Topcare Limited

Albany Nursing Home

Inspection Report

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Summary of findings

Overall summary

Albany Nursing Home is a purpose built nursing home. The home is situated in a residential area of Leyton and is close to shops and public transport. The home has three floors each with its own lounge and dining room. On the day we inspected the service had 60 people, of whom 53 were older people some with physical ill health or dementia and seven young physically disabled people. The home is able to accommodate 58 people in single rooms with own or shared en-suite toilets and has one double room with an en-suite toilet.

The service was not ensuring equipment was safely used and suitable for its purpose. We saw staff were using commodes to shower people (a chair that can be used as a toilet or over a toilet). None of the commodes we saw had foot rests, therefore, people were at risk of damaging their feet or legs while being moved in them. These problems were evidence of a breach of a health and social care regulation. You can see what action we have asked the provider to take at the back of this report.

People were not protected from possible infection risks associated with poor cleaning of the environment and equipment they used. Areas of the home were dirty and dusty and equipment aids used by people, including commodes were found to be unclean. These problems were evidence of a breach of a health and social care regulation. You can see what action we have asked the provider to take at the back of this report.

Medicines were not always managed safely. Storage arrangements were not suitable to ensure medicines were kept at the right temperature. Staff were not always recording when they had opened prescribed eye drops, putting people at risk. These problems were evidence of a breach of a health and social care regulation. You can see what action we have asked the provider to take at the back of this report.

Records at the service were not kept up to date or not fully completed, we saw Do Not Attempt Resuscitation (DNAR) forms. These forms record people's views on resuscitation and some of these had not been completed fully. Records of important meetings such as staff meeting were not kept. Therefore the registered manager and the provider were not ensuring accurate records were kept to protect people against the risk of inappropriate care and treatment. These problems were evidence of a breach of a health and social care regulation. You can see what action we have asked the provider to take at the back of this report.

Most of the people we spoke with felt safe at the service, One person said, "My relative feels safe here," another said, "Safe, yes staff seem very alert." However others said, "I feel safe sometimes," another relative said, "People keep coming into my relative's room I worry about that." We received mixed feedback about the care provided to people. Comments included, "I love it here, it's nice and warm, I'm happy" and "The staff love my friend." However other people said, "When I shout for help no one pays attention," and "When I talk, staff interrupt me or ignore me." We spoke with health professionals who supported people at the service who were positive about the care provided.

Most people we spoke with complained about the lack of activities at the home, one person said, "Nothing to do here, but watch TV, but sometimes it's too noisy even for that." While we were inspecting the service we did see people take part in a bowling game and we saw that some ladies had received a manicure from staff.

We saw that the registered manager and the provider did not have effective systems in place to assess and monitor the quality of the service. Audits we reviewed were not effective in identifying issues with medicines, infection control and maintenance of the building. They did not regularly seek the views of people who used the service. These problems were evidence of a breach of a health and social care regulation. You can see what action we have asked the provider to take at the back of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Some aspects of the service were not safe.

The environment in which people received care and the equipment used by people was not always clean. Staff were not using some equipment appropriately and this risked injuring people.

People were at risk of not receiving their medicines safely.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS).

We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards and the Mental Capacity Act 2005.

People we spoke with told us they felt safe in the home and said staff were available to support them when they needed help. Relatives told us that they felt their relative was safe. However other people said they sometimes felt unsafe at the service.

Are services effective?

Some aspects of the service were not effective.

Staff files we reviewed showed that most staff had received supervision in 2014 and were up to date with most training.

People's needs, preferences and choices, treatment and support were not always met. People and their relatives were not always involved in developing care plans.

Important documents were not fully complete, such as Do Not Attempt Resuscitation (DNAR) forms. The registered manager and the provider were not ensuring they had fully discussed people's choices and recorded these effectively so these important choices were known to the staff team and other professionals.

Are services caring?

Some aspects of the service were caring.

We received mixed feedback about the service from people living at the service and their relatives. They told us staff were kind and caring. However others had a different experience. They said, "Staff did not respond to call bells at night," and "The staff are very busy and they rush when they do come to help me."

