Brightwell Care Limited

Stanton Court

Inspection report

Stanton Drew
nr Chew Magna
Bristol
BS39 4ER

Tel: 01275332410

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an unannounced inspection of Stanton Court on 6 December 2016. When the home was last inspected in September 2015 there were two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified. We found that people had been placed at risk as medicines were not managed safely. Governance systems were not robust to mitigate risks. In addition, people's records were not always accurately kept. 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 Stanton Court, on our website at www.cqc.org.uk

Stanton Court provides nursing and personal care for up to 36 older people. At the time of our inspection there were 26 people living at the home.

A registered manager was in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

The home was going through a transition period as the company had been acquired by a new provider in October 2016. New systems, policies and procedures were being introduced. The new provider recognised that changes needed to be made to ensure improvements to the home took place.

The home was not always safe as the systems and process in place were not effective when a safeguarding incident occurred. We found that incidents were not consistently reported to the local authority safeguarding team or the Commission. Effective action was not taken to minimise future risks. Risk assessments were in place for people but they did not always provide enough guidance for staff on how to minimise the risks identified.

Medicines were managed and administered safely. Staffing levels were at the planned level and people and relatives told us there were enough staff to meet people's needs. Safe recruitment procedures were followed to ensure staff were suitable for the role.

The service was not always effective as consent to care and treatment was not always sought in line with the Mental Capacity Act (MCA) 2005. Mental capacity assessments and best interest decisions had not been completed where appropriate. The registered manager was aware of their responsibilities in regards to (DoLS). DoLS is a framework to assess if the deprivation of liberty for a person when they lack the capacity to consent to care or treatment or need protecting from harm is required.

Staff had not fully completed the home's induction programme. Training for staff had not always been completed or regularly updated in key areas such as the MCA or fire safety. Staff had not been supported by regular supervision. This meant that staff may not have the skills, knowledge or competence to be effective

in their roles.

The service was caring as people were supported by staff that were kind and respectful. We observed positive interactions and relationships between staff and people living at the home. Staff knew people well and understood their personal preferences. Staff were prompt to respond to people's support needs. People, staff and relatives commented on the positive and friendly atmosphere of the home. Visitors told us they were always welcomed in the home.

People were supported with their nutrition and hydration and spoke positively about the food provided by the home. Staff were observed to be attentive to people's daily needs. There had been several positive compliments about the home.

The service was not always responsive. Care plans were not person centred and did always give clear guidance to staff as to how people wished to be supported. Changes in people's care needs were not always reflected in the care records.

People and relatives had highlighted there was not enough activities to keep people stimulated and engaged. Complaints were not recorded in a systematic way so they could be effectively dealt with. Complaints were not always responded to.

The service was not well-led. Effective systems were not in place to monitor and review the quality of care and support. Notifications had not been reported to the Commission as required. The home had not displayed the Commission's rating given after the inspection in September 2015 conspicuously as required. An action plan to show how the home intended to address regulatory breaches from the last inspection in September 2015 had not been submitted to the Commission, nor had effective action been taken. Meetings were held with staff and relatives, but these were not held regularly and minutes were not available to view.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Safeguarding incidents were not always reported or effective action taken to keep people safe.

Risk assessments were in place but they were not always regularly reviewed.

Recruitment procedures were followed and staffing levels were safe.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always complete the induction programme. Staff did not receive regular training to be effective in their role. Staff had not been supported by regular supervision.

Consent to care and treatment in line with the Mental Capacity Act 2005 was not always followed.

The home was meeting the requirements of the Deprivation of Liberty Safeguards.

People were supported with their nutrition and hydration.

People's healthcare needs were met.

Is the service caring?

Good

The service was caring.

We observed positive relationships with people living at the home.

Staff spoke to people with kindness and respect.

People's visitors were welcomed at the home.

Is the service responsive?

Requires Improvement

The service was not responsive. Care records were not person centred.

Complaints were not effectively responded to.

Provision of daily activities was limited. People said they would benefit from more activities.

Staff were observed to be responsive to people's needs.

Is the service well-led?

Inadequate

The service was not consistently well-led.

Notifications had not been sent to the Commission as required.

The home's rating had not been displayed conspicuously as required.

Systems in place to monitor the quality of care and support were not effective.

Meetings with staff were not held regularly and minutes were not always available.

Stanton Court

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.

The inspection was carried out by one inspector, a specialist nurse advisor 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.

Before the inspection we reviewed previous inspection reports and other information we had received about the home, including notifications. Notifications are information about specific important events the home is legally required to send to us.

Some people at the home were not able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences of the home.

