United Care (North) Limited

Clumber House Nursing Home

Inspection report

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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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 18 June and 16 July 2015 and was unannounced. The home was last inspected in August 2014 when it was found to be complying with the regulations which applied to that type of service at that time.

Clumber House Nursing Home is registered to provide accommodation for 36 people who require nursing or personal care and who are living with dementia. It is located in a residential area of Poynton in East Cheshire. There were 32 people living in the home at the time of our inspection.

There was a registered manager at the home. 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.

We found that most people felt safe at Clumber House Nursing Home and thought that the staff were caring. Medicines were administered safely in the home and the people who lived there benefitted from good support from local health and social services. Opinions varied about the food. The home was trying to develop more activities for the people who lived there.

We found a number of breaches of Regulations relating to dignity and respect, need for consent, safeguarding people who used the service from abuse and improper treatment, and good governance. We also found that the registered provider had failed to notify the Care Quality Commission of significant events as it is required to do by law. 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?

The service was not always safe. Management did not use appropriate systems to investigate and prevent instances of suspected or alleged abuse.

Most people in the home felt safe and staff had a good understanding of the meaning of safeguarding. Medicines were administered safely and staffing levels were being reviewed in order to maintain safe levels at night.

Requires improvement

Is the service effective?

The service was not effective because appropriate steps were not taken to ensure that people consented to their care or if they were not able to do this then that appropriate other arrangements were made under the Mental Capacity Act 2005. Deprivation of Liberty Safeguards were not authorised. People were not always asked for their consent to treatment that was being given.

There were some limitations on the way that food was served in the home. Although staff said they received a lot of training this had not been effective in relation to mental capacity arrangements.

Requires improvement

Is the service caring?

The service was not consistently caring because care and treatment was not always given in private. People's confidential records were not always stored securely.

Most people said that they felt the staff were caring and staff told us about ways in which they promoted dignity. Relatives we spoke with were complimentary about the care provided by the home.

Requires improvement

Is the service responsive?

The service was not always responsive. Care planning systems did not consistently reflect a focus on individuals. The home needed more adaptation to meet the needs of people living with dementia.

There was an activities organiser who was working hard to develop and provide activities in the home which would be person-centred meaning they would reflect people's individual personalities and preferences.

Requires improvement

Is the service well-led?

The home was not consistently well-led. Audit systems were not well organised and policies and procedures were incomplete, not adapted for local use and did not correspond to local practice.

Requires improvement

Summary of findings

There was a stable management team and systems in place to provide staff with supervision and appraisal. However the registered provider was not making sure that the Care Quality Commission was notified of significant events.

Clumber House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 June and 16 July 2015 and was unannounced. The inspection was carried out by a team of four inspectors. On the first day the team included two adult social care inspectors, and a specialist adviser who focused upon care for people living with dementia and medicines management. There was also an expert by experience who took part in the inspection. 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 by experience who took part in this inspection had experience of people living with dementia.

Before the inspection we contacted both the local NHS clinical commissioning group and the local authority which had responsibility for commissioning and for safeguarding.

We also asked the local Health Watch group if they had any information about the home. We reviewed all the information the Care Quality Commission held about the home. We considered all the information we were provided with before and during the inspection.

During the inspection we talked with eight people who used the service, three visiting relatives, and six members of staff as well as the registered manager, deputy manager and care supervisor. We looked at six care files as well as other records relating to the way in which care was provided. We looked at four staff files to see how they were recruited as well as management and training records and audits. We looked at the arrangements for administering medicines and how this was recorded. We looked around the home including in some people's bedrooms where they invited us to do so. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We have asked the registered provider to provide us with a report regarding an incident we observed during the inspection.

Requires improvement

Is the service safe?

Our findings

Most of the people we spoke with had no concerns about the care provided in the home. They told us "The staff are lovely - very kind" and "I have no complaints". None of the staff we spoke with had any concerns about safeguarding in the home.