Summary of findings

Relatives and visitors told us they felt people were well cared for and staff treated people with respect and dignity. We saw staff talking with people before supporting them with their personal care to ensure they agreed to this happening.

Are services responsive to people's needs?

Some aspects of the service were not responsive to people's needs.

Most people and their relatives thought there were not enough activities available. They said that they would like to see more group and individual activities available daily.

Where people were not able to make decisions about their care, staff worked with relatives and other professionals to make 'best interests 'decisions.

We saw that people had their comments and complaints listened to and acted on. All staff we spoke with were aware how to support someone should they wish to make a complaint.

Are services well-led?

The service was not well led.

The registered manager and the provider did not have effective systems in place to assess and monitor the quality of the service. Audits were not effective in identifying, assessing and managing risks, or to regularly seek the views of people who used the service.

The service had not completed a survey of people, relatives and professionals since 2012. Therefore the registered manager and the provider were unaware of people's views of the service and any improvements required.

Summary of findings

What people who use the service and those that matter to them say

We spoke with five people who used the service and 15 relatives during our visit. Overall people were mostly happy. Comments included, "I love it here, it's nice and warm, I'm happy" and "The staff love my friend". However others said, "When I shout for help no one pays attention," and "When I talk, staff interrupt me or ignore me."

People told us they mostly felt safe using the service. One person said, "My relative's safe here," another said "Safe, yes staff seem very alert." However others said, "I feel safe sometimes," another relative said, "People keep coming into my relative's room I worry about that."

Everyone we spoke with said they were able to access community health care professionals, such as the GP and district nurses. One person said, "My relative had a problem with their skin, we had a nice nurse that came and helped heal it up." Others said they would like to access the GP more easily to talk about their relative's physical health.

All the people and relatives we spoke with felt confident to express concerns or complaints, they told us, "The manager is always around, available and will listen and act on your complaint or concern."

People told us they had mixed views about the staff at the service, some told us that "Staff speak in their own language I do not know what they are saying," and "My relative is not being looked after, I have to come every day and check on them." However another person said, "The care staff are fabulous and staff are quite good and appear to have all the knowledge and skills they need."

We were told by people and their relatives they did not think the service provided enough activities. One person said, "I've seen some activities, people playing a game and they look like they enjoy it." Another said, "I would like more interesting things to do, rather than throw a ball and watch TV." Several relatives would have liked to see more activities for their relatives who had to remain in bed. One person said, "No one comes in to do any activities with my relative, and it must be a very long day for them, that's why I come every day to break it up."

Many people thought there were enough staff with the correct level of skill, we were told "Staff know what to do and treat people with dignity and respect." However some people said it could be difficult to get help at night, one person said, "I needed help last night I banged 17 times to get help, and they did come in the end."

All the people at the service had care plans and risk assessments and some of these were reviewed. We saw that not all people were involved in their care plans; one person we spoke with did not know what a care plan was.

Albany 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 is meeting the regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

Before our inspection, we reviewed information we held about the service. We asked the provider to complete an information return. We announced the inspection to the manager a few days in advance of our visit, to ensure that the manager would be present and help ensure that people using the service were aware of our inspection.

We visited on the 15 &16 April 2014. One inspector completed this inspection with advice from a pharmacist inspector.

Over the two days we visited we spoke with five people living at the service, 10 relatives, seven staff and the registered manager. We observed the support given to people in the lounge and dining area of the service. We reviewed 10 people's records which included people's support records, and records relating to the management of the service. 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.

Following our visit we spoke with four health care professionals involved in the support of people using the service. We also asked the registered manager some further questions and reviewed records she gave us during the visit.

Are services safe?

Our findings

We found several medicines that were out of date on all three floors of the service, including antibiotics, glycogen (used for diabetics in an emergency to increase their sugar levels) and an Epipen (used for people who have suffered a severe allergic reaction which may affect their breathing). In addition, there were flu vaccines, which had expired in May 2013 and June 2013. Staff told us a nurse had left these after giving last year's flu injections to people. We saw that staff completed a monthly stock check but these had not identified the medicines we found. People were at risk of receiving medicine that was out of date due to inadequate auditing systems.

