Ecce Cor Meum Limited

Breadalbane Residential Home

Inspection report

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Ratings

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

Overall summary

We inspected the service on 9 February 2015. The visit was unannounced. Our last inspection took place on 6 July 2014 and there were no identified breaches of legal requirements.

Breadalbane Residential Home is a care home for up to 15 older people. It is a converted house, which has been adapted and extended to provide accommodation over three floors. There is a passenger lift operating between the floors. The home has one double bedroom; the remainder are for single occupancy. There were 14 people living at the home on the day of our inspection.

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.

During our visit we saw people looked well cared for. We observed staff speaking in a caring and respectful manner to people who lived in the home. Staff demonstrated that they knew people's individual characters, likes and dislikes.

People we spoke with told us they felt safe living at the home. They told us they trusted the staff and felt the staff knew them well and how they liked support to be provided for them.

The home provided care for people living with dementia. There was little evidence of national guidance or best practice on which the home based the care they provided for people living with dementia. This meant the provider could not assure themselves they were meeting the required standards regarding dementia care.

We found the service was not meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS). The manager of the home had not considered if people were at risk of being deprived of their liberty. Staff demonstrated a lack of understanding of the Mental Capacity Act 2005. Where assessments of people's mental capacity had been carried out we saw people had not been supported to make decisions about their care, or consent to the care, they received at the home.

We found there were issues with regard to the management of medicines within the home. This was in relation to the administration, storage and lack of guidance in place for staff to follow when administering 'as required' medicines to people.

Staff we spoke with told us they were aware of their responsibilities with regard to safeguarding people who lived at the home. They were able to tell us about the symptoms of possible abuse taking place and how they would report this. However, we found staff had not acted within the policy and procedures available to them to report incidents of possible abuse. The manager, however, had failed to report all incidents of abuse and alleged abuse appropriately to the CQC.

We were told by the manager the provider carried out checks on the environment of the home however; there were no records of these checks. We found the temperature of the hot water in three people's hand basins and two of the communal bathrooms was 50 degrees centigrade and meant people were at risk of being scalded.

We saw staff had completed 'in house' training on medicines. However, we found the training consisted of a 'competency' check only. We also saw the home did not provide training in dementia care for staff. The provider responded to our concerns and ensured proper training in medicines and dementia awareness was arranged for staff.

We saw the provider did not have a system in place for the purpose of assessing and monitoring the quality of the service.

People told us the food at the home was good and that they had enough to eat and drink. We observed lunch being served to people and saw that people were left unsupervised for periods of time during their meal. This meant staff were not available to respond to people's needs, to offer direct supervision or to maintain people's safety.

People who used the service said they did not have enough to do to make sure their social needs were met. Comments included; "I play records, I like the music. There's nowt else to do. I'd like to go for a long walk. You know, feel the grass under my feet." Another person told us "I just sit in my chair, that's what we do in the afternoon. Just sit in the chair."

We looked at four staff personnel files and saw the recruitment process in place ensured that staff were suitable to work in the home. Staff we spoke with told us they received supervision every three months and had annual appraisals carried out by the manager. We saw minutes from staff meetings which showed they had taken place on a three monthly basis and were well attended by staff.

The home was clean and had personal protective equipment was in place for staff to use however, in two people's bedrooms we noted malodours. The manager told us there were plans in place to change the carpeting.

Summary of findings

We found there were not at all times, enough staff to ensure people's needs were met safely and that people were properly supervised to ensure their safety.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, now replaced by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of 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?

Inadequate

The service was not always safe.

The temperature of the hot water in three people's hand basins and two of the communal bathrooms was 50 degrees centigrade. This meant people were at risk of being scalded.

Staff had not received training in medicines. There was no guidance in place for staff to follow on administration of 'as required' medicines. Temperatures were not being monitored in the areas where the home stored medicines.

Staff told us they knew how to keep people safe and how to recognise signs of abuse. However, staff had not taken the appropriate action when safeguarding incidents had occurred at the home.

There were not enough staff on duty to ensure people's needs were met safely.