When we spoke with most care and nursing staff they were knowledgeable about safeguarding and how it applied to the people who lived in the home. They told us what they would do if they suspected that anything was wrong and said that they were confident that the registered manager would take the appropriate action. Staff told us that they had undertaken training in whistleblowing as part of their induction.

However on the second day of our inspection when one person who lived in the home heard that we were visiting they asked to see us. When we talked with them they reported a number of incidents which concerned us. We reported these to the registered manager who showed us statements which had been provided by staff referring to these concerns. Although the concerns had been brought to the attention of senior staff in the home we did not see a statement from the person themselves and there was a delay in resolving the matter. The person could not be satisfied that their concerns had been properly investigated and responded to.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider had not established and operated effective systems to investigate, immediately upon becoming aware of, any allegation or evidence of abuse.

We brought our findings to the attention of the local safeguarding authority which is undertaking an investigation into this matter. However we were concerned that these concerns had not been reported before this to the local authority and that the home had not promptly submitted any notification to the Care Quality Commission or otherwise brought the matter to our attention.

When we looked at the care files we saw that there were appropriate risk assessments for example relating to the use of bed rails. All the beds in the home were equipped with bed rails which could be used where they were required and we saw that regular checks were made on the condition of them. These were up-to-date and had been reviewed.

We saw the home was well equipped and maintained regularly by a handyman. We saw other risk assessments such as relating to falls, mobility, skin condition and behaviour and which had also been reviewed regularly.

We saw the bedroom windows were equipped with limiters so that they could not be opened too far and present a hazard. However downstairs we found a sash window which had been propped open with the top of an aerosol spray. It was a warm day and this had been done so as to allow some fresh air to circulate. When we knocked the top out of the way the sash window closed sharply and could have trapped someone who was not aware of the risk. We reported this to the registered manager.

We saw that there were good supplies of personal protective equipment such as gloves and aprons throughout the home and that the cleaning supplies cupboard was locked so that access to hazardous chemicals was controlled.

When we arrived to commence this inspection it was 6.30 am and the night staff were coming towards the end of their shift. We saw that the staffing was made up of a registered general nurse together with one senior carer and two care staff although one member of care staff had had to leave the shift because they were unwell. When we walked around the building we verified that this was the level of staffing present.

When we checked the staff rotas we saw that a similar shortage had occurred four times in the last few weeks. We saw also that according to the rotas there were four other occasions over the next month when staff would be reduced to this level. On the second day of our inspection we found that the night staff levels were as described with one nurse on duty together with one senior carer and two care staff.

Staff told us that they found it very difficult when the number of carers was reduced at night. One person who lived in the home told us that they felt the care was poorer at night saying "They keep you waiting because they are low in numbers". We heard staff telling one person that they could not respond to them immediately because they were helping someone else.

Requires improvement

Is the service safe?

We noted that there were references to delays in helping people to get to the toilet at the residents' meetings and that these delays were attributed by them to staff being "too busy". We were concerned that reductions in night staffing to the levels present on this first day of the inspection resulted in inadequate care being provided to people who lived in the home. We raised this matter with the registered manager who told us that she did not use agency staff but was currently recruiting staff who would be able to cover these gaps in the rotas. Staff confirmed that they were aware of recruitment efforts and were looking forward to the new members of staff who would join the staff team. We will ask the registered manager to confirm when this recruitment has been completed and also check staffing levels at a future inspection.

We saw that daytime staffing was made up of a minimum of one nurse and five carers which reduced to one nurse and four carers in the afternoon. On the first day of our inspection two deputy managers were present with the registered manager who had attended when she became aware of our presence. There were a number of additional staff available in the home during the day including an activities organiser, a handyman, as well as domestic and kitchen staff. The registered manager told us that she did not take periods of annual leave in blocks but preferred to take it throughout the calendar year and so might not be present every day of each week.

