Avalon Nursing Home (Dorset) Limited

Avalon Nursing Home

Inspection report

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Ratings

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

Overall summary

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, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection carried out on 13 and 22 and 23 October 2014. At the last inspection in August 2014 we found a breach of regulations relating to the care and welfare of people, respecting and involving people and assessing and monitoring the quality of service.

An action plan was received from the provider which stated they would meet the legal requirements by 30 September 2014.

Summary of findings

At this inspection we found they had failed to make improvements. We have taken enforcement action against Avalon Nursing Home to protect the health, safety and welfare of people using this service.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

Avalon Nursing Home is registered to provide personal care for up to 18 people. Nursing care is provided. There were 17 people living at the home when we inspected. There was no registered manager in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Staff did not always treat people with dignity and respect. Staff knew people's care needs and some personal information about them. We saw good relationships and interactions between some staff and people.

People's need for social stimulation, occupation and activities were not consistently met.

People's care and monitoring records were not consistently maintained and we could not be sure they accurately reflected the care and support that people needed and was provided to people.

There were poor arrangements for the management and administration of medicines that put people at risk of harm. One person did not receive their medicine as prescribed by their GP.

Staff did not have the right skills and knowledge to provide personalised care for people living in the home. This was because they did not always receive a full induction into care, the right training or regular support and development sessions with their managers.

The provider did not always comply with the Mental Capacity Act 2005, which included how to assess people's capacity to make specific decisions.

Policies about keeping people safe and reporting allegations of abuse were generic and we found one instance where the safeguarding policy had not been followed. Staff training records indicated that not all staff had received safeguarding training

The systems and culture of the home did not ensure the service was well-led. This was because people were not encouraged to be involved in the home, they were not consulted, staff were not consulted and the quality assurance systems in place did not identify shortfalls in the service.

Staff were recruited safely to make sure they were suitable to work with people. There were regular staff meetings and handovers to share information between staff.

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 

People were not kept safe at the home.

Care was not always delivered in a way which protected people. One person was observed being assisted to eat whilst lying down. This was contrary to their care plan and placed them at risk of choking.

Systems for the management of medicines were unsafe and did not protect people using the service.

Despite safeguarding procedures and training not all staff knew and understood when and who they needed to report allegations of abuse to.

Staff were recruited safely and there were enough staff to make sure people had the care and support they needed.

Is the service effective?

Inadequate 

People's needs were not effectively met. This was because staff did not have the right skills and knowledge, training and support.

People's rights were not effectively protected because staff did not understand the implications of the Mental Capacity Act 2005.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

People's day to day health needs were not always met.

Is the service caring?

Requires Improvement 

The service was not always caring. Some staff interactions were positive and we saw people benefitted from these good relationships. Other staff did not promote people's independence or respect their wishes.

Is the service responsive?

Inadequate 

The service was not responsive. People did not always have their individual needs regularly assessed and consistently met.

People's need to be meaningfully occupied and stimulated was not consistently met.

Arrangements were in place to share information about people's needs when they moved between services.

Is the service well-led?

Inadequate 

The service was not well led.

There were ineffective systems in place to monitor the quality of the service and drive forward improvements.

Summary of findings

The leadership was not always visible in the home.

Accidents/incidents were not fully investigated in order to prevent reoccurrence.

Avalon 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 checked 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 13, 22 and 23 October 2014 and was unannounced. There were two inspectors in the inspection team. We spoke with and met eight people living at Avalon Nursing Home. Because some people were living with dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with three visiting relatives during the inspection. We also spoke with the manager, clinical compliance executive matron, training manager and four staff.

We looked at five people's care and support records, an additional two people's care monitoring records, medication administration records and documents about how the service was managed. This included staffing records, audits, meeting minutes, training plans, maintenance records and quality assurance records.

Before our inspection, we reviewed the information we held about the service. This included the information about incidents the provider had notified us of.

We did not ask the provider to complete a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they planned to make. This was because we had planned to carry out a focussed inspection to follow up breaches of the regulation identified at the last inspection. However due to the shortfalls identified on 13 October, we returned on 22 and 23 October 2014 to gather further information and completed a full inspection at the home.