During the inspection we spoke with nine people living at the home, four relatives and nine staff members. This included senior staff and the registered manager. We looked at ten people's care and support records and five staff files. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies, audits and complaints.

Requires Improvement

Is the service safe?

Our findings

People were not kept safe as safeguarding incidents were not always dealt with effectively. The provider had policies and procedures in place for safeguarding adults and whistle blowing. This contained guidance on what staff should do in response to any concerns identified. Staff said they knew how to recognise signs of abuse and how to report any concerns they might have. One staff member said, "I would go to a senior member of staff and report it."

The registered manager had reported concerns to the local authority in some cases but this was not consistently completed to ensure suitable action was taken to protect people. For example, one incident in July 2016 had not been reported. We were told by the registered manager they had reported another incident in May 2016 to the local authority. There was no record to confirm this had been completed. These safeguarding incidents had not been reported to the Commission. We also found that when meetings had been held with the local authority safeguarding team recommended actions had not always been completed. For example, staff had not been reissued with the safeguarding policy or completed refresher training in safeguarding. There was no documentation to show the action to minimise risk and keep people safe following a safeguarding concern.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff reported and recorded any accidents or incidents within care records. This detailed what had happened and immediate actions taken. The registered manager kept an overview of the accidents and incidents that had occurred. This showed the nature of the accidents or incidents and the responses taken. However, there was not a robust system to ensure incidents and accidents were reported to the registered manager as this was done verbally. We also found that the overview did not detail if other agencies such as the Commission or the local safeguarding team had been notified. Therefore, this was not always completed when required as we found one accident in May 2016 and one incident in July 2016 that had not been reported. The incident and accident forms and the overview did not effectively detail any preventative measures put in place to prevent re-occurrence. For example, a review of the person's care plan or risk assessment.

Individual risk assessments identified potential risks to people, for example in moving and handling, falls and skin integrity. There was not always sufficient guidance in place for staff on how to support people in minimising risks. For example with falls, health conditions and bedrails. In one care record it stated, 'high risk of falls, needs support from one carer to transfer and mobilise,' but no further details were given of how to support the person to remain safe. We also found that risk assessments had not been reviewed regularly as specified on the assessments. For example, one assessment in regards to falls was completed in December 2015 and was due for review in March 2016. This had not been completed.

An emergency plan was in place. This detailed what to do in the event of emergency situations such as a flood or severe weather conditions. However, the list of people was not up to date and did not provide

details of people currently living at the home. Out of the care records we reviewed we only found two people had an individual emergency support plan in place which detailed the support they would need in an emergency situation. These were both dated from 2014, and people's needs may have changed since this time. For example, a person's mobility may have reduced. The registered manager and staff were not aware if people had individual emergency plans in place. This meant that people's support needs may not be known or met in event of an emergency situation or evacuation. We also found that no risk assessments of the environment had been conducted.

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

A daily check had been introduced which checked the premises and environment in regards to health and safety, odours, fire safety and the kitchen. However, we found this had not been consistently completed. Items that required action were identified for example, a tap that was not working. However, we found boxes that had been left in the hallway, areas that were cluttered and could present a hazard for example the wheelchairs stored in another hallway and a chair on the first floor landing full of equipment. Also, areas that required cleaning for example the first floor carpet was not clean and bins in the toilets that were overflowing. These shortfalls had not been identified on the daily check.

People and relatives said they felt safe living at the home. One person said, "I am perfectly safe here." A relative commented, "This is a safe place for my relative because staff are not overworked and there are enough of them to be kind."

The home followed an appropriate recruitment process before new staff began working at the home. Staff files showed photographic identification, a minimum of two references, full employment history and a Disclosure and Barring Service check (DBS). A DBS check helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with certain groups of people.

We reviewed the staffing rotas from the previous eight weeks and saw that the numbers of staff were consistent with the planned staffing levels. The home was nearly fully staffed with two part time care vacancies. No issues with staffing were raised. Staff told us the team supported when staff members were absent by providing cover. One relative said, "My relative is looked after by the same staff. There is always someone around." Another relative commented, "The home has good staff retention." One person commented, "It is a good sign when the staff have been here a long time."
We reviewed records which showed that appropriate checking and testing of equipment had been conducted. This ensured equipment was maintained and safe for the intended purpose. This included safety testing of mobility aids, electrical equipment and the lift. There were also certificates to show testing of fire safety equipment, electrical equipment and gas servicing had been completed. Systems were in place to regularly test fire safety equipment such as emergency lighting, alarms and extinguishers. Regular practice fire drills had been undertaken.