We checked staff files to make sure that the provider made sure that people who worked in the home were suitable to do so. We saw that staff completed an application form, provided two referees, answered interview questions, and undertook a Disclosure and Barring Service check before starting work. Staff confirmed this process to us. We were, however, unable to check that the provider verified nurses' professional registration as none of the staff present at the inspection were able to confirm this or where these records were kept.

We checked five people's medication records and found each person had a clear photograph on the front accompanying their prescription. We found that all the medicine administration records (MAR) sheets were signed and that the prescriptions tallied with the MAR sheets, PRN or "as required" medication was recorded correctly, and that lotions and creams were in date. We checked the controlled drugs cupboard and found all the drugs including patches to be in date and tallied with the amount in the controlled drug recording book. We checked the temperature of the medicines refrigerator and saw that this was correct and that the home was checking this daily. A recent pharmacy inspection had led to the introduction of a maximum and minimum thermometer for this in line with current best practice. We saw that the home had appropriate arrangements for the disposal of used medical needles and other sharp medical instruments.

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission is required by law to monitor the implementation of Deprivation of Liberty Safeguards (DoLS). We discussed the requirements of the Mental Capacity Act 2005 (MCA) and the associated DoLS with the home's management team. The MCA 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. DoLS are part of this legislation and ensure where someone in a home may be deprived of their liberty, the least restrictive option is taken.

We saw that care files contained evidence of consent to specific treatments such as flu vaccination. We also saw an instance of a service user who had been assessed as having impaired capacity to make decisions, where some care decisions such as arrangements for end of life had been signed by a relative but it was not clear whether the relative had the authority to make those decisions for them. Where mental capacity tests were present they tended to be restricted to one general issue rather than to specific elements of care and did not take into account changes in people and proportionality to the actual decision required. Related mental capacity care plans contained standardised wording which was the same from one person to another. We asked the registered manager to review these as well as current "do not attempt cardio pulmonary resuscitation" documentation to ensure that it was valid and recorded how and with whom these decisions had been discussed.

We saw an example where one person who lived in the home had made a request to staff not to use bed rails. There was no evidence of a best interest meeting to support this request. When we talked with this person they told us that they aspired to moving on from the home although this did not appear to be part of their care plan. We were concerned that there was no evidence that DoLS had been considered and an application made to the local authority for the appropriate authorisation. We were told that a number of people living in the home were living with dementia and in several care files there were references to safeguarding them with the provisions of the MCA. However we were told that the home had made no applications for authorisations under the Deprivation of Liberty Safeguards.

We were concerned that given the level of care and supervision that many people living in the home would require and the restrictions on their movements provided by, for example, the external doors to the home being code locked, that people were not being given the appropriate safeguards provided for by legislation.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People must not be deprived of their liberty for the purpose of receiving care and treatment without lawful authority.

Another person told us that they were required to have bed rails even though they would prefer not to have them. We discussed their reasons for this and possible explanations for the home's actions. This person told us that they understood the risks and would still prefer not to have bed rails in use. Although there was a mental capacity assessment in this person's file it seemed to have been undertaken when the person was new to the home. It cited this newness to the home as the reason why this person could not make certain decisions. These reasons continued to be cited in subsequent reviews although they are not valid grounds to declare a person's mental capacity impaired. During our discussion we found the person able to express their choices on this matter clearly. This person should either have been asked to consent to the use of bedrails to which they could decline or if, following a valid mental capacity assessment their ability to make this decision was impaired, then a best interest decision should have been made and recorded.

We undertook our SOFI observation in the smaller lounge on the second day of our inspection. This was interrupted when we witnessed staff trying to carry out a medical procedure against the person's wishes, causing pain and distress. It was clear that this person did not consent to this procedure. We reported this matter to the registered manager immediately as well as to the local safeguarding authority and have asked the registered manager for a full report on developments after our inspection.

These issues were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment must only be provided with the consent of the people who lived in the home. It was also a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which defines abuse as any situation where a person's liberty of movement is restricted, whether or not they resist this.

Requires improvement

Is the service effective?

