monitor how the service had been provided and to identify shortfalls. However, it was not sufficiently robust to identify the concerns we found at this inspection. **We have recommended the provider reviews its governance and auditing systems.**

People and their relatives said that they felt safe, free from harm and would speak to staff if they were worried or unhappy about anything. They told us that the manager was approachable. Staff knew how to identify the signs of possible abuse, and knew how to report any allegations of bullying or abuse.

We have identified several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told this provider to take at the back of this 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?
The service was not safe.

Risks to people had not been managed safely. Where risks had been identified, care records did not demonstrate how people had been protected.

Sufficient numbers of suitable staff had not always been provided to keep people safe and to meet their needs.

People's safety had been promoted because staff understood how to identify and report abuse.

Requires improvement

Is the service effective?
The service was not effective.

People's care needs were not managed effectively. Care records did not include sufficient detail to ensure people's needs were met.

People were supported to have sufficient to eat. However, drinks were not always available to people who had been nursed in bed, which left them at risk of dehydration.

When people did not have the capacity to consent, suitable arrangements had been made to ensure decisions were made in their best interests. Deprivation of Liberty Safeguards (DoLS) applications to deprive people of their liberty had been made lawfully to ensure people's rights were protected.

Requires improvement

Is the service caring?
The service was caring.

People were supported by kind and friendly staff who responded to their needs quickly.

People's privacy and dignity has been promoted and respected.

Good

Is the service responsive?
The service was not responsive.

The care provided to people was not delivered in a person-centred way. It was not responsive to people's individual preferences and wishes.

Appropriate activities were provided for more independent people to enjoy. However people who remained in their rooms did not receive activities to provide sufficient stimulation to ensure they were not at risk of isolation.

People felt able to raise concerns and the registered manager responded to appropriately to them.

Requires improvement

Summary of findings

Is the service well-led?

The service was not well-led.

The culture of the service was open and friendly.

People and their relatives were routinely asked for their views of the service. future plan which was shared with people, relatives, staff and other stakeholders.

A system for auditing the service was not sufficiently robust to the identify shortfalls that had been found during this inspection.

Requires improvement

Regency Court 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. The 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. This inspection took place on 18 and 19 August 2015 and was unannounced.

The inspection team consisted of one inspector, a specialist advisor in nursing care 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's area of experience was caring for an elderly relative.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed this and information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law. We used this information to decide which areas to focus on during our inspection.

Some people who used the service were unable to verbally share their experiences of life at Regency Court Nursing Centre because of their complex needs. We therefore spent time observing the care and support they received over lunch time. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

During the inspection we spoke with nine people and to four relatives of people who lived at Regency Court Nursing Centre. We also spoke with seven staff and to the registered manager.

We looked at the care plans and associated records for six people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents and complaints. Records for four staff were reviewed, which included checks on newly appointed staff and staff supervision records.

We also spoke with a community occupational therapist who was visiting to provide treatment to a person who lived at Regency Court Nursing Centre. They gave us their permission to include their comments in this report.

The service was previously inspected on 29 August 2013 when the service was found to be compliant.

Requires improvement

Is the service safe?

Our findings

There was a system in place to identify potential risks to people. Risk assessments had been conducted on each person and identified where people required help. For example, they identified people who were at risk of pressure sores, falling and malnourishment. However, records of care provided had not been adequately maintained to confirm risks to individuals had been adequately managed. For example, one person's wound care plan identified the type of dressing to be used and that it should be changed every third day. The accompanying notes did not confirm that this plan had been followed. They indicated that the time-span between changes were varied, from three days to as much as 10 days. This meant that nursing interventions may not have adequately supported the healing process. We spoke with the registered manager about our findings. She informed us she was not aware of this but did inform us the wound had healed successfully.

The care needs profile of a second person indicated that they were anxious and confused and experienced mood swings. A psychiatric referral had been made in June 2015 which resulted in a change in medication. The manager advised us that the person was now a little calmer in themselves. However, on 17 August 2015 the daily notes indicated, 'X is very demanding. They take the carer off the floor and which means they are not able to attend to the other residents.' The care plan advised staff to, 'keep X occupied as much as possible.' However, there was no guidance to staff with regard to what they should do or how they should approach this person. Care records did not consistently demonstrate how people were supported in relation to risks to their health or safety. This is in breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were less dependent on staff for their needs said their call bells were responded to promptly. One person told us that they preferred female carers to undertake personal care. "They know that's my preference, but when they're busy they do use males." However, a relative told us, "No, there's not always enough staff especially at weekends. Quite often there's only one on the floor when there's supposed to be two."