Is the service effective?

Requires Improvement

The service was not always effective.

We found the service was not meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS). Staff demonstrated a lack of understanding of the principles of the Mental Capacity Act 2005.

People were supported to access health care services to meet their individual needs.

Records regarding nutrition were not completed appropriately by staff.

Staff received supervision and appraisals were carried out.

Staff had not received training in dementia. The home environment did not include any adaptations for people living with dementia such as signage and items which would aid recognition of their rooms.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed staff interacting with people in a kind and caring manner. People told us they were well looked after by staff.

We spoke with people's relative who told us they were always welcomed by staff when visiting the home and there were no restrictions on times they could visit.

We saw incontinence products in use on the chairs in the lounge which compromised people's dignity.

Summary of findings

Is the service responsive?

Requires Improvement 

The service was not always responsive.

Care records lacked personalisation. There was limited reference made to people's preferences.

There was a programme of activities in place for people. However, people told us they would like to be able to go out more. We saw people were unoccupied and unsupervised for periods of time.

Is the service well-led?

Inadequate 

The service was not always well led.

Staff told us they felt supported by the manager and the provider.

The provider did not have a system in place for assessing and monitoring of the quality of service provision.

There was no effective accident, incident and complaint analysis carried out and therefore, people were not protected from unsafe care.

The provider had informed CQC about some significant events that had occurred but they had failed to inform CQC about all reportable events.

Breadalbane Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 9 February 2015 and was unannounced. The inspection team consisted of one adult social care inspector, a specialist advisor with a background in dementia 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.

At the time of our inspection there were 14 people living at the home. During our visit we spoke with eight people who used the service, two visiting relatives, six members of staff, the cook and the home manager. We spent some time looking at documents and records that related to people's care and the management of the service. We looked at five people's care records. We also spent time observing care in the lounge and dining room areas to help us understand the experience of people living at the home. We looked at all areas of the home including the kitchen, people's bedrooms and communal bathrooms.

Before our inspection, we reviewed all the information we held about the home, including previous inspection reports.

Before our inspections we usually ask the provider to send us 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 improvements they plan to make. On this occasion the provider had not received their PIR.

Inadequate

Is the service safe?

Our findings

Some of the people living at the home told us they thought there were enough staff on duty to meet their needs. We spoke with eight people and four of them told us they felt safe living at the home. One person said "I can't fault them. This place is small. It's what I want. I know where I am and what to do." We spoke with the relatives of one person who told us they would like to see more staff on duty. We saw there were two care staff on duty between 7am and 9pm which included one senior carer. Staff told us the manager was usually available during the day if they needed extra help.

We asked staff about the dependency of the people living at the home. They told us there were three people who required support from two staff with their needs. They also said there were nine people who had dementia and required one staff member to support them. On the day of our inspection the manager was not present at the home until after lunch time. One of the care staff had brought in an extra staff member to help out. At lunch time we observed two members of care staff supporting people with moving and handling equipment in the lounge. We saw the two care staff were rushed and seemed under pressure.

During lunch we saw most people were able to eat independently however, for a significant period of time there were no staff in the dining room. A staff member came in to the dining room on one occasion to see if people were comfortable and enjoying their meals but were not in attendance throughout the meal or on hand to offer assistance. One member of staff was assisting someone with their lunch in the lounge and another was fetching food from the kitchen.

We saw one person was eating their lunch with their hands. We saw that another person who was having their food and fluid intake monitored only ate half of their meal. Staff were not present throughout the meal to observe what the person ate. Later when we looked in the persons daily records we saw staff had recorded the person had 'enjoyed their lunch' and did not specify the amount eaten. This meant staff were not available to respond to people's needs, to offer direct supervision or to maintain people's safety.

We spoke with the cook who told us they worked from 7.30am until 1pm. The evening meal was prepared by them and later served to people by care staff. We saw the domestic staff employed at the home did not provide cover at weekends. Staff told us they cleaned the home at weekends. We saw the home did not employ dedicated laundry staff. This was carried out by the care staff. This meant staff were not available to supervise or provide care to people when carrying out domestic duties within the home.