We saw that at 8am the night staff were being replaced by the dayshift and that there was a handover meeting where key information about people who lived in the home was exchanged and any significant events noted. We saw that the home management made specific allocations of staff to areas of the home as well as to the people who lived there including which staff should work together.

At around 8.20am we saw the kitchen assistant providing the new menu for that day where people could see it. They told us that each day people were asked for their lunch choices and again in the afternoon for their choices for teatime. We saw that there was a menu displayed in the main entrance to the home but we could not reconcile this with the dishes being served on the second day of our inspection. One of the reasons for this was that the menu provided the meals scheduled for the whole week. We found it difficult to use this to identify what was being provided on the day of our inspection and think that people who used the service would do so as well. In any event we were told that the dishes served on the second day of our inspection did not match the menu because last minute availability of seasonal produce had led to alterations.

We spent time talking to the cook and her assistant in the kitchen. The kitchen appeared clean, well-equipped and organised. The cook showed us that there was a four weekly menu which differed depending on the season. People were offered a choice of what they could eat. The cook displayed a good knowledge of the special diets which some people required. The cook maintained their own training records which demonstrated that this was up-to-date. The cook showed an awareness of the requirements of recent food hygiene inspections and showed us how they had responded to these. The kitchen had recently been rated with the maximum score for hygiene by the local authority and it was clear that the cook was keen to respond to the changing and different tastes of the people who lived in the home.

Opinions were variable about the quality of food at Clumber House Nursing Home. One person told us “The food looks delicious” and another person said that they “Enjoyed lunch” but left quite a lot of it because the portions were too large. A third person said “I think the food is good”. Other comments included “I would not rave about it (the food)”, “Not bad”, and “Not very good – sometimes okay”. This last person told us though that they often asked and received an alternative dish if they did not like what was on the menu.

We saw that most people were served lunch in the lounge eating from individual tables. We were told that people preferred not to eat in the dining room but we saw that it was small and could not have accommodated even half of the people living in the home at one time. Although five people ate their lunch in the dining room on the first day of the inspection, none did so on the second day. When people did use the dining room food was first plated up in the kitchen rather than people being able to choose the quantities they wished, the table was not laid and a menu was not provided for them. This provided a functional rather than a pleasurable or social occasion. The only menu in the room related to another event on another day some weeks before and which had passed. We did not feel that people were being offered a genuine choice as to where or how they ate because of these arrangements.

We saw that staff responded to individual preferences for example by making food available so that people could “snack” when they preferred this to joining in at formal mealtimes. Drinks were offered at various times throughout the day and fresh fruit was available from a dish in the main lounge. We were told that only biscuits were served with the evening drink and two people who lived in the home complained to us about the lack of other evening snacks

Mandatory training such as health and hygiene, moving and handling and dementia awareness were organised by the home and provided by an external training agency. We saw that staff undertook an assessment at the end of each part of the training to demonstrate that they had understood it and this was then filed on each member of staff’s personal file. Some other elements of training were separately organised by the registered manager. When we talked with staff they confirmed that they undertook training in areas such as infection-control, health and safety, risk assessment, food hygiene, safeguarding and fire safety.

Staff also told us that they had undertaken induction training and that this had included training relating to safeguarding and whistleblowing. Staff told us that they had completed this training within the last year and that there were was additional training in dementia care as well as resuscitation.

Requires improvement

Is the service effective?

Some staff also identified that they had received training in the Mental Capacity Act and DoLS in the same period. However not all staff we talked with were confident in talking about this training which we were told was provided via elearning. We could not reconcile this with the records we were shown which showed that all care and nursing staff had completed this training in the previous few weeks. Given the issues we found in the home relating to consent and to DoLS we suggested that the registered manager urgently reviewed this area of training to make sure that it was effective.

We saw that a number of staff had National Vocational Qualifications at level II and at level III. One member of staff told us that they felt there was a lot of training provided and that they particularly appreciated the opportunity to pursue NVQ.