Is the service safe?

Our findings

The service was not safe.

Most people, who were able to tell us about their experience of the home, told us they felt safe at Avalon Nursing Home. One person said: “I feel safe here and looked after. When I first came here I wasn’t planning on staying for good, but I liked it here so decided to sell my home and stay”. Another person, however, told us that they did not always feel safe. They said that they “dreaded it” when staff assisted them with personal care, as it was "rushed" and they were "manhandled", which caused them pain. They told us that they had a painful right leg, but staff would forget and touch it, which caused them pain. We looked at this person's care plan contained no information regarding their painful right leg. We discussed this with the clinical compliance executive matron who told us that they would speak with the person about this and arrange for the GP to visit them. They also told us that they would raise a safeguarding alert with the local authority.

One person was at high risk of aspiration (choking). Their file contained a safe swallow plan by a speech and language therapist which stated, "Ensure patient is sitting upright for all food and drink.” However, during the lunchtime period of the first day of our inspection, we found that a member of staff was assisting the person to eat whilst they were reclined on their side. The member of staff told us, "[person] won't sit up. This is the only way I can feed [person]." We discussed our concerns with the clinical compliance executive matron who told us that they would investigate and raise a safeguarding alert with the local authority. This person also required thickened fluids. Instructions contained in the person’s safe swallow plan stated that fluids should be of a ‘custard consistency’. We checked this person’s fluids in their room during the second day of our inspection and found that the fluid was not of this consistency and was very runny. This meant that the person was at risk of aspiration and choking as they had not been positioned correctly or received fluids of the appropriate consistency to reduce this risk.

We observed one person in a wheelchair being pushed out of a lift by a member of staff. The member of staff was struggling to push the person out of the lift and repeatedly hit the person's knees and feet against the lift door that was closing. We saw that after several attempts, the person’s feet fell from the wheelchair’s footrest, which may have caused injury to the person.

These shortfalls in the planning and delivery of care were a repeated breach of Regulation 9 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider also had not complied with this regulation at our previous two inspections in June and August 2014.

We saw that all of the people living in the home had a personal evacuation plan so that staff and emergency services knew how to safely support the person in an emergency.

The provider did not have suitable arrangements in place to ensure that service users were safeguarding against the risk of abuse. One person had multiple large bruises upon their admission to the home. Staff had recorded these bruises on a body map and taken photographs of them. However the origin of these bruises had not been investigated and a safeguarding alert had not been raised with the local authority. We discussed our concerns with the clinical compliance executive matron who confirmed that the bruises should have been reported and they would raise a safeguarding alert with the local safeguarding team.

Records showed that eight of the 44 staff employed had not received safeguarding training and a further nine members of staff had not received safeguarding training for over a year. This meant that some staff may not have the knowledge or skills to ensure that people in the home were safeguarded against the risk of abuse. We spoke with two members of staff on duty during the inspection who told us that they had received safeguarding training and were able to tell us the different types of abuse a person could be subjected to and steps they would take if they thought a person was being abused.

This was a breach of Regulation 11 (1) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to safeguarding people who use the service.

We looked at medicines plans, administration and monitoring systems in place for people. Medicines were not always given as prescribed. One person had been prescribed medicines for pain relief. They did not receive their medicines on five occasions over two days as the

Is the service safe?

provider had run out of stock. This meant that they might have experienced pain. The provider's medicine policy stated: "Stock is checked weekly by the nurse in charge/ manager/nominated senior staff." However we found no records to show that this was taking place.

Staff had not received adequate training and competency assessments to ensure the safe management of medicines. Only three of the seven registered nurses responsible for administering medicines had received training within the last 18 months to two years. Competency assessments had not been carried out and we confirmed this with the training manager. This meant that people living at the home and the provider could not be assured that staff had the necessary skills and knowledge to administer medicines safely.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that general medicines were stored appropriately in secure lockable cupboards. We saw that for medicines that were required to be kept cool a fridge was being used. We saw that the fridge temperatures were recorded daily to ensure it was working effectively.

