Bayview Nursing And Residential Care Home Limited

Bay View Nursing and Residential Home

Inspection report

2-6 Bay Road
Clevedon
Somerset
BS21 7BT

Tel: 01275343109

Date of inspection visit:
06 June 2017

Date of publication:
08 August 2017

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 6 June 2017 and was unannounced. When the service was last inspected in January 2016 we found three breaches of the regulations of the Health and Social Care Act 2008. The breaches related to staffing, person-centred care and good governance. These breaches were followed up as part of our inspection.

You can read the report from our last comprehensive inspection, by selecting the 'All reports' link for Bay View Nursing and Residential Home, on our website at www.cqc.org.uk

Bay View Nursing and Residential Home is registered to provide accommodation and nursing care for up to 40 people. At the time of our inspection there were 22 people living at the service.

A registered manager was in post at the time of inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager is also the sole provider of the service.

At our previous inspection the provider was not consistently responsive to people's needs. People did not have up to date care plans that reflected their current care needs. At this inspection insufficient improvements had been made. The quality and content of care plans was variable. Care plans were not person centred and not always descriptive of people's needs.

At our previous inspection the provider had ineffective quality assurance processes in place that would help drive forward improvements. At this inspection insufficient improvements had been made. The provider did not have effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who used the service.

The provider had inadequate arrangements for reporting and reviewing incidents and accidents.

The risks associated with people's care were not consistently managed safely. There was not always sufficient guidance for staff on how to keep people safe because the plans contained limited information.

Medicines were not consistently managed safely.

People were not cared for in a safe, clean and hygienic environment.

People's rights were not consistently upheld in line with the Mental Capacity Act (MCA) 2005. This is a legal framework to protect people who are unable to make certain decisions themselves.

Staff were not consistently supported through a regular supervision programme. Supervision is where staff meet one to one with their line manager.

People's nutritional needs were assessed and care plans provided guidance for staff on how to meet these needs. Food and fluid monitoring charts had been completed, but it was unclear how these were monitored.

When asking people if they felt well cared for we received mixed feedback. During our observations we observed some positive interactions. The maintenance person demonstrated an excellent rapport with people. However, a number of interactions between staff and people using the service were often task focussed rather than person centred.

At our previous inspection the provider was not deploying sufficient numbers of staff to ensure they could meet people's care and treatment needs. At this inspection we found sufficient improvements had been made.

Records showed that a range of checks had been carried out on staff to determine their suitability for work. This included obtaining references and undertaking a Disclosure and Barring Service (DBS) check.

Staff had undertaken safeguarding training. They understood their responsibilities with regard to safeguarding people from abuse.

New staff undertook an induction and mandatory training programme before starting to care for people on their own.

People had access to on-going healthcare. Records showed that people had been reviewed by the GP, the community nutrition nurse, the mental health team and specialist nurses such as a tissue viability nurse.

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them. There was a full time activities coordinator in post. They consulted people about their needs and compiled weekly activity plans.

On the day of the inspection we were informed by the provider that they intended to close the service. The provider has also formally notified the local authority about their closure. The service is currently working with the local authority and relatives to find suitable alternative placements for people. The provider told us that their aim is to close in August 2017. Owing to their impending closure the service will not be placed into special measures.

At this inspection we found four breaches of the regulations of the Health and Social Care Act 2008.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

The risks associated with people's care were not consistently managed safely.

Medicines were not managed safely.

People were not cared for in a safe, clean and hygienic environment.

A range of checks had been carried out on staff to determine their suitability for work.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights were not consistently upheld in line with the Mental Capacity Act 2005.

Staff were not consistently supported through a regular supervision programme.

New staff undertook an induction and mandatory training programme before starting to care for people on their own.

Staff monitored people's healthcare needs and made referrals to other healthcare professionals where appropriate.

Is the service caring?

Requires Improvement

The service was not always caring.

When asking people if they felt well cared for we received mixed feedback.

Observed interactions between staff and people were often task focussed rather than person centred.

The service did not consistently treat people with respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not have up to date care plans that reflected their current care needs.

The provider had systems in place to receive and monitor any complaints that were made.

Relatives were welcomed to the service and could visit people at times that were convenient to them.

Is the service well-led?

Inadequate

The service was not well-led.

The provider has failed to fully meet all the regulations.

The provider did not have effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service.