We found it difficult to reconcile some of the other different training records. The training matrix was confusing. In some instances dates did not tally with either individual training records or certificates. There were two different versions of the matrix and the key to the names differed between them so that it was impossible to reliably establish from these records which training had been completed. When we followed up on medicines training we were told it had been completed recently in April 2015 but no certificates had been received and the records we saw gave the most recent data was February 2014. We were shown the up to date certificates on the second day of our inspection. The fact that training for the nursing staff was managed and recorded separately to training for the care staff made the position more complex. We have commented further on the adequacy of record-keeping in the home in the well-led section of this report.

We were told that the home received general practitioner services from a single local practice which we were told visited every Monday. The registered manager told us that she felt this provided people who lived in the home with good access to medical care. We also saw from the care files that people received support from community professionals such as a speech and language therapist and one person told us about their involvement with a local authority social worker. Staff told us that they felt the support for people living at home with dementia was good and that they could call upon the local community mental health team who would allocate a community psychiatric nurse if required. We saw an example of where the home had asked for specialist advice and had responded to this advice by changing the person's care arrangements accordingly.

We recommend that the registered manager considers ways in which people can be offered more informed choice over what they eat and where they dine.

Requires improvement

Is the service caring?

Our findings

One person told us that the care in the home could be variable. They said of the staff "Some of them (staff) are very good". A relative told us that their relative was cared for well – "They are very well looked after". This relative told us that they were very satisfied with the standard of care, that "Personal hygiene is good" and that they were involved in care planning. They told us that the staff were approachable and responsive to any concerns expressed.

However two people were not so positive when they talked about staff – one told us they had experienced occasional rudeness from some staff if any aspect of care was questioned and another said that "The staff are sometimes a bit rude if complaints are made" and told us they thought that one member of staff was "Very bossy" and could be "Quite nasty". Two people told us that there could be delays in staff responding to requests with toileting. We discussed these comments with the registered manager who told us that she monitored the call bell system and did not agree that there were delays. We noted that the call bell system was quite a new model and could provide electronic intelligence for the registered manager to monitor this. Although we did not observe any delays during our inspection the registered manager agreed to investigate these concerns and the opportunities afforded by electronic monitoring.

We saw that staff were often caring in their approach and spoke with people in a respectful way responding to their compliments and thanks with phrases such as "You're welcome". We saw that staff knocked on people's bedroom doors before entering. We noticed that when domestic staff entered a person's room to clean it they knocked before entering and then engaged with the person in friendly chat which was obviously enjoyed by both parties. It was evident that the staff group and the people who lived in the home were on friendly and familiar terms with each other.

However we were concerned to see that certain care tasks were carried out in the lounge where other people could observe them. One instance involved a procedure to which the person did not consent. Staff continued to undertake the procedure in front of the other people in the lounge including ourselves even though the person themselves was unwilling to receive it and protested. This meant that other people witnessed their distress. This compromised that person's dignity and privacy and was unpleasant and distressing for the other people to watch.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who lived in the home must be treated with dignity and respect.

We saw that one person had brought their cat with them when they were admitted to the home. The cat was allowed to roam throughout the home and we could see that it had become something of a family pet for the benefit of all the people living there.. The home advertised a policy of "pets allowed".

One relative told us about a person who had been admitted from another home a few months before our inspection. They told us that they were very happy with the progress their relative had made in the home and felt that the care provided had stopped their relative's condition from deteriorating. This relative told us that they felt that the home involved them whenever they visited. A second relative we spoke with also said that they were involved in care planning but a third told us they could not remember ever being asked about their relative's care plan.

We saw that each bedroom had a copy of a service user guide which provided information about the home. This included assurances that personal preferences would be recorded but we did not often see these reflected in care plans. The complaints and comments procedure contained in the service user guide was out of date and gave the name of the nominated individual of a former company as well as referring people to a former regulator no longer in existence.