We found appropriate arrangements were in place for the management of controlled drugs which included the use of a controlled drugs register and separate storage from other medication. We carried out a check of stocks and found it corresponded accurately with the register.

We looked at five staff recruitment records and spoke with one member of staff about their recruitment. Recruitment practices were safe and relevant checks had been completed before staff worked with people. This made sure that people were protected as far as possible from individuals who were known to be unsuitable to work with vulnerable adults.

People and relatives said there were enough staff. We looked at the staff rotas covering a period of three weeks and saw that there was a minimum of five staff on duty in the morning and the evening which were the busier times of the day. However, the manager was not able to evidence how staffing levels were calculated and whether it was based on people's individual needs. This meant that there was not a system in place to ensure that staffing levels were reviewed and adjusted to meet people's needs.

Is the service effective?

Our findings

The service was not effective

One member of staff told us they were unable to recall the last supervision meeting that they had with the acting manager or other senior staff. Another member of staff told us that they had not received an induction when they first started working in the home. There were 44 staff employed by the service. We looked at the provider's supervision file and saw that it contained records of seven supervisions and two probationary reviews that had taken place between the 1 January 2014 and 23rd October 2014. The provider's supervision policy stated that all staff should receive formal supervision at least six times per year.

One of the supervisions that took place in July 2014 identified the need for further training in moving and handling and professional boundaries for one member of staff. The following supervision with this member of staff identified that they also required training in deprivation of liberty safeguards, fire prevention, infection prevention and control and hydration and nutrition. However, during our inspection we found that these training needs had not been addressed.

One member of staff who commenced employment in April 2014 had 21 different areas of training to undertake. However we found that they had only completed five all of which were all on the same day in April 2014. This member of staff had not received training in: person centred care, safeguarding, Mental Capacity Act 2005, health and safety, fire safety, dementia awareness and medicines.

None of the staff employed by the home had completed First Aid training. We discussed this with the training manager who acknowledged this and confirmed that this would be looked into.

This was a breach of Regulation 23 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staff did not receive adequate supervision, appraisal and training to enable them to fulfil their roles effectively.

We looked at the care records for six people. One person's care records stated they were required to be repositioned four hourly to prevent skin breakdown. The "24 hour care record", for 20 October 2014, showed that the person was not repositioned for a period of six hours. The record for 22 October 2014 also showed that the person was not repositioned for a period of 10 hours. This meant the person was at risk of unsafe or inappropriate care because the records did not show that they had received the support required to meet their needs.

Staff recorded people's weights on a monthly basis. However we found inconsistencies in the weights recorded. For example, one person's care plan indicated that they had lost 6kg during the past month. The care plan had been reviewed and staff had been instructed to change the mattress that the person used. However we saw another weight record which showed that the person had not lost any weight. This meant the person was at risk of unsafe or inappropriate care because their care records contained conflicting information.

This was a breach of Regulation 20 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

We spent time talking to people and observing the care and treatment people received in the home. We found that people were not always cared for in a way which promoted their welfare and safety. At 13:55 one person had a cushion, placed behind their back. They were asleep pushed forward in their seat, and were at risk of falling forwards from their chair. They still had their soiled clothes protector on from lunchtime. We raised our concerns with staff. On the second day of our inspection, during the afternoon, this person again, had a cushion behind their back and was at risk of falling forwards from their chair.

People who used the service and relatives told us about the food provided. Feedback received was positive. One person told us, "The food is good, I've got no complaints." Another person commented, "The food is lovely." People told us they got choice at mealtimes. One person told us, "If I don't like something I can always ask for something else."

The home had a four week menu rota. Analysis showed that whilst people were given some choices, some of the lunchtime meals did not contain sufficient variety. For example, for 11 of the days rota, the main meal choices were shepherd's pie or spaghetti bolognaise, beef casserole or beef curry, battered cod or fish pie and chicken casserole or sweet and sour chicken.

The provider had not made suitable arrangements to implement or work in accordance with the Mental Capacity

Is the service effective?