We looked at the staffing levels at Regency Court Nursing Centre. On the day we visited we were informed there were two nurses on duty supported by six care assistants. The registered manager informed us a member of staff had phoned in sick that morning and there was no time to find cover for them. We observed care being provided over the lunch time period on one floor. We observed seven people who were nursed in bed with no call bells available or fluids within reach. Another person was in their room in a wheelchair. They were unable to speak, but tapped their watch and pointed. The person did not have a call bell so we sought help from a care assistant, who came immediately. Yet another person had rung their bell and started to take themselves to the toilet as no one could help quickly enough. A care assistant, who was serving lunches at the same time, did go to the person and apologised to them. But, then they had to keep going into the next door room to attend to someone else. This was in between going back to the lunch trolley to serve the meal, which was at the end of the corridor.

Another person needed to be hoisted and two care assistants were needed. After 10 minutes the care assistant went to get help from another who had been detained elsewhere. It was 1.30pm before one person was served their lunch on this corridor. We noticed a lot of meals that went back that had just been picked at and, whilst people told us they could manage independently, there wasn't enough staff to check in on people and offer some encouragement.

Later in the afternoon we became aware of someone sounding distressed. We found a person in a state of undress shuffling along the corridor. The person appeared frightened and distressed. On asking if they needed help they declined and then went back into their room. There was a lack of staff presence meaning no one noticed this person's distress.

It was 3.20pm when another person told us they had rung their bell 10 minutes previously and they were getting anxious as they needed to change as they were shortly going out for the afternoon. We asked how long they would wait before calling again and they, reluctantly, did ring a second time. Again a carer came promptly but there still wasn't enough staff to undertake the care needed. Eventually two carers did come along at 3.30pm.

The provider used a tool, known as the 'staffing ladder' to calculate the staffing levels required for each location. This demonstrated that staffing levels had been determined by occupancy levels but not dependency. The registered

Requires improvement

Is the service safe?

manager informed us that she had used this to calculate that two registered nurses supported by a team of seven care assistants were required between 8am and 8pm each day. However she also stated that, in her view, a minimum of five care assistants were required to ensure people's needs had been met safely. Between 8pm and 8am, each night one registered nurse supported by a team of four care assistants, all of whom were awake and on duty were required.

We were also advised how the staff were deployed around the service during the day time shifts to ensure people's needs were met. A registered nurse and four care assistants were expected to provide care to 26 people who were accommodated on the ground floor and the first floor. Of these, three people required nursing in bed, eight people needed help with mobilising and six people lived with dementia. On the second and third floor a registered nurse and two care assistants provided care and support to 14 people. Of these, six people lived with dementia, four people were nursed in bed and six people needed help to mobilise. The remaining care assistant was expected to provide care and support wherever they were required. People living at the service had a high level of need, many requiring two staff for support. The staffing deployment meant that people did not always receive this support in a timely or safe way.

We were provided with copies of staff rotas covering a four week period from 17 July 2015 to 13 August 2015. They confirmed staffing levels, particularly care assistants, varied between five and seven during the day. The registered manager informed us that these variations were due to staff taking annual leave. Our observations and understanding of people's dependency indicated that there were insufficient staff on duty to meet the needs of people safely. This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with who lived at Regency Court Nursing Centre all said that they and their possessions were safe. They felt free from harm and would speak to staff if they were worried or unhappy about anything. One person told us, "There's nothing wrong here." Another person said, "Do you know, if anyone was cruel to me, I know the other carers wouldn't stand for it." A third person advised us, "You can speak to the manager if you need to." A fourth person commented, "They (the staff) don't shout or swear. I'm not worried about anyone." People's safety had been promoted because staff understood how to identify and report abuse. Staff were aware of their responsibilities in relation to keeping people safe. They were able to tell us about safeguarding protocols and the potential signs to look for and the different types of abuse that people might be subject to. Staff were aware of how to report any concerns to the registered manager or to the nurse in charge. This was in line with the provider's procedures and the local authority protocols for reporting safeguarding issues. Records showed that staff had received training, and refresher training, to ensure they understood what was expected of them.