We reviewed the medicines audit that was completed in January 2014. We saw the pharmacist had highlighted several areas the service needed to review. For example, the need to monitor temperature storage arrangements for medicines requiring refrigeration. When we checked the rooms used for storage of medicines temperatures were not being recorded for the medicines fridge and there was no evidence that the fridge was being cleaned. This meant that medicines were not stored appropriately. The audit also noted eye drops had been opened, but there was no date of opening recorded. We saw this practice was still happening on two of the floors, for five people eye drops had been opened but the opening date had not been recorded. There was a risk that people may have been given eye drops, which were not suitable for use.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see the action we have asked the provider to take at the end of this report.

We saw that people's safety had been put a risk because the provider had failed to ensure people were protected from the risk of exposure to a health associated infection due to poor standards of cleanliness and hygiene.

During the inspection we asked people and relatives if we could see people's bedrooms. We looked at 26 bedrooms and en suite toilets over the three floors of the home as well as six bathrooms and three rooms where medicines were kept. In all of these rooms we found dirt and dust, we saw stains on carpets, lino either missing or coming away from the wall, as well as missing or broken tiles on the bathroom walls making it very difficult to clean. When staff had spilt fluid in bed rooms such as medicines or drinks these had not been cleaned up. We saw PEG feeds (prescribed liquids that are given to people through a tube in the stomach) were splattered on people's bedroom walls as well as over the equipment used to dispense the feed. We saw toilets, commodes (portable toilets), as well as bathing hoists had not been cleaned. This increased the risk of people, their visitors and staff acquiring infections.

We met with the cleaning staff, and reviewed cleaning schedules and saw these did not give detailed information about what the cleaner should be doing in each room daily.

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see the action we have asked the provider to take at the end of this report.

The provider and the registered manager had not ensured equipment was maintained, safe and suitable for its purpose. Emergency equipment such as airways, oxygen masks and tubing, were out of date.

People were using equipment that was not fit for purpose which may have injured them. Although there were shower chairs, we saw staff were using commodes for people to manoeuvre and sit on when being assisted to shower. None of the commodes had foot plates and two were missing arm rests. Staff were unaware they should have been using wheelchairs with arm and foot rests to move people who were unable to walk to and from bathrooms and toilets. Therefore, people were at risk of injury while being moved in the commode chairs.

We saw the service had emergency equipment on each floor of the service, this included oxygen masks and tubing, portable suction machines and airways. However we saw that often the equipment was out of date or missing. For example, on the ground floor tubing attached to the oxygen cylinder was not covered so may have become damaged or dirty, there was no oxygen mask and several airways were out of date. We asked the registered manager who monitored the emergency equipment. She told us she was responsible for this and had completed two monthly checks but she had not been recording her findings. Staff we spoke with did not know where to find the emergency equipment on each floor. Therefore people who lived at the home were at risk of not receiving appropriate emergency care due to equipment not being available and out of date.

Are services safe?

This was a breach of Regulation 16 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see the action we have asked the provider to take at the end of this report.

The service did not use agency staff, the registered manager explained that as a qualified nurse she would cover in an emergency and be available to help staff daily if they needed hands on support. Staff we spoke with confirmed this and said this allowed continuity of care for people living at the service. We saw the service employed qualified nurses as well as care workers, the registered manager constantly reviewed the skill mix at the service to ensure she had sufficient number of staff with the correct knowledge to provide care to people at all times. However people we spoke with said that staff did not respond to their needs as quickly at night they told us, "Staff did not respond to call bells at night," and "The staff are very busy and they rush when they do come to me."

We saw staff had received training in safeguarding and staff we spoke with understood what abuse was and possible signs. However, although they were aware they should report this to the manager they did not understand what the local authority did or, indeed, how to contact the local authority themselves. Staff we spoke with did not understand the service's whistle-blowing policy; therefore staff were not sure what to do if they needed to report any concerns.

People and their relatives told us that on the whole they felt safe from abuse and harm; relatives said that they sometimes felt uncomfortable when people wandered into their relatives' rooms; one person said, "I worry about the people who wander and go into my relative's room." However, they told us that staff did come and help when this occurred but sometimes it was distressing.