Act 2005. One of the five care files we looked at stated that the person had bed rails fitted to their bed. Their care plan stated that they had an appointed IMCA (Independent Mental Capacity Advocate). There was no capacity assessment on file for this decision and the IMCA had not been consulted about the decision. There was no information to demonstrate that the service had taken any steps to work in the person's best interests. We saw this person also had a DNAR (Do not attempt resuscitation). We saw that there was no record on their DNAR form to show whether they or their IMCA had been consulted in this decision to ensure that it was in the person's best interests. This meant that the provider had not acted in accordance with the Mental Capacity Act Code of Practice.

We saw that a second person had a "do not attempt resuscitation" (DNAR) form on their file which had been signed by their GP but was incomplete. It contained no information to show whether the person, their relatives or friends had been involved in the decision. Therefore this form may have been completed without consulting the person, or their representatives.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service was not meeting the requirements of Deprivation of Liberty Safeguards. The manager had some understanding of who had restrictions placed on them and we found that they had made applications for these to be authorised under Deprivation of Liberties Safeguards (DoLS). However we found one person who lacked capacity to make decisions about their care and treatment had a specialised chair in their bedroom, which meant they would have been restricted from getting up independently. There was no assessment in place to demonstrate that use of this chair was in their best interest.

Is the service caring?

Our findings

The service was not always caring.

We spoke to one person who was visibly distressed. They told us a member of staff had taken their chewing gum without their consent. We asked this person what reason the member of staff had given for doing this. They told us, "[staff member] said it was a choking risk, but it's not, I chew gum all the time and I've never choked, it keeps my mouth moist and clean, I can't understand it." We looked at this person's care plan which detailed that the person had capacity to make decisions. The removal of this person's chewing gum by a member of staff did not respect the person's wishes or independence.

People were involved in planning and making decisions about their care and support on admission to the home. There was little evidence to show people's involvement following this. The provider's quality assurance policy stated, "The home seeks the views of its service users, relatives, and others involved in a person's care through regular meetings." Care plans were reviewed on a monthly basis but there was no record to show that people had been involved with this process. Two people in the home who told us that they were not involved with their ongoing plan of care.

People's preferences and life histories were documented in their care plans. However, not all preferences were recorded and some staff did not know people's preferences, likes and dislikes. For example, we saw that one person had been given a drink of tea without giving them a choice of how they preferred it. When the member of staff returned, they told the member of staff, "I can't drink this; it's got no sugar in it". This demonstrated that staff did not always know people' personal preferences or check this with them.

One person being assisted to eat in bed. We saw that they were not appropriately positioned. When we asked the member of staff supporting them about this they told us, "She is like a monkey this one, she slips down." This was disrespectful to the person.

These shortfalls in respecting and involving people were a repeated breach of Regulation 17 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider also had not complied with this regulation at our previous inspection in August 2014.

Throughout the inspection we observed staff interactions with people in various parts of the home. We saw that most staff interaction with people was positive. Staff respected people's privacy and dignity, such as ensuring that privacy screens were used when people required hoisting and knocking on people's doors before entering. During lunch we saw that staff interaction with people was positive. Staff encouraged people and offered food at a suitable pace, waiting for them to finish the previous mouthful.

Four people who told us that staff treated them with dignity and respect. One person said, "They are lovely." Another person told us, "The girls are nice, there are no problems." All of the relatives whom we with spoke with told us the staff were caring. One person told us about the system they had in place with staff as they liked to get up early in the morning.

Information about people was not always treated in a confidential way. On one occasion we saw people's personal records had been left out on a fire mantle in the living room. We saw that when staff wished to discuss a confidential matter they did not do so in front of other people who lived at the home. We observed bedroom and bathroom doors were kept closed when care was being provided.

Is the service responsive?

Our findings

The service was not responsive.

All of the care plans we looked at were reviewed monthly. Some people's choices and views were reflected but there was a lack of evidence to show how people had been involved in ongoing decisions about their care.