We looked at a number of care plans and then talked to staff about how well they knew the people who lived in the home. We found the staff had a good understanding of people's needs and could explain to us how they provided care which reflected these, making adjustments where these were required. We talked with the people who lived in the home and found that the information contained in the care files and knowledge displayed by the staff accurately reflected them. Not all the people living in the home we spoke with were aware that they had a care plan, however. It was not always clear that people had

Requires improvement

Is the service caring?

consented to their plans or had contributed to them. The registered manager showed us how she endeavoured within care plans to obtain a signature from a relative that they had been involved in or knew about a care review.

We saw that people's confidential care files were kept in a lockable cabinet in a corridor outside the registered manager's office but close to some bedrooms and so accessible to visitors if it was not secured. Although this provided easy access for staff to the information they required we noted that although the cabinet door was closed it was not usually locked and therefore personal information could be accessed by unauthorised persons.

On the second day of our inspection we made sure that each time we accessed a file from the cabinet we closed the door. However when we returned we found the door had invariably been left open again by staff. We found instances where personal care charts were left in open view in corridors rather than in people's bedrooms. In one instance this included on the visitors book meaning that everyone entering the home could read it. We saw that the care supervisor's work station was located in the same corridor as the files. This meant that any information such as on the screen of the care supervisor's computer would be visible to people passing by.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's records of care and treatment were not maintained securely.

With saw that most care staff treated people in a dignified and respectful way. We asked staff about other ways in which they promoted people's privacy and dignity. They told us they did this by making sure that people had choices and that they listened carefully. They told us that they would take steps to provide personal care in private and never in public.

We saw that most people got up in the morning and gathered in one of the two lounges whilst some people preferred to remain in their rooms. We asked some of the people who were up earliest if this was their preference and they confirmed that they like being up and about at this time.

The registered manager told us that home had resumed working towards achieving the Gold Standard Framework in end of life care as part of the Care Homes Quality Hallmark Award.

Requires improvement

Is the service responsive?

Our findings

Clumber House Nursing Home was described to us as a home primarily for people with physical disabilities rather than one specialising in people living with dementia. Where people were living with dementia they were usually living in the home primarily because of their physical care needs. Nevertheless there were people living in the home who were living with dementia and we saw that for some people this had been the main reason for admission. We therefore looked to see how the physical environment and other arrangements in the home had been adapted to meet their needs.

There are 32 bedrooms in the home all of which are single with 28 having ensuite toilet facilities. The rooms each have a TV point and emergency call points. The bedroom accommodation is on two floors with access between provided by use of a passenger lift. The home's website states that people who live in the home may bring their own furniture. There is a level spacious garden at the side and rear of the home with disabled access provided via a ramp from the dining room and lounge.

We saw that the activities organiser had started to personalise the environment in the main corridor by using a life history notice board which featured photographs and items of interest about people who lived in the home. However we did not see evidence of other adjustments which could have been made to the environment such as the use of memory clocks in the lounges. Signage to help people to find their way around was variable in the home and although there were photographs on bedroom doors, people's names or other memorable items which could help them to find their way around were not displayed alongside them.

We looked at the arrangements for care planning in the home. We saw that the care plans covered major areas such as nutrition, mobility, pressure care, choice, continence, hygiene and oral care. We saw that these had been reviewed on a monthly basis and that the care plan as a whole had been reviewed as well. We saw that a daily report was kept on all care provided in the home and that this was used to update the care plan. We found that the care plans we checked were all up-to-date. Additional charts recording personal care such as positioning were placed in each bedroom.

We noticed that on some of the care plans a life history form had been completed so the care could be tailored to meet individual characteristics and preferences as well as life experiences. However it was not clear to us how this information was used to make the care more person-centred which is particularly important when providing care for people living with dementia. We did not understand why it was not available for every person living in the home.

We checked other records such as of bathing in the home. We were told that people should receive bathing at least weekly but we could not reconcile this with the records that we were shown. The manager told us that this because of poor record keeping and that everyone was bathed except where they refused. We have commented further on the adequacy of record-keeping in the home in the well-led section of this report.