The ordering, retention, and administration of people's medicines were safe. Medicines were stored within a locked medicines room. Medicines that required additional storage in accordance with legal requirements had been identified and stored appropriately. Registers of these medicines matched the stock numbers held. The temperatures of the medicines room and the medicines refrigerator were recorded daily to ensure medicines were stored correctly. The home used an electronic Medication Administration Record (eMAR). This showed the person's photograph, allergies and medicines. The system ensured medicines were given at the correct time.

Requires Improvement

Is the service effective?

Our findings

The service was not consistently effective as staff did not receive regular training in all areas they required. Nor, did staff always fully complete the home's induction programme. An induction programme was in place for when new staff began working at the home. This was not yet aligned with the Care Certificate. All the staff we spoke with confirmed they had completed a period of shadowing a more experienced member of staff. One staff member said, "I had a two week induction where I buddied up with a senior member of staff who showed me what to do." However out of three induction programmes we reviewed none had been fully completed. Two had some elements completed and one had not had anything completed even though these staff members had started in August 2016. The induction programme highlighted policies and procedures that staff needed to be aware of such as fire safety, health and safety and meal arrangements. As the induction programmes had not been completed it was unclear what information new staff had been given before they commenced work.

We reviewed the training records and saw that staff had received training in areas such as moving and handling and safeguarding adults. However, we saw some training had not been renewed for a period of time to keep staff updated or had not been completed by all staff. For example, in health and safety training. Out of 57 staff members 38 had not completed this training and 18 had completed this training in 2011 or 2012. This could mean that staff's knowledge and skills were not up to date. No staff had any recorded training in fire safety. We saw training specific to the needs of people living at the home was limited. For example, there was no training for staff in diabetes. Only 14 members of staff had received training in dementia awareness and, except for one person, these were all prior to 2011. We also saw that only four members of staff had completed training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards. Staff we spoke with had limited knowledge of the MCA.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We found that consent to care and treatment was not always sought in line with legislation and guidance. The process in relation to mental capacity assessments and best interest decision making was not being completed where appropriate. In all the files we reviewed we did not see any documentation of mental capacity assessments. For example, we reviewed two care plans of people who had a sensor mat in place in their room. This is a mat that alerts staff when the person steps on it and can be a form of control. There was no documentation of the consent given to have this in place nor a relevant mental capacity assessment to determine if the person had the capacity to agree with this decision. We viewed another care record where a person had bedrails in place. A relative had signed to consent for this. If a person does not have capacity to

consent to this decision, documentation needs to establish this and a best interest decision can then be made.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager was aware of their responsibilities in regards to the Deprivation of Liberty Safeguards (DoLS). Authorisations had been applied and renewed for where appropriate for five people. No conditions were currently in place.

People and relatives said that staff asked consent before giving care and support. One staff member said, "I always ask people if they want a shower. If they don't I ask again at another time," Another staff member described when personal care was given, "I always ask people's consent. I talk people through so they feel comfortable."

We found that staff had not received regular supervisions with a senior member of staff. Supervisions are where staff members meet one to one with their line manager or a senior staff member to discuss their performance and development. The information showed that staff did not always receive their supervision as scheduled. We saw that 13 members of staff had not received supervision since March 2016. Out of 45 staff members only 18 had received their supervision scheduled for September 2016. A new supervision format had been introduced in November 2016, which included an observation of practice as well as time to discuss areas such as training, personal development and staff's health and well-being. Staff members spoke positively about the new system. One staff member said, "Supervision is happening regularly now." Another staff member said, "It is useful to get feedback."

People were supported to have sufficient to eat and drink. People spoke positively about the food at Stanton Court. We observed people being regularly offered a choice of drinks. There was also an area where people and visitors could help themselves to hot and cold drinks. The menu for the day was displayed on a board in the dining room and in the hallway. One person said, "Excellent food, I always enjoy it." Another person said, "The food is very good, they will cooks something else if I do not like it." People chose different areas of the home to have their meal in or within their room. The dining room was limited with the amount of people it could accommodate and we saw two people having their meal there. We observed other people eating their meals on tray tables in the lounges and conservatory. People did not always appear at a comfortable height, as the chairs were low and the tables wobbled when people cut their food up. It was difficult for people to be socially interactive with others during mealtimes because of current arrangements as people were sat apart. The registered manager said the seating options at mealtimes had been identified as needing improvements. Changes were being considered to make the dining room accommodate more people and in a way that would promote social interaction.