The majority of staff felt well supported by the provider.

Bay View Nursing and Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 6 June 2017 and was unannounced. The inspection was undertaken by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

When the service was last inspected in April 2016 we found three breaches of the regulations of the Health and Social Care Act 2008. During this inspection we checked that the improvements required by the provider after our last inspection had been made. It was rated as 'Requires Improvement.'

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about) other enquiries from and about the provider and other key information we hold about the service.

We spoke with seven people, one relative, eight members of staff and the registered manager. We also observed the lunchtime experience and the activities undertaken by people.

We reviewed the care plans and associated records of five people and a sample of the Medicines Administration Records (MAR). We also reviewed documents in relation to the quality and safety of the

service, staff recruitment, training and supervision.

Inadequate

Is the service safe?

Our findings

The risks associated with people's care were not consistently managed safely. Care plans contained risk assessments for areas such as skin integrity, falls and nutrition. Where risks had been identified, the care plans contained some guidance for staff on how to reduce the risks. However, there was not always sufficient guidance for staff on how to keep people safe because the plans contained limited information. For example, one person was at risk of falling, and the care plan guidance for staff was "Has got a frame but often forgets to use it. Needs support, encourage to move slowly and stop regularly". There was no mention of avoiding clutter or ensuring the person was wearing well-fitting footwear at all times or whether they should be wearing glasses. In another person's plan it had been documented that the person had been assessed as a high risk of falling. The person didn't like the hoist and needed two staff to assist them. Later in the plan it was documented that the person would not consent to using the hoist and that the person put themselves and others "at risk as she is unwieldy, heavy and non-compliant". The language used was unprofessional and undignified and in addition, did not provide clear guidance for staff on how to assist the person if they fell.

At our previous inspection we found some people did not have a Personal Emergency Evacuation Plan [PEEP] should there be an emergency. Although PEEP's were in place they were of poor quality. For example, in one person's plan it had been documented that the safest place for them to be evacuated to was upstairs as it was a short distance from their room. This did not demonstrate that people would always be moved to a place of safety during an emergency and could potentially put them at a greater risk. Since our previous inspection the service had a 'grab bag' in place which contained essential items needed in case of an emergency.

Medicines were not consistently managed safely. Although some of the Medicine Administration Record (MAR) charts had photographs at the front to aid identification, others didn't. This meant that staff administering medicines that were unfamiliar with people using the service, such as agency staff might not be able to recognise people who were unable to confirm their own identity. In addition, people's preferences in relation to how they preferred to take their medicines had not been documented, such as with a particular drink of their choice. Again, this could make it more difficult for staff that were unfamiliar with people to ensure they took their medicines. This was particularly relevant because the nurse on duty during the morning of our inspection was an agency nurse.

Protocols for medicines that might be required in addition to people's regularly prescribed medicines (PRN) were not in place. Having PRN protocols in place can help staff to know when people might require additional medicines as well as helping staff to identify any trends.

One person was prescribed a medicine to alleviate their anxiety on an "as required" basis. Although the medicine had been administered five times according to the MAR chart in use, staff had only documented once on the reverse of the MAR the reason why. Stating the reason is considered good practice so that staff can easily see why the medicine was required. Although we saw that notes had been added to the electronic care notes when the medicine had been administered, the notes did not always demonstrate that staff had

sought to relieve the person's anxiety using methods other than medicines. For example, on one occasion it had been documented that the person was "awake after 2am, calling out and wandering the corridor. Reassured a lot but didn't settle. (name of medication) given)". But on 27 May 2017 the medicine had been administered at 00.45 hours. The reason documented within the daily notes was "Slept and woke up at midnight. Diazepam 2mg given, then slept til report time."

We saw several medicine instructions had been transcribed by staff, but had not been countersigned by another nurse to confirm accuracy. For example, pain relief for one person and eye drops for another had not been countersigned. This was not in line with the provider's own Medicine Policy which stated "The trained nurse must complete the MAR chart and have a second signature to ascertain correctness." Another person was having a reducing dose of an anticonvulsant medicine. The MAR had been handwritten by staff, but the dosing and timing schedule was confusing and was not clear. The agency nurse administering the medicines said they found it difficult to understand. In the person's daily notes it had been documented on 2 June 2017 that a new MAR chart had been ordered, but this did not arrive until later during our inspection.