We spoke with the manager about how the home determined the number of staff they needed. They told us they did not use a specific tool to do this. They said they would bring in additional staff if people's needs increased but felt that the home was adequately staffed at the time of our visit. They said care staff had always managed to carry out additional tasks. We concluded there were not at all times, enough staff to ensure people's needs were met safely and that people were properly supervised to ensure their safety. This was a breach of Regulation 22 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked around the home and saw there were a number of issues relating to the maintenance of the home. These included door handles to rooms of the home, including people's bedrooms were broken or had been attached to the door in a way that made them difficult to use. We found some of the sinks in peoples en-suite areas did not have plugs and some of the taps were very stiff and difficult to use. The toilet seat in one person's room was in the corner of their en-suite and it was broken.

There were items of equipment which were used to support people which were not clean. For example, the bath chair and the lap strap on the bath chair were stained and had a build-up of dirt in places. We noted malodours in some areas of the home. We asked for the maintenance records for the home to see when the issues had been reported and were to be actioned. We were told by the manager that the issues were not recorded as the provider carried out all aspects of checks of the premises and addressed maintenance issues as they arose. Following the inspection we were sent certificates for gas and electrical safety which showed they were up to date as these were not available at the time of our visit.

Inadequate

Is the service safe?

We tested the temperature of the hot water in people's bedrooms and communal bathrooms and toilets. The hot water in two people's hand basins and two of the bathrooms reached 50 degrees centigrade. This meant people were at risk of being scalded. We spoke with the manager who told us the provider checked the hot water temperatures throughout the home but records of the checks were not made. We asked if there were records available to show any other environmental checks were being carried out. The manager told us there were none available.

We asked the manager if risk assessments relating to health and safety had been completed for the home. They told us there were a number of these throughout the home which were displayed at the point where a risk had been identified. We saw in a number of areas of the home 'environmental risk assessments' were on the walls however; these were not dated, nor did they show a review date. The risk assessments related to people using the area for example, going up or down the stairs. This meant that risks to people's health and safety were not recorded in a way which ensured they were managed, reviewed and updated as required. This was a breach of Regulation 10 (Assessing and monitoring the quality of service provision) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with staff who told us they had received training in safeguarding vulnerable adults. Records we looked at showed only nine out of 19 staff were up to date with this training. Staff said they knew how to protect vulnerable adults and keep people safe. We asked staff what action they would take if people came into conflict with each other in either a verbal or a physical way. Staff told us "people often have a go at each other and we often have to separate people." Both staff members told us they would record incidents of this kind in people's care records and report to the senior care staff on duty. We spoke with the manager who told us these incidents had not been reported to them or to the local safeguarding team. We were told there were no incident forms to reflect these types of incidents had occurred.

We saw in the care record of one person there was a body map document in place which showed numerous bruises and grazes the person had without any explanation of how they had occurred. The manager confirmed they did not report unexplained bruising to the local safeguarding team.

The home had policies and procedures in place for safeguarding vulnerable adults and we saw these were available and accessible to members of staff. We saw that staff had not followed the policy and procedure available to them in response to the incidents that had occurred. Our review of the service history showed in five years the service had only reported one incident regarding safeguarding to the Care Quality Commission. This was a breach of Regulation 11 (Safeguarding service users from abuse) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment records for three staff. We found recruitment practices were robust and each staff member had undergone pre-employment checks before they started work at the home. Each record showed detail of the person's application, interview and references which had been sought. We spoke with one staff member who confirmed this recruitment process had been followed. This showed that staff were being properly checked to make sure they were suitable to work with vulnerable adults.

We looked at the arrangements in place for ordering and disposal of medicines and found these to be safe. People's medicines were stored securely in a locked room. We found there were issues with the administration and storage of medicines at the home. We saw staff were not recording the temperature of the room where medicines were stored. This meant medicines were not being stored within the manufacturers recommended temperature range which may impact on their effectiveness.