We spent various periods of time in the two lounges which are provided in the home. We visited the smaller lounge and saw that people were comfortable. We saw only limited interaction between staff and the people who lived in the home although at one point the deputy manager came into the lounge with a small dog and a family member and went over to one person and had a conversation. On the second day of our inspection the television was on but it was not working properly and would have been very difficult to watch. We found the indistinct picture and sound irritating even for a short period. We pointed this out twice to staff who said they could do nothing about it as the handyman was not at work that day. Although not working properly the television remained switched on. Part way through the morning a part of the lounge was cordoned off so that some people could participate in relaxation therapy.

We visited the larger lounge on both days of our inspection. The furniture in this lounge was arranged on the edge of the room and therefore was not conducive to conversations between the people who lived in the home. We saw that the activities organiser held a type of quiz session in the morning on the first day and a similar activity on the second day. The activities organiser took steps to make sure that people understood that participation was voluntary. However when the activities organiser was otherwise occupied most of the people in this lounge were

Requires improvement

Is the service responsive?

either asleep or sitting in their chairs and had very little to occupy them. Some people told us they preferred not to use the communal areas and were not interested in activities.

We saw that some people were able to leave the home and go for shopping trips and to visit the local community. We talked with the activities organiser for the home and found them to be enthusiastic about improving activities. They had undertaken a national vocational qualification in understanding dementia which they told us they found very helpful. They were keen to learn more and develop the role further. They told us that they regularly took some residents to the local shops and organised the relative support group. We also saw that they provided hand massages. The activities organiser pointed out that some people did not wish to engage in activities and would not always allow carers to help them but sometimes they would listen to music in the lounge with the stimulation lamps on.

The activities organiser told us that knowing the person's background history, their likes and dislikes was the key to good dementia care, and the home was just beginning to get to grips with this. They were hoping for support from the registered manager to engage with people's families more to help fill in their personal profiles.

We saw that people were able to exercise choice about where they went in the home and choose between lounges, using the dining room or remaining in their bedroom. If people did not wish to get up until later in the day they were able to do so.

We saw that a residents' meeting was taking place on the first day of our inspection. This was chaired by the activities organiser. Only three people chose to attend and raised issues relating to doors slamming at night, delays and being helped the toilet and issues surrounding laundry. We saw the minutes of previous meetings for the past few months. It was not clear to us what action the home had taken to respond to the concerns raised or to communicate this to the people who lived in the home.

We recommend that the registered provider develops a greater choice in activities available for people who live in the home particularly at times when the activities organiser is otherwise engaged on more individual tasks.

We recommend that the programme of activities is better informed by person-centred information gathered about each person's individual preferences and life history.

Requires improvement

Is the service well-led?

Our findings

Opinions amongst people who lived in the home about whether it was well-led were variable. One person said it was "Well run" and another that it was "Well run but with some reservations". Another person told us "The management is not good, it's not a good team, and "The manageress (registered manager) is only here a couple of days a week".

We were told that some months previously there had been a major upheaval in the management of the home when the current registered manager had left. Around the same time a number of other staff left also. When the registered manager returned so did the other staff. It was clear that the senior staff represented a stable management group who knew each other and the home very well. One member of staff told us that they enjoyed working in the home and that "It feels much better than a few years back when staffing was inadequate".

Staff told us "Everyone gets on well here – we all work as a team" and that Clumber House Nursing Home was "Like my second home". The staff were organised into two groups with the nursing staff supervised by qualified nurse and care staff supervised by the care supervisor. We saw that there was a positive working relationship between the registered manager and the two supervisors. All the staff we spoke with confirmed that they received supervision and that there were arrangements in place for annual appraisal.

We saw the home had a number of audit systems in place intended to assure the standard of service to people who lived in the home. These included audits of medication and care plans as well as falls and infection-control audit. These audits were not filed in date order and were found in in different places. This made it difficult to check whether or not the audits were up-to-date or being completed regularly because the most recent ones were not always obvious. We were eventually able to ascertain that they were up-to-date but only after the registered manager found further completed documents in another file which allowed us to complete our inspection. This made it difficult to obtain a comprehensive picture of how the home was performing overall.