Nursing staff supported people to take their medicines. People we spoke with confirmed they were happy with the way medicines were administered. They told us that medication was administered on time and that supplies didn't run out. Storage arrangements for medicines were secure and were in accordance with appropriate guidelines. Medicines were administered as prescribed. Medicines Administration Records (MAR) were up to date, with no gaps or errors, which meant people received the medicines as prescribed. Where people were prescribed when required (PRN) medicines there were clear protocols for their use. The registered nurses commented that there was a competency assessment for drug administration and that a newly appointed nurse had completed training during their induction period.

Requires improvement

Is the service effective?

Our findings

People who were capable were able to access drinks in the lounge and there were jugs of water in rooms. However, many people who were in bed couldn't reach fluids and were at risk of becoming dehydrated. For example, at approximately 12 noon, one person was asleep. There was no call bell within their reach. They had an empty cup and half a beaker of water on their table which was also out of reach. At 1.30pm the person was awake and was being helped to eat their lunch in bed. We saw no evidence that any fluid was offered. At the end of the meal the staff member asked the person if they wanted a cup of tea. This didn't arrive until about 3.00pm whilst we were in the person's room talking to them. This came with a biscuit and was part of the afternoon tea and coffee round. We also noted the person was perfectly capable of drinking and eating independently. The person also said, "Oh it's so lovely to see someone to talk to, can you stay with me for a bit?"

We observed a second person who had been cared for in bed had an empty beaker on their table, again out of reach, and no call bell. We looked at the fluid intake chart that was in the person's room. There were time delays of some four and a half hours between times when fluids were recorded as taken. When we visited this person's room it was 3.00pm. The only recording for the day was at 8.30am and stated that fluid was offered but not taken. Therefore the person may have been at risk of dehydration.

Another person, who was in bed, had not eaten their dinner. They informed us they were full up from breakfast. We could not see what time meals had been taken, but on looking at the food intake charts in the room, it was noted the person had breakfast but not eaten any lunch. There was no evidence that alternatives had been offered or reasons given why the person was not eating on the documentation we looked at. On other days documentation indicated the person had hardly eaten anything. This meant that the person may be at risk of malnutrition.

Care records we looked at demonstrated that a Malnutrition Universal Screening Tool (MUST) had been used to identify people who were at risk of dehydration or malnutrition. However, guidance for staff to follow with regard to how they should reduce risks and records of care provided were not sufficient to evidence what had been done to protect people. For example, there was a care plan in place for one person which identified they were, 'at risk of malnutrition, choking and aspiration'. However records indicated there was a delay of nine weeks delay from the time this risk had first been identified until their GP was contacted for advice. Apart from staff being instructed to feed the person, there was no record of any other interventions by staff, or any action taken to seek advice from specialists whilst waiting for appointments, to protect the person from further risk of weight loss.

The above evidence demonstrated that people were not always protected from the risk of inadequate nutrition and hydration. This was a breach of Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2014.

We also spoke with people who were in the communal areas. They told us that they could choose where they wanted their meals and that they usually had two choices on the menu. One person commented, "The food is okay really." Another person told us, " We get nice homemade cakes," and a third person said, "We always have enough and they come round with teas and coffees."

We observed the care and support provided to people who had their lunch in the dining room. Interactions between people and staff were positive. Members of staff spoke in a friendly manner when they served food or helped someone to cut up food to ensure the mealtime was a pleasant and sociable experience. Staff asked people, "Would you like your pudding now?" We also heard discussions about television programmes people had seen the previous evening. People who needed one to one support with their meal were assisted gently and calmly. Adapted cutlery and crockery was provided so that people could eat their meal independently. The chef had served pureed diets on segmented dishes so that the meat and vegetables could be kept separated which was more appetising to look at and eat.

People confirmed they believed that staff were competent and skilled at their roles. One person commented, "They (the staff) know what they're doing." Another person told us, "Yes, I think they're good at what they do." Records we looked at confirmed the training nursing and care staff had received. This included health and safety, fire safety, food hygiene, nutrition and hydration, safe moving and handling techniques, infection control, administering medicines

Requires improvement

Is the service effective?

safely, identifying abuse and neglect, and reporting this to the appropriate authority. The records we looked also included training with regard to understanding dementia and managing people with behaviours which challenged. All staff had also received induction training which followed nationally recognised guidance to ensure they acquired the skills and knowledge needed to provide good quality care. Staff we spoke with confirmed they had received sufficient training to ensure they were able to provide people with the care they required. They also confirmed they felt well supported by the manager in their work.