Some bottles of medicines in the trolley had not been labelled with the date of opening or the expiry date which meant there was a risk that people could be given medicines that had expired. The provider's policy stated "All medicines have a certain shelf life. The date and time of opening should be written on the label". A bottle of eye drops in the medicines fridge had been labelled as opened on 1 April 2017 and the dispensing label instructed staff to discard after 28 days, but the bottle was still in the fridge. The agency nurse disposed of these when we showed them.

Although the temperature of the medicines fridge and of the clinical room was monitored, there was no guidance for staff on what the temperature should be. This meant that staff did not know what the temperature should be or what action they should take to ensure that medicines were stored safely and at the correct temperature. In addition, the minimum and maximum temperature of the fridge was not being monitored in line with the Medicines and Healthcare Products Regulatory Agency (MHRA) recommendations. This had also been highlighted during the latest pharmacy advice visit on 8th May 2017.

People were not cared for in a safe, clean and hygienic environment. In parts of the building it was malodourous. In the basement bathroom the toilet was not flushed or cleaned. The cleaning schedule highlighted that the bathroom had not been cleaned on the 3 and 4 June 2017. In another bathroom wallpaper was hanging off the wall. There was a rusty bin. People's bathroom products were stored in a basket in the bathroom. They were not labelled and were therefore at risk of being shared. This increased the risk of cross infection. Clean bedroom linen was left on the tiled surfaces. Soiled laundry was left nearby on the floor. A rusty old radiator was left against the wall. The most recent local authority food safety and hygiene inspection awarded the service a three star rating. They were previously awarded a five star rating.

Some people needed to be assisted to move using a hoist and sling. Hoist and sling details were listed within the care plans. However, staff said that although some people had their own slings, others were shared amongst people. This meant there was a risk of cross contamination. In addition, the Department of Health Prevention and control of infection in care homes best practise guidance states that "Slings should be laundered in hottest wash cycle allowable according to the manufacturers' instructions and not shared between residents". The service was not following best practice.

The provider had inadequate arrangements for reporting and reviewing incidents and accidents. Records showed the accident details and immediate actions were recorded. However, many of the viewed accident forms were incomplete regarding follow-up actions. They did not include the manager's report regarding the details of the investigation, actions taken and outcome.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection the provider was not deploying sufficient numbers of staff to ensure they could meet people's care and treatment needs. At this inspection we found sufficient improvements had been made. Staffing rotas viewed for the previous two weeks demonstrated that staffing levels were maintained in accordance with the assessed dependency needs of the people who used the service. On the day of our inspection the absence of the kitchen staff was covered by the provider and a relative. Where required the provider also used agency staff. We observed that there was enough staff on duty to meet the needs of people using the service. However, the layout of the building meant there were periods during the day when it was difficult to locate a member of staff. One member of staff said "There is usually enough staff, but it is a big building." We reviewed call bell response times. The provider advised that the target response time was three minutes. This target in the main was met. We did note two exceptions on the sample reviewed for 5 June. The provider was unable to explain why this was the case but provided assurances that no person was placed at risk.

Records showed that a range of checks had been carried out on staff to determine their suitability for work. This included obtaining references and undertaking a Disclosure and Barring Service (DBS) check. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal background and whether they were barred from working with vulnerable adults.

Staff had undertaken safeguarding training. They understood their responsibilities with regard to safeguarding people from abuse. They were able to explain the actions they would take if they suspected a person was being abused. Staff also understood the term 'whistleblowing'. This is a process for staff to raise concerns about potential malpractice at work.

A full time maintenance person was in post. Regular maintenance audits relating to fire safety records, legionella, water temperatures, maintenance of safety equipment, gas safety, boilers, call systems, portable appliance testing (PAT) and window restrictors were undertaken. The provider told us that the maintenance person is leaving the service and one of their relative's will be taking over their duties until the closure.

People told us they felt safe living at the service. Comments included; "As safe as you can feel"; "Yes I feel pretty alright here"; "Yes I feel safe"; and "On the whole I do."

Requires Improvement

Is the service effective?

Our findings

People's rights were not consistently upheld in line with the Mental Capacity Act (MCA) 2005. This is a legal framework to protect people who are unable to make certain decisions themselves. In people's support plans we saw information about Deprivation of Liberty Safeguards (DoLS) being applied for. These safeguards aim to protect people living in care homes from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely.