We looked at the medication administration records (MAR) for eight people. We saw the MAR's in use were printed by the dispensing pharmacy and included details of the person concerned such as their GP and their date of birth. We saw there were 11 missed signatures/gaps on the MARs. This meant it was not clear if the person had received their medication.

Inadequate

Is the service safe?

We found that the coding system in place to explain reasons why people may not have received their medicines was not being used correctly by staff. For example, we saw one person was prescribed eye drops, one drop to be taken four times per day. However, the person was only receiving this medication three times per day as staff had recorded 'O' which meant the person was in bed. The person had missed 21 possible doses of the medication. We also saw one person had 'as required' medicines available to them up to four times per day; the staff had recorded 'O' meaning the person was in bed. This meant the person had missed a possible 21 doses of the medication. We asked the manager if the person had been offered this medication and they told us they did not know.

We saw there was no guidance in place for staff to follow when administering 'as required' medication to people. For example, one person was prescribed medication for staff to use when the person was agitated. There was no guidance in place for staff to follow with respect to the signs and symptoms the person would present with when they needed their medication. This meant the person was at risk of not receiving their medicine when they needed it. The manager confirmed they were not auditing the MAR records in use and were not aware of the gaps or issues we had found. This was a breach of Regulation 13 (Management of medicines) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(f) and (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We were told by the manager that no-one living in the home was subject to an authorised Deprivation of Liberty safeguard (DoLS). The manager said they had not identified people who were possibly at risk of being deprived of their liberty therefore; applications had not been made to the local authority. There was no evidence that any contact had been made as yet with the local DoLS team to gain advice regarding this to ensure people's rights were protected. Our observations of the home and people's care plans suggested some people may be at risk of having their liberty deprived. For example, the front door of the home was locked and the manager told us some people were under constant supervision of staff and also requiring regular hourly checks at night.

The MCA (Mental Capacity Act 2005) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. The manager told us nine of the 14 people living at the home had dementia. Having dementia can affect a person's ability to make decisions from time to time; it may also affect their capacity to do so. Therefore, assessments of people's mental capacity must be both time and decision specific. However, the five mental capacity assessments we looked at showed there had been no consideration of this.

The manager told us assessments of people's mental capacity had been carried out to determine if the person was able to make decisions. They said people were able to make decisions about their care and no one living at the home had required best interest decisions to be made with the involvement of relevant professionals. We looked at five people's care records and saw that although people were able to make decisions about their care, none of them had been supported to do this, nor had they given their consent to the care they received at the home.

We spoke with staff about their understanding of Mental Capacity Act 2005 (MCA). They told us they supported people to make choices about their support and would respect people if they refused any aspect of care such as medication. However; they were unable to tell us about how the processes in place at the home for assessing people's mental capacity and under what circumstances this should be done. They told us they made decisions about people's care which were in the person's best interests on a daily basis but were not aware of the formal processes which should be followed regarding this. We looked at training records for all staff who worked at the home which showed only one staff member had completed training on Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). This demonstrated staff were not aware of their responsibilities under this legislation. This breached Regulation 18 (Consent to care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staff training records which showed some staff had completed a range of training which included infection control, fire safety, moving and handling, first aid and food safety. The manager told us the training provided to staff was carried out by an external provider. We saw staff had completed training in medicines however, we were told this was done 'in house' and consisted of a competency check by the manager. This was also the case with food hygiene. We saw none of the staff at the home had completed training in health and safety and dementia. There was no evidence of a training plan in place to make sure these training needs were met. This meant the provider had failed to identify the training needs of staff which would ensure the provision of appropriate and safe care to people living at the home. This was a breach of Regulation 10 (Assessing and monitoring the quality of service provision) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed the care given to people with dementia and saw that staff lacked the skills they required to support people living with dementia. One person was constantly walking in a curved path out of the lounge room and back

again. We saw staff did not intervene. Another person living at the home told us "(the person) does that; it's just that the pattern on the carpet gets them going. Gets them all jumbled up."