One person's care plan contained personal care details for another person. The 'mobility' section of the care plan gave the name of a different person who lived in the home. The care plan also stated that the person was at high risk of falls and required a "strap to aid the prevention of falls from [wrong person's] wheelchair." We spoke with this person and looked at their wheelchair, and saw that there was no strap in place. We later found that this part of the care plan related to another person living in the home. It was therefore not clear whose needs the care plan reflected putting both people at risk of inappropriate care.

Another person who told us that they felt embarrassed when their personal care was delivered by male members of staff, and would prefer to receive personal care from female staff. We asked them if their preferences had been discussed with them and they told us that they had not. On the day of our inspection there were four female members of staff on duty. We looked at this person's care plan and found that there was no record of preference regarding their care needs.

During our inspection we found that the activities coordinator had left the employment of the home on the 6 October 2014. We saw that there was a reliance on this person to organise and run activities. One person told us that since the activities coordinator had left, there were no activities to keep them occupied. They told us: "All I can do is watch TV." For two of the three days we saw no evidence that people were involved with any activities to keep them meaningfully occupied and stimulated. On the third day of our inspection the provider arranged for an additional member of staff from another of the provider's homes to provide activities. We saw that activities were only provided to people in the conservatory of the home. Seven of the 17 people who lived in the home were cared for in bed; we looked at their care plans and saw no records that showed if they were involved with any social activities. We asked the manager to provide evidence that people's social and recreational needs were being met. This was not provided to us during or following the inspection. This meant that people who were cared for in bed were at risk of social isolation and lacked stimulation.

Care plans contained basic information which focused mainly on people's health care needs and provided little information about people's social needs. For example, the 'communication' section in the care plan for one person who was cared for in bed stated: "Likes singing and appears to enjoy 1:1 time with staff." When we spoke with this person they were able to tell us about their interests, such as certain board games, yet none of this was reflected in their records and they told us no one had spoken with them about their care plan. They said that apart from the television there was nothing much for them to do.

These shortfalls in the planning and delivery of care were a repeated breach of Regulation 9 (1) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider also had not complied with this regulation at our previous two inspections in June and August 2014.

People's needs were recognised and shared when they moved between services. Staff and a relative told us that when a person was admitted to hospital staff, provided a referral letter explaining why they required hospital support, a copy of their medicine administration record (MAR), a contact list of people who are significant in their life and information about their diagnoses.

The manager told us no complaints had been received in the last 12 months. We examined the provider's complaints log which corroborated this. We saw that a copy of the complaints procedure was on display in the main hall of the home. People we spoke with told us that they no complaints about the service they received. One person told us, "If I had to complain I would speak to the manager."

Is the service well-led?

Our findings

The service was not well-led. The systems that were in place to monitor the quality of the service and drive forward improvements were ineffective. We found the home was poorly organised and although staff responded to people's needs as they arose, this was reactive rather than proactive and planned.

The home had been without a registered manager since December 2010. This was a breach of the provider's conditions of registration. During our inspection the manager of the home was in the process of applying as registered manager for Avalon Nursing home and its sister home next door. The management structure also included a clinical compliance executive matron to provide additional support to the home.

The management team was not always visible in the home. This did not enable them to observe the day to day culture in the service including behaviours and attitude of staff.

At our previous two inspections of the home in June and August 2014 we found that the provider was breaching Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to assessing and monitoring the quality of service provision and assessing and managing risks relating to the health, welfare and safety of people or others who may be at risk from the carrying on of the regulated activity. At this inspection we found additional breaches of this regulation.

At our previous inspection in June 2014, we found that the provider did not have a Legionella risk assessment and had not undertaken a Legionella test since September 2012. Legionella are water-borne bacteria that can cause serious illness. Health and safety regulations require persons responsible for premises to identify, assess, manage and prevent and control risks, and to keep the correct records. Following this inspection the provider wrote to us and told us that they would arrange for a Legionella test to be completed. At this inspection we found that the Legionella test had been completed on 30 June 2014. We saw that the results showed that one sample was found to contain a non-harmful Legionella species and that the action required was to pasteurise the water system and retest. However at this inspection we found that this had not been completed to ensure that people were not at risk.