People we spoke with were unable to confirm they had been involved in the process of drawing up care plans and reviewing them. However, people told us that staff respected their wishes and enabled them to retain their independence wherever possible. They also told us they had given their consent before care had been provided. One person told us, "The staff work extremely well together. If I want help I just need to ask and they will give it to me. Sometimes I need help in the bath when I am breathless. The nurse visits me every morning to make sure I am alright." A relative said, " Well we've been talking things through as we've gone along as 'X' has needed a lot of time to settle." Another relative said, "Well nothing much changes so there's no need." Records we looked at confirmed that care plans had been regularly reviewed. However there was no documentary evidence of people or their relatives being involved. The manager confirmed that, where people's needs changed the individual or their family were consulted to ensure their wishes were taken into account.

The registered manager and staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. They knew that, if a person was assessed as lacking capacity, decisions about their care and treatment would need to be made on their behalf and in their best interest. The manager told us three people at the home did not have capacity to make certain decisions. The manager confirmed she had completed capacity assessments and had also made DoLS applications on their behalf. Records we looked at confirmed they had been completed in an appropriate manner. Members of staff confirmed they had received training and it helped them to ensure they acted in accordance with the legal requirements.

People's healthcare needs were met. People told us that medical attention had been sought on their behalf when needed. One person told us, "Oh yes I've seen the doctor several times." Another commented, "I had a nasty cough and the doctor came and prescribed antibiotics and they've been good with all that and making sure I get them on time." A relative told us, "Yes, they've been very good and needed to keep in close contact with the doctor and they've always let me know what's going on." Records we looked at documented when appointments had been made and included information about treatment or care that was required.

People also told us about having their hair done, chiropody, manicures, and eye tests. One person commented, "Oh yes that's all sorted. You can see the hairdresser here or some people have their own hairdresser coming in, it's up to you!" Another person said, "My feet and toe nails are seen to here, and the girls do my finger nails."

Good

Is the service caring?

Our findings

People gave us very positive feedback regarding the caring nature of the staff. One person told us, "They're very friendly and helpful, I find them extremely pleasant." Another person commented, "They always seem happy and cheerful in their work, even when it's difficult." A third person said, "I really like it here. There's always a lot of laughter. It's nice and peaceful." We were also told, "What's great is that the caring pervades across the building, across all the staff from the cleaner upwards. No one is rude they're very respectful of each other as well as us." A relative explained to us, "X (their family member) has been here since May and has dementia. X was very agitated but things have calmed down now. They asked me to bring in a photo album and the manager has spent time going through pictures and helping. They (the staff) have a lot of patience and are very calm."

Our observations indicated that positive caring relationships had been developed between people using the service and the staff. We heard staff speaking with people in a warm and friendly manner, examples of this included, "Would you like a biscuit? Help yourself," "Shall I move those flowers so you can see?" and, "Let me know if you need anything." We also saw a care assistant put their arm around someone going back to their room as they walked together along the corridor. The registered manager informed us how such relationships have been developed. "We expect the staff to treat people as adults, as if they were their own mother or father. We expect staff to speak to them and also to listen. There is training provided so that staff understand what is expected of them and I show them how to speak with people by leading by example."

The provider set up a system where each person in turn was 'resident of the day.' This meant that, each month, the nurse on duty had arranged to meet with the identified person and their relatives to talk about the care they have received. The purpose of this was to make sure they were satisfied and to find out if changes to the care provided needed to be made or if there was any more that is required to ensure their wishes and preferences had been taken into account. The manager was unable to confirm that such discussions were reflected in care records.

We asked staff on duty about the care needs of identified individuals and how they should be met. They demonstrated they were knowledgeable about the care each person required and appreciated the importance of respecting people's individuality. Staff told us they were expected to attend a hand over meeting at the beginning of each shift where they learnt about the current needs of individuals and how they were expected to meet them. They also said, if they needed to they would refer to each person's care plan to ensure they had the necessary information to meet people's needs.

We also asked staff how they preserved people's privacy and dignity. They told us that they knock doors before entering people's bedrooms and make sure that curtains are drawn when they are providing people with personal care. People told us that staff were polite and respectful. Our observations also confirmed this. Staff on duty consistently knocked on doors, closed doors when undertaking personal care and referred to people by their preferred names.