Where people using the service had Deprivation of Liberty authorisations in place the conditions applied to these had not always been met. For example, one person had a condition that staff should document the reasons for administering one of their medicines, but this was not happening consistently. The same person had a condition that specialist occupational therapy advice should be sought, but there was nothing documented within the care plan to indicate that this had happened. The DOLs authorisation for another person had a condition that relevant capacity assessments must be undertaken, but the capacity assessment was poor in quality. In addition, the permanent nurse on duty was unaware of any DOLs conditions. Other staff also did not demonstrate an understanding of DoLS and who was subject to a DoLS authorisation. Training records highlighted that most staff had completed mental capacity and DoLS training.

Consent to care and treatment was not always sought in line with legislation and guidance. Although we saw some mental capacity assessments, they did not always indicate that staff fully understood how or when they needed to be undertaken. In addition, we saw that some care plans contained conflicting information in relation to people's capacity. For example, in one person's plan the mental capacity assessment had not been fully completed as some sections of the form were incomplete. It had been documented on the assessment that the person had "no capacity", but later in the care plan it had been documented that the person had "variable capacity."

Although there was documentation in place to show that best interest decisions had been made when people lacked capacity, the specific decisions that were being considered were not always clear and did not always appear to be relevant. For example, we saw documentation for a best interest decision for a "falls risk." The outcome of the process was unclear and did not refer to any decision being reached or any less restrictive option being considered. There was nothing documented in relation to any discussions that had taken place. We also looked at documentation in relation to a best interest decision for one person to have support with their medication. Although the names of the people involved had been listed, there was no detail of what had been discussed or what the outcome was.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff undertook an induction and mandatory training programme before starting to care for people on their own. Staff told us about the training they had received; this covered a variety of subjects such as

moving and handling, infection control, health and safety and first aid awareness. The nurse on duty told us they had received training in order to meet their professional development needs. For example, they said they had completed mandatory eLearning training as well as venepuncture, syringe driver and tissue viability training. The training records demonstrated that staff mandatory training was in the main up to date. When people were asked whether they felt staff had appropriate skills and training. Comments included; "Oh I hope they do"; "I suppose"; "All really good"; "Yes"; and "I believe so, yes."

Staff were not consistently supported through a regular supervision programme. Supervision is where staff meet one to one with their line manager. Staff said they had not received regular supervision sessions.

People's nutritional needs were assessed and care plans did provide guidance for staff on how to meet these needs. For example, in one person's plan it had been documented that they were at high risk of malnutrition and that the person should be weighed monthly, that they ate better when in the dining room with others and that staff should "sensitively support and encourage" the person. Records showed the person's weight had increased. Specialist advice had been sought when appropriate and their recommendations had been followed by staff. Food and fluid monitoring charts had been completed, but it was unclear how these were monitored. For example, fluid intake charts did not have any targets documented and there was no evidence that the charts were reviewed by the nurse on duty. Therefore there was a risk that if people's food and fluid intake was poor, that this might not get recognised by care staff or escalated to the nurse in charge.

People had access to on-going healthcare. Records showed that people had been reviewed by the GP, the community nutrition nurse, the mental health team and specialist nurses such as a tissue viability nurse.

Requires Improvement

Is the service caring?

Our findings

When asking people if they felt well cared for we received mixed feedback. Comments included; "Some of the staff are very caring"; "I think I am cared for"; "Depends on by who you mean, some yes, some no"; "Yes"; "Not really"; "They are as good as gold"; and "Mostly patient, some of them are a bit irritable." Recent compliments received by the service stated; "We all feel that the care she has received has been exceptional"; "The level of care and sensitivity shown to time has been heartening for his soul and ours"; "Thank you for maintaining his dignity at all times and supporting the family as whole through this sad period."

During our observations we observed some positive interactions. The maintenance person demonstrated an excellent rapport with people. When they approached people and spoke with them, people seemed relaxed and happy in their company. We observed the activity coordinator providing a group activity session. This involved reading "The Daily Sparkle". The Daily Sparkle is a reminiscence newspaper, published 365 days a year, which offers an ever changing range of nostalgia topics and activities, targeted at the elderly and those with dementia. People were engaged and happy to talk about and share their memories.

A number of Interactions between staff and people using the service were task focussed rather than person centred. For example, during morning coffee, people were assisted into the dining room and given a drink, but only one member of staff sat with people and encouraged them to drink. When people had finished their drinks, nobody was asked if they wanted another cup. People were then told they were moving to the lounge, rather than being asked if that was their choice.