All nurses and midwives who practise in the UK must be on the Nursing and Midwifery Council register. They must have a current pin number to prove registration. The home's records showed that five of the seven nurses pin numbers had expired. Of the 14 nursing shifts for the week commencing 20 October 2014, six of the shifts were being led by nurses without current pin numbers. This meant that the provider had not ensured that their nurses were legally able to practise. Following our inspection the provider wrote to us confirming that the seven nurses were on the Nursing and Midwifery Council register.

There was a system in place to report accidents and incidents. Accidents were recorded in a log book. However, records showed that people's care plans and risk assessments were not always reviewed and updated in light of accidents and incidents involving them. One person was recorded as obtaining three large bruises in the same area over a period of three months. The accident record stated that the cause was "unknown". There was no record of any investigation into the bruises, no safeguarding referral and nor was there any action taken to prevent reoccurrence.

Records showed that there was an effective system in place to ensure the premises and equipment was functioning correctly and safe to use. We saw that the fire alarm system, emergency lighting and firefighting equipment were checked and serviced when required. Records also showed that testing of portable electrical appliances (PAT testing) had been carried out within the past year, as well as a gas safety and boiler check.

We saw other health and safety checks in place including checks of the bath hoist, mobile hoists, bed rails, water tank pressure mattress, wheelchairs and call bell. However, the manager could not provide evidence that all the slings in the home were regularly checked and showing their name, size and serial number. This meant that people could be at risk from slings being used that could cause them skin damage, or that could be unsafe.

The home's management lacked understanding of the principles of good quality assurance which meant best practice was not recognised or developed to move the service forward and improve outcomes for people. In addition to this the quality assurance systems had not identified the shortfalls we found during this inspection.

Is the service well-led?

The provider did not have an effective system in place to seek the views (including the descriptions of their experiences of care and treatment) of people using the service, to enable them to come to an informed view in relation to the standards of care and treatment provided and drive improvement.

A resident survey was completed in August 2014; it was sent to 17 people and relatives. A summary report of the findings was then produced and circulated. It gave results in pie chart form and was only the result of the questions with tick box answers. We looked at the original questionnaires. These showed that a number of relatives had used a free text box to raise concerns. We saw that three relatives raised concerns about staff shortages and turnover. Another relative raised concerns about the number of staff on duty at night-time and the lack of transport for trips out. We found that the action plan did not acknowledge these comments or address any of the concerns. We also noted that one relative indicated that they were dissatisfied with the level of cleanliness in the home, however when we looked at the provider's satisfaction graphs, this was not reflected, which meant the graph was incorrect. This did not enable people using the service and others to be actively involved in developing it.

A relative's meeting was held in September 2014 and 16 relatives had attended. We saw that one of the topics that three relatives had raised was the lack of activities in the home and interaction with people. We saw that the response from the provider was to appoint a new activities co-ordinator. However, when we visited the home we found that the newly appointed activities co-ordinator had left the home, which meant people continued to be at risk of social isolation.

These shortfalls in the assessing and monitoring of service provision were a repeated breach of Regulation 10 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider also had not complied with this regulation at our previous two inspections in June and August 2014.

The provider's policies and procedures had been reviewed in July 2014.The provider's safeguarding and whistleblowing policies were generic and had not adapted to reflect the service. They did not contain contact details for the relevant local authority. However these were displayed for staff and others on a poster in the home.

Within the home's employee handbook whistleblowing guidance for staff stated, "Go to matron or the appropriate official organisation or regulatory body". There was no information about who the organisations or regulatory body was or how to contact them and it did not state that staff were legally protected in accordance with Public Interest Disclosure Act 1998. This meant that the provider had not taken steps to ensure that suitable guidance was in place for all staff and that there was reassurance for staff that they could report any concerns without worrying that they will suffer because they are aware of their rights under the Public Interest Disclosure Act 1998. It did not support staff to challenge poor practice including whistle-blowers by ensuring that they are protected.