Requires improvement

Is the service responsive?

Our findings

People told us that they had enough baths and showers but couldn't just have one when they wanted. One person told us, "Well they don't ask you; you just have one when it's your time." A person who would need two care assistants to assist said, "I'm not due for a shower very often. It all depends if they've got time but it's only once a week." When we asked people about going to bed they told us, "Well, we tend to retire about 9.30pm." When we asked if they could stay up and watch the TV if they wanted to, they said, "Well, oh, I don't know really, but we have a telly in our rooms" Another person, who needed assistance, told us, "I get put to bed when the night staff come on duty." A third person told us, "I feel I'm in my wheelchair too much. They put me in an ordinary chair if they have time. The physio comes in once a week. They gets me up and standing." They also told us that they weren't supported with any exercises in between physio visits to support their mobility.

The registered manager told us about the documents that nurses were expected to use to assess and record people's wishes and preferences, to ensure care provided was personalised. The documentation was entitled 'My Day My Life' and was used to assess people's needs before admission, and to record people's individual life history and preferred routines. This information would be reviewed and amended when the person was identified as 'resident of the day.'

Nurses we spoke with stated that care plans were personalised and reviewed regularly with relatives and residents. One nurse confirmed that, "Documentation was completed soon after admission with relatives and residents and also reviewed with them." There was no evidence in care plans we looked at that they were based on an assessment of the individual's life history, social and family circumstances, or personal preferences. Pre-admission documentation we examined was superficial. There was no evidence that records supported what we had been told by nurses. Care plans did not include information about people's preferences or wishes. It was not possible to determine if the care provide was person centred and had been tailored to meet individual needs and wishes. For example, we were informed that one person, who had recently been admitted, was now very poorly and close to end of their life. Whilst care records charted the decline in this person's health, a care plan had not been drawn up to guide staff in providing the care required. We were informed by the registered manager that interventions by staff ensured the person was comfortable, pain free and was not alone. But there was no information to confirm this and how their wishes had been considered in end of life care. Care records of a second person indicated they lived with dementia and frequently became confused and anxious. Their care plan instructed staff to 'keep X occupied as much as possible.' However, there was no further information about how X would like to be occupied. The provider did not ensure that people received personalised care and treatment based on their assessed needs and preferences. This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014..

The lounge area in the morning was lively with people chatting and the activity coordinator being very engaging with people. There was a shared sense of humour and warmth. People in the lounge told us that there was, "Always something going on." One person said, "We do all sorts. We play games. We go on trips out for fish and chips. We have music sessions and we have had a miniature horse come in. It even went in the lift to visit people!" Another person commented, "We've had owls come in. We have been to the theatre. We're close by to the seafront and there's the garden, we go out there too!" During the afternoon, the activities coordinator provided a group crossword in the lounge where six of the ten people in the lounge participated. Those six people were thoroughly enjoying themselves and were involved in the activity. The activities coordinator also gently drew some quieter people in the room into the conversations which related to the crossword.

There was an activities timetable which had been displayed in communal areas throughout the premises. Activities that were available to people included art and craft sessions, gentle exercise sessions and a variety of games and quizzes.

Aside from the people in the lounge, many people remained in their rooms and several people were in bed. The timetable identified that the activity for the morning was to be one to one for people who were in their rooms. However, we did not see any evidence of this. Instead the activities coordinator served teas and coffees to people in the lounge. The registered manager has informed us the

Requires improvement

Is the service responsive?

activity had been provided before we arrived and had been provided after the activities coordinator had finished serving teas. Whilst there was a range of stimulating activities on offer for people who were able to engage with this, it was not clear how the social and occupational needs of people who remained in their rooms had been met. The registered manager informed us that care staff on duty would be expected to meet such needs.

People confirmed they knew who to speak to if they had concerns. They also told us they knew what to do if they wished to make a complaint. They were confident that the registered manager would listen to them and would take seriously any concerns they had. One person told us, "We are encouraged to tell the manager about any problems we have. We talked about the food as I found it was cold when it was served to me. The manager has implemented a few changes and now my meals are hotter when I get them." Nurses and care assistants were able to explain to us their role if people needed help to express their concerns or to make a complaint. There was an effective complaints system available and any complaints were recorded in a complaints log. There was a clear procedure to follow should a concern be raised. The registered manager demonstrated that complaints received had been fully investigated and the results discussed with the complainant.