At the lunch time service people were not offered choices of food and drink. We observed that people living with dementia were not shown pre-prepared meals or pictorial indicators of the food choices to enable them to make an informed decision. There was limited social interaction around meal times with a number of staff remaining silent throughout the meal. When observing one member of staff assisting one person to eat there was no social interaction. A blanket approach was adopted by the service regarding the use of utensils. People were given large table spoons to eat with irrespective of whether they required them, or not.

Some of the staff demonstrated how people preferred to be cared for and demonstrated they understood the people they cared for. They demonstrated an understanding of people's personal histories and interests. One member of staff talked about people they cared for; "[Person's name), I do not know much about his background. He is visited by his family. He likes nature and has an interest in birds. He prefers his care provided by a man." Another member of staff told us; "[Person's name] is moving shortly. Their sight is not overly great. She likes you to take your hand to ensure she's safe. She's very sensitive to noises. Sometimes you rub her hand to let her know you are there. We ask people when they want to get up. Everyone here is very friendly and supportive of each other."

We observed that people remained in their wheel chairs. No-one was observed to be transferred from chair to seats or vice versa. People were not given the choice between their wheelchair and a seat.
The service did not consistently treat people with respect. The provider told us they had called relatives

about the pending closure of the service. People had yet to be informed directly of the closure. One person told us; "No one has told me, but I am not stupid." Another person told us; "It's gossip whether it's going to close, or not." One relative told us they had not been told about the service closing until their visit on the day of our inspection. The provider gave him a bit of paper with the local authority's number on to ring, telling him he has to arrange everything with the family.

During the inspection we also requested that a notice displayed in the provider's office be removed. The wording contained inappropriate and disrespectful language about a person's medical condition.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection the provider was not consistently responsive to people's needs. People did not have up to date care plans that reflected their current care needs. At this inspection insufficient improvements had been made.

The quality and content of care plans was variable. Care plans were not person centred and were not always descriptive of people's needs. Some people we spoke with did not have an understanding of the meaning of a care plan and were unaware of its content. There was limited information for staff to inform them of people's preferences and choices. There were short tick box profiles of people titled "All about me" kept in people's rooms. They were task orientated and provided brief details about mobility needs, personal hygiene needs and support required with meals. They did not contain personal information regarding life histories and interests. Staff had a limited understanding of people's lives before they moved to the service.

Dementia plans contained information specific to people's needs and provided staff guidance on how to assist the person. For example, in one plan there were details of what time of day the person might become agitated. However, the guidance within the person's dementia plan, although detailed, did not cross reference with their emotional and psychological plan. In their dementia plan it had been documented "In the evenings when becomes distressed and confused, give Diazepam as prescribed." In the emotional and psychological plan it had been documented "Can be calmed by two members of staff when gets agitated. Has medication for agitation which can be given whenever gets agitated. Try to explain things, explain where he is." The guidance for staff was not consistent regarding how to manage the person's agitation.

Some people had air mattresses in place as part of their care plan for preventing pressure sore formation. These were weight specific and therefore needed to be set according to the person's weight. However, mattresses we looked at were not set correctly. For example, one mattress was set at 80kg, but the person's last recorded weight was 52.6 kg. Another mattress was set at 30kg but the persons last recorded weight was 45.6 kg. One mattress was set at 140 kg, and the person's weight was 68.8 kg. When we asked staff if the person weighed 140kg, they said no, but added that the dial was broken and said that if they turned it down, the air would come out. Daily checks of people included mattress settings and these had all been signed. It was unclear how staff would know if mattresses were set correctly because people's weights were not recorded on the charts in their bedrooms. When we discussed this with the registered manager, they said that care staff knew people's weights and should set the mattresses correctly. There was not a robust checking process in place to ensure that air mattresses were set correctly. Air mattress pressures that are not correct, could increase the risk of pressure sores developing and may also be uncomfortable for people to lie on.

This is a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had systems in place to receive and monitor any complaints that were made. The service had received one formal complaint this year. The provider met the complainant. The concern was taken forward

and actioned to the complainant's satisfaction. People told us that they would feel comfortable raising any concerns they have with the service.

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them.