Staff received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered manager was unaware of recent changes in the DoLS requirements and said she would ensure her staff were updated as a matter of urgency. Staff we spoke with understood the MCA and DoLS and were able to talk about people at the service who had recently received capacity assessments and the reasons for these assessments.

The service had risk assessments for each person who lived at the service. We saw risk assessments for moving and handling, pressure care and challenging behaviour. These had been updated on a regular basis. However, some risks that we observed had not been recorded and staff we spoke with was not always aware of people's individual risks. . Staff told us that if people's level of risk changed this would be communicated at daily staff handovers and in peoples care records.

Are services effective?

(for example, treatment is effective)

Our findings

The registered manager and the provider were not protecting people against the risks associated with unsafe or unsuitable premises, due to inadequate maintenance.

We reviewed the environment at the service; we saw that most of the 26 bedrooms were in need of repair. We saw most had broken toilet seats, cracked tiles and stains on carpets or lino. We also saw stains on chairs, as well as areas of plaster which had fallen off the walls. Several of the radiator covers were falling off and in eight of the rooms people were unable to see out of their windows due to damaged double glazing. We reviewed the maintenance book and spoke with the maintenance person and the registered manager. We saw that not all these items had been reported. The registered manager told us she would inform the provider about the faulty double glazing as she was unaware that so many rooms were affected. Some relatives said, "It's due to be painted, the walls are always bashed because the staff need to move the beds." The maintenance person was aware of the problems with staff accidently knocking the beds against the walls and said they were looking at ways to reduce this happening.

This was a breach of Regulation 16 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager and the provider were not protecting people against the risk of unsafe or inappropriate care and treatment due to lack of proper information about them and maintenance of accurate records.

We reviewed Do Not Attempt Resuscitation (DNAR) forms. These record people's views on resuscitation. We saw that, of the five we reviewed, none had been completed fully. For example, several were missing important information such as the individual's personal details; none had been completed to show that either the person or their relatives had been involved in the decision. We told the registered manager who agreed to review all the DNAR forms with the local doctor, people using the service and their relatives to ensure they were completed correctly.

We asked people and relatives if they had been involved in developing their care plan, most did not know what a care plan was. However, others remembered when they came to the home being asked information such as, what they liked to eat, did they have any hobbies and important people in their life. One person said, "I've told them about my relative's likes and dislikes, however I keep finding them not following my advice." They then went on to say, "But when I tell the staff, they stop, apologise and say they will do it the way I have asked and the way my relative wants." The home had a culture of relying on word of mouth rather than reading care plans which increased the risk of people's needs being overlooked.

We reviewed care plans on each floor of the service, we saw that current care records had information missing, out of date records and information in people's individual care files were difficult to locate. Staff we spoke with were unaware of people's care plans.

The registered manager told us she was about to change the current care plans, as she was aware the care plans in use were not fit for purpose. They were not person centred and did not cover areas such as choice, preference and addressing people's social needs. We saw she had training arranged for all her staff and planned that these new care plans would be completed with people and their relatives within eight weeks of the inspection. Staff we spoke with were aware of the plans to implement new care plans.

When planning care, staff did not always account for people's individual needs. In several people's moving and handling care plans we did not see important information on the size of sling that should be used for people. The Health and Safety Executive (HSE) guidance 'Getting to Grips with Hoisting People,' states "the selection of the wrong size sling could result in discomfort if the sling is too small and the risk of the person slipping through the sling if it's too large." We asked staff how they knew what size of sling to use for people, they said, "I would look at the person and choose." The service may have been placing people at risk of harm by not recording in people's care plans the size of sling that should be used.

This was a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see the action we have asked the provider to take at the end of this report.

Staff made referrals to other professionals such as speech and language therapy (SALT) when they needed advice on people's swallowing. We saw people had been prescribed thickening powder, to prevent them from choking. However this was not recorded in some people's care plans. Staff we spoke with fully understood how may scoops of thickener

Are services effective?