We looked at the care records of five people and saw there was little in the way of guidance for staff to follow on how to meet the needs of people who were living with dementia. For example, we saw comments such as "staff to reassure", "remain patient." We saw these comments across all five care records and felt they did not indicate the individual support needs of the person concerned.

Staff told us they felt the home were meeting the needs of people living with dementia however, they could not give us any examples of how people's care and support needs differed between people who did and did not have dementia.

We saw the signage in place around the home was not adequate for people living with dementia. Information to tell people which bedroom was theirs consisted of photographs which had been selotaped to people's bedrooms doors. We also saw handwritten names on bits of paper. In some cases there was nothing at all to identify people's bedrooms.

We spoke with six staff and none of them were able to tell us about a model of care in use at the home, the National dementia strategy or NICE guidance (National Institute for Health and Care Excellence) with respect to caring for people with dementia. The manager was also unable to provide any examples of how the home implemented guidance available. Due to the lack of implementation of best practice guidance the provider could not assure themselves they were meeting the required standards regarding dementia care.

Staff told us people were supported with accessing health care services such as GPs, dentists and opticians. We saw evidence to support this in the care records we looked at. One person told us "There's nothing they wouldn't do for you. If you have any pains, they get a doctor or a nurse and you get all the help you need. They shower me, so I've nothing to do for myself. They say I can ask them anything. They give me my tablets before my meals when I need them. They always give me tablets for my pains and they do cream my legs lovely." This showed people living at the home received additional support when required for meeting their care and treatment needs.

We observed lunch being served to people at the home. We saw the dining room was set nicely with table cloths, place mats and condiments available for people to use. We saw staff supported people into the dining room while a small number of people chose to eat their meal in the lounge.

We saw that one person did not eat all of their lunch yet their records showed they had 'enjoyed their lunch'. We also saw in another two people's care records that a staff member had recorded what the person had eaten for their lunch at 10.45am. We discussed this with the manager who told us they would deal with these issues.

People told us that they liked the food. The menu for the day listed roast beef and Yorkshire pudding with mash and veg, plus apple crumble and custard. There was no choice. When the meal came out it was pork steak with mashed potatoes, broccoli and swede with peach cobbler and custard for dessert. The meal was well presented and looked appetising and good portions. People weren't given the option of second helpings.

We saw lunch was served from 11.30am and tea at 4pm - 4.30pm. One person told us another person sat on the same table "X (the person) hasn't been eating. They've been trying to get weight back on. They (the staff) give lots of special drinks. We don't need to choose stuff here as they know what we like and don't like. They make me special food "cos there's lots of things I can't eat." We spoke with the cook who told us people were asked on a daily basis what they would like to eat. They said there were plenty of alternatives available for people however; we saw these were not included on the menu. We saw that Breadalbane House had received the 'Eat well Award'.

Requires Improvement

Is the service caring?

Our findings

We observed staff interactions with people throughout the inspection and saw that all of the staff who worked at the home displayed warmth, kindness and compassion to each person they supported. We saw the majority of people who lived at the home appeared clean and well groomed. We saw people wore nail polish and jewellery.

Some of the people living at the home were able to tell us their views on the care they received. One person was complementary about the staff and the home in general. Another person said, "It's OK, its nice here – could be worse." It was the person's birthday and staff told us there would be a cake later.

We saw staff approaching people with respect and support was offered in a sensitive way. We saw one person assisted to the bathroom by a staff member. The person appeared unsteady and used a mobility aid when walking. We saw the staff member was patient with the person offering continual encouragement about their mobility. This showed that staff took time to support people with their personal care in a way which promoted their dignity.

The staff we spoke with were able to tell us how people preferred their care and support to be delivered. They also explained how they maintained people's dignity, privacy and independence. They told us about the importance of knocking on doors before entering people's bedrooms and making sure curtains were closed when supporting people with personal care. This showed staff had a clear knowledge of the importance of dignity and respect when supporting people.

We saw the home had 'seat covers' in use on all of the chairs in the lounge. The manager told us these were to protect the seats if people with incontinence issues had accidents. We felt these compromised people's dignity.