Requires improvement

Is the service well-led?

Our findings

People said they felt Regency Court Nursing Centre was a well-run home with a culture of openness and that all the staff were approachable. Several people mentioned the registered manager by name. One person commented, "She's often around and sometimes joins in with the quizzes." Another person said, "The manager is very approachable and is like a mother figure. You'll often see residents in her office whilst she's working in there." Relatives said that they were always made to feel welcome when they visited and they could come at any time. One told us, "We've recommended the place, even though the building is a bit run down you can't beat the care." The atmosphere in the home was of a friendly, environment where staff and people engaged positively.

People also told us meetings had been held between themselves, their relatives and the registered manager. A relative told us, "I'm sure they asked people about choosing the carpet for in here (the lounge)." The registered manager informed us that such meetings had been arranged in order to communicate information related to the running of the service and about the provider. They also provided an opportunity for people to ask any questions or discuss any ideas they may have to improve the service. We were shown copies of minutes of the last two meetings. They had been held in March 2015 and in June 2015. The agenda items that had been discussed included housekeeping and catering, staffing and staff recruitment, activities and events that have been organised, and feedback from satisfaction surveys together with actions that would be taken to rectify any shortcomings identified. The agenda items also included 'open floor or any other business' in which the registered manager provided an opportunity for people to raise any new topics they wished to discuss.

Staff informed us they found the registered manager was approachable. They found the culture of the service to be open and inclusive. The registered manager arranged regular meetings with all staff which was used to share information from the provider and to seek the views and opinions of all staff employed at the service. One member of staff gave us an example where the registered manager had asked for their views. The member of staff advised that some curtains in some areas of the service needed to be changed as they were getting old. The registered manager acted upon this information and they were changed for some new curtains.

The registered manager informed us that she had worked on ensuring the culture of the service was open and inclusive. They told us they treated people as individuals and had ensured they visited people on a regular basis in order to get to know them and to help people feel they were approachable. The registered manager also said that she expected staff to use this as a model so that people felt able to speak to all staff.

Feedback about the service had also been sought through satisfaction surveys that people and their relatives had completed. The provider had summarised the findings of the last survey into one report. The strengths of Regency Court Nursing Centre were identified as the staff employed there, that people were treated as individuals, and that people were happy and content. Comments that were reported included, 'Staff are helpful and kind,' 'Friendly environment – happy staff,' and 'Everybody is very good to me.' Some areas for improvement had also been identified. They included, 'The quality of care people received and the promptness of staff attending to people's needs.' The minutes of the quarterly meeting for 3 June 2015 advised that the registered manager had received the report that day. The action point for this item stated that they would draw up an action plan to address identified shortfalls which would be shared with people by the next meeting.

Quality assurance systems were in place. The registered manager provided us with documentary evidence that demonstrated how the service had been monitored. Along with records of meetings and surveys, there were a range of audits which had been undertaken. They included routine checks of the environment, safety checks and maintenance checks. Falls and accident audits had been completed to determine if there were any patterns which required action. Each audit had been reviewed by a representative of the provider during a monthly visit they made to the service. This evidenced that action plans had been checked to ensure shortfalls had been remedied and the service improved. The registered manager also carried out competency audits for nursing and care staff with regard to their skills and knowledge. This helped the registered manager to determine if refresher or additional training was required. However, the systems that were in place were

Requires improvement

Is the service well-led?

not sufficiently robust to identify the shortfalls requiring improvement that have been highlighted in this report including staffing levels, person-centred care planning and nutrition and hydration risks.

We recommend that the provider review its governance and auditing systems to ensure compliance with the Regulations.

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 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: Care and treatment had not been designed with a view to achieving service users' preferences and ensuring their needs are met. Regulation 9 (3) (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 (RA) Regulations 2014 Staffing How the regulation was not being met: Sufficient numbers of suitably qualified, competent, skilled and experienced persons had not been deployed in order to meet service users' needs. Regulation 18 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met: The nutrition and hydration needs of service users had not been met. Regulation 14 (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 How the regulation was not being met: The registered manager could not demonstrate that all that is reasonably practicable had been done to mitigate any identified risks to service users. Regulation 12(2) (b).