(for example, treatment is effective)

people may need to make the consistency of drinks and liquid food suitable and told us this was recorded in the kitchen. We saw this information was available as indicated. We met a person who had recently been admitted to the service, staff had been told that they had swallowing difficulties. This person needed to be reassessed to enable them to enjoy a more varied diet. We saw staff had made an urgent referral to the SALT team and told the person and their family what was happening. This ensured the person was involved in discussions about their nutritional needs and confirmed staff had identified this person's changing needs.

People had access to healthcare professionals and this was recorded in their care records. We were told by the registered manager she had recently changed the service's GP, so now the service only used one GP practice. We saw the GP visited the service three times a week. Staff told us this was much better and the GP was reviewing people's medicines and changes had been made as a result.

We saw from staff records the service had an induction programme and were shown the booklet staff completed. Staff we spoke with said they had completed the induction programme when they started and found it helpful but short.

The manager told us that staff had not received an appraisal in 2013 and records reviewed confirmed this.

However, records showed that the manager had started the appraisal process for staff for 2014. We saw that staff had received supervision in March 2014. Staff we spoke with confirmed this.

The manager arranged staff meetings monthly for day and night staff. However, she did not keep records of these meetings. Staff that missed the meetings were, therefore, unable to read the minutes and may not have received important information. Staff we spoke with had not attended staff meetings so did not know what had been discussed. We asked the registered manager about this and she told us that staff meetings had not been recorded and there were planes in place to ensure all staff meetings were recorded and available to all staff.

The registered manager told us that training records we reviewed were not up to date. Following our inspection the registered manager sent us the training matrix. We saw that most staff had completed training in areas such as, first aid and safeguarding. We asked the manager what training was mandatory and she told us she believed safeguarding, moving and handling, first aid, fire safety, dementia, food hygiene, first aid, health and safety, safeguarding, DoLs and MCA. and infection control training which all should occur annually. We saw that most staff had not received infection control training for sometime. The registered manager told us that training in infection control was needed for all staff and this was being arranged.

Are services caring?

Our findings

We received mixed feedback from people living at the service and their relatives. They told us that most staff were kind and caring. One person said, "I'm well looked after by staff who know what they are doing" and one relative said, "The staff always give me a kiss and a cuddle when I arrive and check I'm ok and update me on my relative." However, others had a different experience, they told us staff did not respond to call bells at night," and "The staff are very busy and they rush when they do come to me." We asked staff if they had enough time to meet everyone's individual needs. They told us that sometimes it was difficult but not impossible.

We saw from people's care records some people did not have their personal histories, choices and preferences recorded. However when we spoke with staff they were able to tell us about the people they were caring for and their likes and dislikes. Staff agreed they did not really have the knowledge about what people did before they came to the service and this information would be helpful to include in people's care records. Staff and the manager said new care plans were about to be started and these would include information about people's past life and preferences and choices. We saw some people and their relatives had been involved in planning their care, treatment and support they required. We saw this was recorded in care records. However other people had not been involved. However, relatives we spoke with told us they had never seen a care plan or been involved. Other relatives said sometimes staff got it wrong about how they should care for a relative, but this was quickly rectified this when told. People and relatives told us staff responded to them in a caring way, by checking they were ok when they came to visit, calling them when a relative was unwell and one person said, "[they] cheer me up when I'm having a bad day."

Relatives and visitors told us people were well cared for and staff treated people with respect. We saw staff had received training in dignity and respect and were able to tell us how they included this in their work. We saw the service had 'do not disturb' signs that people could place on their door if they did not want to be disturbed when they had family and friends visiting. One relative told us "Staff treat people with dignity and respect; they close doors, curtains and allow families private time by having do not disturb signs." One family told us that when their relative was dying they were allowed to stay overnight. They said, "I will never forget the time I was given to be with my relative."

We observed people in the lounge areas on all three floors using SOFI. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We saw staff did not engage or interact with people. For example, we saw that people were often left on their own for long periods of time without staff support. We observed a number of disputes between people living at the home and saw that people would often shout for staff assistance when distressed and staff would take sometime to respond. We saw one staff member available in the afternoon to be with people in one of the lounges. However, we saw that this staff member did not communicate or engage with people and often sat away from people in their office in the main lounge.