There was a full time activities coordinator in post. They consulted people about their needs and compiled weekly activity plans. They told us; "This is by no means set in stone, we change stuff on the day depending on the residents. The plan has changed loads, once I knew them as individuals it made it easier." Regular activities included exercise sessions, films, board games, hand massages, crafts and music. People had access to Wi-Fi and accessible computers. The laptop which had been used for film projections had broken and was not replaced. One person told us that the highlight of their week was when their social worker came and took them out for tea and cake in the community. They stated; "I wish we could go out and meet people, it's my favourite thing to do. More events and celebrations would be wonderful."

Inadequate

Is the service well-led?

Our findings

The service was not well-led. The provider has informed the Commission and the local authority of their intention to close the service. Their target date is the end of August 2017. They are currently working with the local authority to find new placements for people. Owing to the impending closure the service will not be placed into special measures.

The provider has failed to fully meet all the regulations. Since the previous inspection in April 2016 there have also been repeated breaches of the same regulations. These include good governance and person centred care. Since the previous inspection in April 2016 the service has failed to fully implement the actions in their plan to ensure they are no longer acting in breach of the regulations. Examples of areas where they failed to implement the actions stated in their plan included; "The Manager is currently checking the input of care on Care Docs system and informing the keyworker where information is lacking" and "I have decided to return to using written care plans alongside Care Docs, for our carers to refer to when delivering 24 hour care. The delivered care will then be written up on Care Docs in the normal way." The quality and content of care plans was variable and not up to date. A recent care plan audit identified that seven care plans required updating; people's journals had not been updated; some essential contact records were missing; and some chart monitoring records were due for an update. Three of the care plans were last updated in October 2016.

The provider did not have effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service. Their auditing processes had failed to identify that people were not cared for in safe and clean environment. Personal Emergency Evacuation Plan [PEEP] were of poor quality. Medicines were not consistently managed safely. The provider had inadequate arrangements for reporting and reviewing incidents and accidents. People's rights were not consistently upheld in line with the Mental Capacity Act (MCA) 2005. Staff were not supported through a regular supervision programme. The provider was not consistently responsive to people's needs.

We saw the latest medication audit dated March 2017. One of the issues we noted had also been noted during the audit. This was in relation to the lack of double signatures for handwritten entries on MAR charts. This showed that although the provider was aware of the issue, no action had been taken to rectify it and no regular checks of MAR charts had been implemented.

The manager did not regularly communicate with staff about the service to involve them in decisions and improvements that could be made. The most recent staff meetings were held in October 2016 and February 2017.

The provider had failed to become compliant with Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the service did not hold regular staff meetings the majority of staff felt well supported by the provider. Comments included; "People are looked after well. I am well-supported by the registered manager.

They are always there for staff and residents"; "The registered manger is nice. She's approachable and responsible. We do everything well. We meet the needs of the people. One member of staff told us; "I know we're closing down but I was already looking for another job. The manager is wonderful, but other staff don't listen. I think the care staff feel vulnerable." Another member of staff told us they did not feel comfortable talking to the registered manager.

Resident meetings were not held regularly. The most recent meeting minutes held in May 2017 had yet to be produced. The previous meeting was held in October 2016. Issues discussed included activities, trips out and food. One person suggested having different foods such as donuts and fresh fruit. We observed that people did not have access to snacks and fruit during the day. People had yet to be formally notified of the home's impending closure.

People's feedback was also sought from a recent questionnaire. Eleven people provided feedback. The analysis identified that people liked the food and there were adequate choices. They felt they were treated with respect. They stated that they did not have enough fruit. Where negative responses were received there were no action plans in place to take the issues of concern forward, such as the provision of fruit and having more walks and physical activities.

Annual customer surveys were conducted with relatives. Four responses were received in the survey conduct in May 2017. The service received positive responses. They felt that staff treated their relative in a dignified and respectful manner. Their relative's care needs were met and they are able to make their own choices.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not person centred and were not always responsive to people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights were not consistently upheld in line with the Mental Capacity Act (MCA) 2005. Where people using the service had Deprivation of Liberty authorisations in place the conditions applied to these had not always been met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's risks were not consistently managed safely. Medicines were not consistently managed safely. People were not cared for in a safe, clean and hygienic environment. The provider had inadequate arrangements for reporting and reviewing incidents and accidents.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

The provider did not have effective systems and processes for identifying and assessing risks to the health, safety and welfare of people who use the service.