People had access to healthcare services. Records showed when people were reviewed by healthcare professionals such as the GP or the chiropodist. When people were at risk due to their skin integrity. Records were kept of the preventative actions taken. Referrals were made in a timely manner when people's health deteriorated. However, we found that three people who had diabetes did not have a specific care plan in place on how to manage their health condition in line with recommended national guidance such as Diabetes UK or NICE. We saw from one person's daily notes, observations recorded that may have required

further action to be taken around their health condition. For example it was written on 5 November 2016, 'unresponsive.' At a mealtime, we also observed a staff member giving a person a dessert. Their relative who was with them, checked that it was suitable for their family member. Due to their health condition, there are certain foods they omit from their diet. The staff member had not considered whether the dessert was appropriate for this person.

Good

Is the service caring?

Our findings

People were supported by staff who were kind and caring. People and relatives spoke positively about the staff at Stanton Court. One person said, "It is the staff that make the difference. They are brilliant." Another person said, "Staff are fantastic, they treat me royally." A relative said, "Staff are kind to [Name of person], they speak so nicely to him and are very attentive."

We saw positive interactions between staff and people living at the home. We observed that staff had friendly relationships with people. One person said, "I get on well with staff, they humour me. We have a good relationship." Another person said, "I love it here, the girls are lovely, they look after me and we have fun."

Staff told us that the home provided good care. One staff member said, "Stanton Court provides good care. There is a good atmosphere, it is like a family." One person said, "Staff are kind. I am very satisfied with everything they do." Another person said, "The carers are lovely, they are amazing."

We observed staff treating people with kindness and compassion. People were comfortable in the presence of staff. We observed that staff listened to people and gave people time to respond. For example, asking people what they would like to eat or drink. We observed a member of staff supporting a person with their lunch. The pet cat came in and the staff member said, "Oh look, here comes the cat." The person then engaged in a conversation with the person about the cat.

People told us their privacy was respected. Staff told us they always knocked on people's doors before entering and we observed this taking place. One staff member said, "I always knock on the door." People told us that staff were sensitive to maintaining their dignity. For example, when providing personal care making sure that doors were closed and curtains were drawn. One relative said, "Staff treat [Name of person] with dignity, they are very kind and respectful." Another relative said, "They have a nice manner with him. I like the approach they use. They treat him in a respectful dignified way."

Staff spoke of the positive atmosphere within the home. One staff member said, "It is relaxed, everyone gets on. People are happy and content." One person said, "I like it here." Another staff member said, "It is very homely." One relative described the atmosphere as, "Happy and friendly."

Staff were knowledgeable about maintaining confidentiality within their role. One member of staff described this as, "Not sharing personal information."

The home had received 17 positive compliments since January 2016. One compliment read, "Thank-you for all the exemplary care you gave to Mum when she was in your care." Another compliment said, "Thank-you for the wonderful care you gave my sister. She was so content living at your nursing home and she told me that she felt much loved." Another person had written, "We are so grateful that he was able to spend his last few years in such a friendly and loving environment."

Family and friends could visit when they wished. One staff member said, "They can come whenever they wish." During our inspection we observed several family members visiting. One comment we read said, "I cannot tell you what it has meant to me to know that she was loved and safe and it has been wonderful to be welcomed whenever I to see her, whatever the time of day." Another comment said, "Always welcoming to relatives and visitors."

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to people's needs. Complaints were not always effectively recorded or responded to. We reviewed the complaints file which held a complaint from February 2015. There were no complaints to view within this file from 2016. However, we found two complaints from relatives held within a safeguarding record. One complaint made in July 2016 had been investigated and responded to. The complainant had reported they had not received a response within the timeframe specified in the provider's policy at that time. There was no documentation to show the second complaint made in June 2016 had been acknowledged, investigated or that the person who had made the complaint had received a response. This meant that issues raised with the home were not always effectively actioned to improve outcomes for people.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records contained a photograph of people and essential information. Care records were not person centred and gave limited details about people's backgrounds, family and interests. For example, not detailing where a person grew up, their previous employment or known hobbies. Care plans gave information such as people's preferred name, communication needs and usual routines. For example, 'able to communicate well' and 'usually settles around 7pm.' Care plans recognised people's religious and cultural needs. For example, 'likes church and mixing with people for social occasions.' However, the guidance for staff available of how to support people in their preferred way was minimal.

We found that care records were not reviewed regularly or when needed following an identified change or concern in a person's care and support needs. For example one care record said, 'review all details annually'. However, the last review date was September 2014. We reviewed the care records for one person who had a urinary catheter in place. Their catheter had been repeatedly blocked, but no recorded action had been taken to address this. This meant the person may not receive care needed in accordance with their individual need.