We saw one person who was new to the service was finding it very difficult to cope with the noise in the lounge they were in, and they wanted to have control of the television. On the second day of our inspection, they told us the manager had supported them to move to a quieter lounge on a different floor where people did not mind them having control of the television. They told us, "it's much better since I have moved, I'm away from all those women who row [other people who lived at the service], and the television is now at a level I can enjoy." This showed some staff responded in a caring way to this person's needs.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Most people and their relatives said there were not enough activities available for them. We saw the home did not currently have an activities worker. However a staff member was undertaking this role until another activities worker could be employed. People told us that when the activity worker had been in place at the home, they had found out what people liked to do. One person said, "[the activity worker] found out what I liked to do, I like a bit of gardening or looking at the flowers." A relative said, "I've never seen anyone doing activities with people, everyone sits in the living room watching the TV, I've brought up my concerns to my mum's social worker." Another said, "When we arrived staff asked about my mum's hobbies, but nothing has happened since."

We did see the service offered events for people who lived at the service, their relatives and friends such as barbeques and an Easter event was advertised. Relatives told us these events were fun and they enjoyed attending them. People and relatives said they would like to see more personal activities available daily, such as gardening, cooking and one to one support to those who were unable to leave their beds. We saw the service offered foot spas and manicures and some of the people we spoke with told us they enjoyed being "pampered." Before the activities worker left we saw exercise to music and going out to the pub were offered to people. The registered manager told us she had recently started working with another care home nearby and people could attend a reminiscence group at this home. We did not meet anyone who had accessed this group. During the inspection we did not see anyone who was bedbound being offered activities. Therefore the registered manager and the provider were not ensuring that all people at the home had access to activities suitable for their needs.

The service provided residents and relative meetings every three to four months and we were told the last meeting had been held on the 27 February 2014. However there were no minutes available from this meeting. We asked people and relatives if they had attended, but no one was able to remember. We reviewed the minutes of the meeting on the 2 September 2013 and saw people wanted more activities. We did not see an action plan completed for this meeting, but we did see staff had fed back people's concerns to the registered manager.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see the action we have asked the provider to take at the end of this report.

Where people were not able to make decisions about their care, staff worked with relatives and other professionals to make 'best interests' decisions for people. When we visited we saw arrangements were in place to carry out assessments of people's capacity to make specific decisions, if this was necessary. Staff told us they had been involved in assessing people's capacity along with professionals and were able to explain the process and how they involved people and their relatives in these decisions. We asked if people using the service had access to an independent advocate. The registered manager told us people's social workers would access an Independent Mental Capacity Advocacy (IMCA) if this was necessary. However the service did not have access to an independent advocacy service for other people using the service.

The service encouraged relatives and friends to visit people and we met several relatives who told us how welcoming the service was. One person said, "The staff always have a cup of tea ready for me," another said, "My friend's room is lovely and warm, I get a cup a tea, have a chat with my friend and then we both have a snooze, it's all very relaxing."

The registered manager told us and we saw evidence that the service worked closely with other organisations, such as the local authority safeguarding team, district nurses and other community services. We spoke with community services who told us referrals were made to them appropriately and that the service worked well with them.

We reviewed the provider's compliments and complaints records. We saw people had their comments and complaints listened to and acted on. We reviewed the most recent complaints and saw the manager had responded in line with the service's policy. We saw lessons were learnt from complaints such as, changing the way care was provided to people. We were told these were discussed at staff meetings and staff we spoke with confirmed this. People we spoke with told us they had confidence in the registered manager and when they had concerns she acted quickly and made herself available. One person said, "If I had a complaint, I would tell the manager she is always

Are services responsive to people's needs?

(for example, to feedback?)

around and very helpful." Another said, "If I had any concerns I would tell the staff they listen and act on any concerns." Staff we spoke with were aware how to support someone to make a complaint.

Are services well-led?

Our findings

The registered manager did not have effective internal systems in place to assess and monitor the quality of the service to identify, assess and manage risks, or to regularly seek the views of people who used the service.