We saw the staff were friendly and supportive with a group of visiting relatives who took one of the residents out for a pub lunch to celebrate their wedding anniversary. We spoke with the relative of one person who told us they liked the fact the home was, "small and friendly" and, said the staff were "good to visitors".

Staff we spoke with told us they liked working at the home and felt they provided people with good care. One staff member told us, "They mean a lot to us and we always do our best for them." Another staff member said, "We've known a lot of the people here for a long time and we've become like family really. We do as much for them as we would our own family. This is a good home as we really do care."

We asked people living at the home and their relatives if they had been involved in care planning or reviews of care. All of the people we spoke with told us they had not. One person said, "I'm not interested in what they've got written down for me. They know what they're doing. I've never signed anything." The five care records we looked at confirmed this. People's relatives we spoke with told us they had not signed any care plans or looked at any documents regarding the care of their relative. We saw care plans in place with spaces for people or their relatives to sign, however these spaces were blank. We also saw where regular monthly reviews of care plans were carried out; this was done by staff with no involvement of the person. This meant that people, or where appropriate their relatives, had not been involved in their care planning.

Requires Improvement

Is the service responsive?

Our findings

We looked at the care records of five people living at the home. We saw assessments of people's needs had been carried out and care plans put in place. The assessments included nutrition, moving and handling and falls. Care plans showed evidence of review and being updated when there was a change in the person's needs. We found 'life history' documents were in place for the purposes of gathering information to ensure personalised care was provided. A life history document enables staff to understand and have insight into a person's background and experiences. One person's life history had not been completed. We saw care records contained information about people's likes and dislikes such as preferred time of rising and going to bed. This showed care records reflected people's preferences.

We saw there was a sign up in the reception area of the home which stated there was an activity planned for each day. This included visits to the home by a mobile library service and chairs exercises by an external provider on a monthly basis. However, we saw people were spending periods of their day not engaged in any meaningful activities. For example, on the day of our visit the planned activity was 'floor basketball'. We saw this was carried out by one staff member with little involvement from people. The activity lasted ten minutes and was then put away. People then remained in their chairs until lunch time with little interaction from staff.

We spoke with eight people living at the home and asked how they spent their time and did they have activities available to them. One person told us, "We have 'Music and Movement' coming in every 3 weeks and occasional visits from an entertainer with guitar and songs." Another person told us, "I play records. I like the music. There's nowt else to do. I'd like to go for a long walk. You know, feel the grass under my feet." We asked one person how they would be spending their afternoon and they told us, "Just sit in my chair. That's what we do in the afternoon. Just sit in the chair."

We looked at records which showed the activities people had taken part in. We saw that 'creaming legs' and 'nail care' were noted for one person. This was part of their planned personal care rather than an activity. Another record stated 'sleeping' and 'relaxing'. The staff told us they had not had training on planning and facilitating activities. We spoke with the manager who said two staff who worked at the home took a lead on activities. We were told they had not received any appropriate training, nor did they have dedicated time for this.

We saw in two people's records a staff member had recorded that both people had participated in activities which we saw had not taken place on the day of our inspection. These records were also completed in the morning but were intended to reflect how the person had spent their day. We spoke with the manager about this and they told us they would address this immediately. This meant the home was not appropriately meeting the social needs of people who lived there. This was a breach of Regulation 17 (Respecting and involving service users) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the way the home responded to concerns and complaints. People we spoke with told us they would go to the manager if they had any concerns. We also spoke with a visiting relative who told us, "We feel comfortable going to the owner or the manager if there are any issues they are all approachable." The manager told us people had access to the complaints procedure as there was a copy displayed in the reception area of the home. The complaints procedure gave clear timescales for dealing with complaints.

We looked at the complaints log and saw the home had received one complaint since our last inspection. The complaint was from relative regarding missing clothing. We saw there was no evidence to show how the manager had investigated the complaint, and there was no resolution recorded. We spoke with the manager who told us they had undertaken the investigation and they told us the complainant was 'happy to leave it' but were not satisfied with the findings. This showed complaints were responded to appropriately.