When we looked at the monthly audits of care plans we found that the same information and the same action plans were being transferred from one month to the next. We asked the registered manager to review this practice as it suggested that the audits did not provide a thorough check on the quality of the care plans. The manager also showed us how she kept a record every three months of whether care plans were updated and if they were not she would discuss this with the relevant nurse. We also found maintenance and inspection records relating to the physical aspects of the home such as the electrical and gas systems, fire alarms and lifts.

We were provided with a full set of policies covering key areas of activity in the home. All had last been reviewed in October 2014 and were identified for the next review in October 2015. All these policies and procedures had been signed by an officer of the company which owned the home. However we were concerned at the discrepancy between some of these policies and the practice we observed. For example the home's policy on the use of bedrails required that the person concerned consented to this practice, but we found evidence that this was not the case. The policies made several references to the use of Deprivation of Liberty Safeguards but these arrangements had not been made for any of the people living in the home who might have needed their protection. The policy for dementia care made reference to the guidelines issued by the National Institute for Care and Health Excellence (NICE) but we saw instances of lack of privacy, inadequate staff attention, poor communication between the person living with dementia and staff, and conflicts between staff and carers, all of which are cited by NICE as requiring attention as part of the guideline.

The policies appeared to be drawn from a standard set designed to be adapted to each home which used them. This meant that they had spaces which would allow them to be adapted to local circumstances. We found a number of gaps. For example the complaints policy did not identify who the responsible complaints officer was and the space for the name of person responsible for conducting disciplinary hearings was not complete. This would limit the usefulness of these policies to staff who consulted them.

Taken together with other references in this report relating to training, bathing and other records this was a further breach of Regulation 17 of the Health and Social Care Act

Requires improvement

Is the service well-led?

2008 (Regulated Activities) Regulations 2014. Adequate systems and processes were not in place to allow the assessment, monitoring and improvement of the quality and safety of the services provided.

We looked at the quality surveys which had been completed in February and March 2015. The majority of them were positive giving the home either excellent or good ratings. The questionnaires had been completed by family members and people who lived at the home. However the twelve questionnaires completed by people who lived at Clumber House Nursing Home were not dated.

The questionnaires were a tick box with excellent, good, satisfactory, poor and space for comments. One comment included 'At present very satisfied with the care my relative is having.' Another person wrote "Home is managed well, always a pleasant welcome. Has greatly improved since the Matron came back".

One person stated that they regarded involvement in care planning as "Poor" however another wrote that they were involved with the care plan and decision making. Other comments included "Management approachable, friendly, helpful, queries dealt with efficiently, made to feel welcome, clean, express views, staff courteous and helpful and independence adequately promoted". However one person we spoke felt that they did not see the manager and did not really know her.

The registered provider and registered manager are each required to notify the Care Quality Commission of certain incidents which take place in the home but have not informed us about the events which we observed during this inspection. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 which requires registered persons to notify the Care Quality Commission of certain significant events.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People who lived in the home were not treated with dignity and respect.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **People's records of care and treatment were not maintained securely. Systems and processes were not established and operated effectively so as to assess, monitor and improve the quality and safety of the service provided and to assess, monitor and mitigate the risks relating to the health, safety and welfare of people living in the home and others.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The registered person did not notify the Commission without delay of incidents specified in the relevant regulation.**

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 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People were given care and treatment without their consent. Where a person was unable to give their consent the registered person did not act in accordance with the Mental Capacity Act 2005.

The enforcement action we took:
We have served a warning notice to be met by 1 October 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The Registered Provider had not established and operated effective systems to investigate, immediately upon becoming aware of, any allegation or evidence of abuse. People were deprived of their liberty for the purpose of receiving care and treatment without lawful authority.

The enforcement action we took:
We have served a warning notice to be met by 1 October 2015.