We saw the registered manager had not completed any internal audits during 2013. We reviewed three audits, which had been undertaken in March 2014. These looked at infection control, domestic services and catering. We were told that all these audits had been completed by the activities worker, who had since left. We saw gaps and question marks in the audit where the staff member had been unable to complete them. The registered manager had not reviewed these audits so was unaware of the gaps. None of the audits had identified the issues we found during our inspection, such as, broken equipment and inadequate cleaning.

An external medicines audit that had been completed in January 2013 by the pharmacy used by the provider showed several actions the pharmacists recommended had not been actioned. For example, very large oxygen cylinders should have been mounted on a purpose built trolley and secured to the wall. The Health and Safety Executive requirements (HSE) state oxygen cylinders should be secured to a wall. This is to ensure they do not fall over and become damaged; oxygen can become very dangerous if the valve is damaged.

We asked the registered manager what support she received from the organisation. She told us that she had not received supervision for sometime due to the changes to the management structure. She confirmed that the area manager was supportive and available when needed. The registered manager told us that although the provider was not a qualified healthcare professional, he was supportive in relation to the financial management of the home. The registered manager attended the 'care home forum' set up by the local authority every six months, and discussed different topics such as end of life care. She told us she found these meetings very helpful. By attending these meetings the service had reviewed the way care plans were completed and concluded improvements were needed.

We saw the service had not completed a 'relatives and service users' questionnaire since 2012. We were told at the 2012 survey, 56 questionnaires had been sent out and 22 responses had been received. The responses were then rated into good, satisfactory and poor. The results showed that most people said the service had stayed the same, 31% said it had improved and 9% said it had become worse. The areas people had most concern were cleaning of the home, quality of the food, activities available to people, quality of care and access to the manager. We asked to see the action plan arising from these comments and were told the registered manager had not completed one. We were therefore unable to identify if anything had been done to address the concerns of the people who lived at the service and their relatives.

This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see the action we have asked the provider to take at the end of this report.

We found the manager knew her staff well and supported them. However staff were unsure what the key challenges, concerns and risks were within the service.

All the staff we spoke with fully understood the emergency plans for the home, they knew what to do if the fire alarms went off at the service; we saw that regular fire alarm testing took place. People and relatives were informed of these tests, we spoke with several relatives who said, "Yes we have regular fire tests, the staff are well practiced."

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines. The registered person was not protecting people against unsafe medicine management as they did not have appropriate arrangements in place for handling, using, dispensing and disposal of medicines.

Regulated activity	Regulation
	Regulation 15 (1) (c) HSCA 2008 (Regulated Activities) Regulations 2010 Safety and Suitability of Premises. The registered person had not ensured premises were safe and fit for purpose due to inadequate maintenance.

Regulated activity	Regulation
	Regulation 12(1)(a)(b)(c)(2)(a)(c)(i) HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and Infection control. The registered person had not ensured people were protected from identifiable risk of acquiring an infection as appropriate systems and standards of cleanliness and hygiene were not maintained.

Regulated activity	Regulation
	Regulation 10 (1) (a) (b) HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision.

This section is primarily information for the provider

Compliance actions

The registered person did not have effective systems in place to assess, monitor the quality of the service to identify, assess and manage risks. Regularly seek the views of people who use the service.

Regulated activity	Regulation
	Regulation 16(1) (a)(b)(2)(3) HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment. The registered person had not made proper arrangements to ensure equipment was properly maintained, in sufficient quantity, suitable and comfortable for its purpose and used correctly.

Regulated activity	Regulation
	Regulation 20 (1)(a)(b)(i)(ii)(2)(a) HSCA 2008 (Regulated Activities) Regulations 2010. Records The registered person and the provider had not ensured people were protected against the risk of unsafe or inappropriate care and treatment arising from lack of proper information about them.

Regulated activity	Regulation
	Regulation 9 (b)(i)(ii) HSCA 2008 (Regulated Activities) Regulations 2010. Care and Welfare. The registered person had not taken proper steps to ensure that people were protected against the risk of receiving care or treatment that is inappropriate or unsafe.