Inadequate

Is the service well-led?

Our findings

We spoke with six staff who worked at the home. They were all very positive and complimentary about the support they received from the manager and the provider. One staff member told us, "The manager is great. They do their job, we do ours and we all just get on with it. If we're bothered by anything we can go to them or the provider no problem. They want people to be happy at work." Another staff member told us, "I've always found the manager approachable."

We saw regular staff meetings took place at the home and were attended by the provider. We spoke with staff about this and they told us, "I think it's good that they attend the meetings. It means they know what's going on and they should." This suggested the home promoted an open culture where staff felt supported when they raised concerns about matters which affected their role or people who lived at the home.

We spoke with the manager and asked how they sought people's views and opinions with respect to the way the service was provided. The manager told us there was a suggestion box located in the home for people to give their views and opinions on the service. This was relatively new so there was no feedback at present. We were shown minutes from the most recent resident meeting in November 2014. The manager told us the meetings were held every three months. The minutes showed evidence that where suggestions had been made the manager had taken action. For example, a person had suggested loaning books from a mobile library. We saw the manager had arranged for this to take place. We saw evidence which showed people's relatives were also invited to the meetings.

We asked the manager about the systems in place for the purpose of assessing and monitoring the quality of the service provided to people living at the home. We looked at the systems in place for accident and incident management. We saw there had been seven accidents/ incidents in October, November, December 2014 and January 2015 which included people who had slipped, had been found sat or lying on the floor in their bedroom and lounge area. Incidents had not been monitored and we saw no actions had been taken in response to them. There was also no analysis carried out by the manager to monitor for any patterns or trends. This showed that an effective system was not in place to monitor accidents and incidents which occurred at the home.

The manager showed us a care plan audit they completed on a monthly basis. We saw the audit consisted of a list of care plans which people had in place. The audit did not show how the manager was assessing the effectiveness of the care plans or any other issues relating to care planning. The manager confirmed they did not complete any other audits in relation to the provision of the service.

Throughout the inspection we brought a number of issues to the attention of the manager. We identified a number of breaches regarding the management of medicines, suitable arrangements were not in place to ensure the service was meeting the requirements of MCA 2005 or Deprivation of Liberty Standards and there was no system in place to assess and monitor if staffing levels were sufficient.

We found risks to people's health, safety and welfare were not always identified and managed and there was no system in place to audit risks to the environment or premises and the monitoring of accidents and incidents, including safeguarding incidents which had occurred at the home. We found there was no system in place to monitor training staff had attended. We also found the provider had failed to identify that staff did not have training on how to meet the needs of people living with dementia, health and safety or the safe management of medicines.

All of these issues demonstrated to us that the provider was failing to protect people living at the home and others who may be at risk, against inappropriate or unsafe care and treatment, by means of an effective operation of systems designed to regularly assess and monitor the quality of the service and identify, assess and manage risk. This was a breach of Regulation 10 (Assessing and monitoring the quality of service provision) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 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 11 HSCA (RA) Regulations 2014 Need for consent 11.—(1) Care and treatment of service users must only be provided with the consent of the relevant person. (2) Paragraph (1) is subject to paragraphs (3) and (4). (3) If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care 9.—(1) The care and treatment of service users must— (a)be appropriate, (b)meet their needs, and (c)reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **12.**—(1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include (f) where equipment or medicines are supplied by the

This section is primarily information for the provider

Action we have told the provider to take

service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs;

(g) the proper and safe management of medicines;

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing 18.—(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17.—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— (a)assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b)assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; (c)maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; (d)maintain securely such other records as are necessary to be kept in relation to— (i)persons employed in the carrying on of the regulated activity, and (ii)the management of the regulated activity; (e)seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services; (f)evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

The enforcement action we took:
Warning Notice

This section is primarily information for the provider

Enforcement actions

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 13.—(1) Service users must be protected from abuse and improper treatment in accordance with this regulation. (2) Systems and processes must be established and operated effectively to prevent abuse of service users. (3) Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse.

The enforcement action we took:
Warning Notice