There was no one designated to arrange daily activities, although concerns about the lack of activity provision had been highlighted at resident and family meetings. On the rota a member of staff would be allocated 90 minutes per day in order to provide activities. However, we did not observe any activities taking place. People and relatives told us there was a lack of stimulation. One person said, "I just sit here with my eyes closed as I am so bored." The provider told us this would be addressed. There was an activity list of monthly events for the year. This had included a theatre trip, pub lunches and visits to local places of interest. A monthly timetable was devised which showed planned celebrations for people's birthdays, the home's anniversary and a carol concert and people told us these took place as planned.

Care records held documentation recording the activities people had been engaged with. These demonstrated a lack of organised activities. For one person we saw that in March 2016 their activities were watching television in their own room and a visit from a family member. We also found that these records

were not consistently completed. For example, the same person had activities completed for April, July and October 2016 but records were not completed for May, June, August or September 2016.

People told us that staff were responsive to their needs. One person said, "Staff are so attentive, they sit and chat with me, they are like family. They help me select my clothes, they pay attention to detail and I will do anything I need. I have to rely on them for so many things and I feel comfortable with them." Another person said, "They come quickly if I ring my bell." We observed that call bells were answered promptly. One relative told us how they had concerns as their relative was not eating well. Staff had suggested they make a list of foods they enjoyed. As a result, these foods had been incorporated into the menu. Another family member told us the home had prepared a packed lunch for their relative as they were attending a hospital appointment and they may be some time.

We reviewed minutes from a resident and relative meeting held in August 2016. We saw items such as activities, financial matters, the premises and environment were discussed. Actions taken were communicated to people. For example, the introduction of a new coffee machine, a photo board and a new medicines system. However, we found the minutes available to view before this meeting were from November 2015.

A new system to monitor and review people' satisfaction with the home had been introduced in November 2016. This asked a different person each week their views on the food, staffing, their care plan and raising concerns.

Inadequate

Is the service well-led?

Our findings

The service was not well-led. At the previous inspection in September 2015, two breaches of the regulations were found. The provider was required to send us an action plan that detailed how they intended to meet the regulations identified. This had not been submitted. At this inspection in December 2016 we found improvements had not been made and further shortfalls were identified.

Systems to monitor and review the quality of the service were minimal. We were shown audits of accidents and incidents and audits of people's weights. However, there were no audits of care records, training, health and safety or the environment. If audits of care records had been completed this would identified where information was due for review, needed including or had not been consistently completed. For example, updates to individual emergency plans, risk assessments, mental capacity assessments and activity records. Also, health and safety audits would have identified that the fire risk assessment dated July 2014 was stated as due for review in July 2015. This had not been completed. The lack of robust and effective governance systems had been highlighted at the last inspection in September 2015 and no significant changes or improvements had been made. The number of breaches identified at this inspection shows how the quality and safety of care had not been adequately monitored.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Notifications had not always been submitted to the Commission as required. We found an incident that had resulted in a serious injury had occurred in May 2016. This had not been reported to the Commission. In addition, a safeguarding notification had not been submitted in May 2016. A notification is information about important events which affect people or the home which the home is legally obliged to submit to the Commission.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

When a provider has been given a rating by the Commission it is required to conspicuously display this within the home and on its website. We found that this information was not displayed within the home. The new providers had displayed this information as required on their website. However we found that another website relating to the home was still active. The rating given to the home in after the inspection in September 2015 of 'requires improvement' was not displayed on this website. The information on this website gave misleading information to people, as it referred to 'Excellent' and depicted three stars next to the Commission's logo.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff spoke positively about the registered manager. One staff member said, "The manager is approachable and friendly." Another staff member said, "He is good, helpful and supportive." Staff said they worked well as

a team. One staff member said, "We are a close staff team. You can ask anyone anything"

The home was going through a transition period as new providers had taken over the home in October 2016. This meant that new systems were gradually being introduced and the home was changing to new policies and procedures.

A survey had been conducted in November 2016 for people and relatives and therefore the results had not yet been analysed. Positive comments were made such as, "It is a very caring nursing home, long may it continue." Responses were positive around the staff, meeting people's needs and maintaining and respecting people's privacy and dignity. However, responses highlighted a lack of activities, maintenance issues and poor communication to families. One comment stated, "Lack of communication to families and no activities on a daily basis."

The registered manager organised team meetings and staff confirmed this. The registered manager told us these were held every six months with the care staff. However, the last meeting minutes available to view were from February 2015. We were told there had been a meeting since then but no minutes were produced. We saw a recent meeting had taken place with the nursing staff in September 2016. We reviewed the minutes and saw that supervision, audits and responsibilities were discussed. However, the last meeting to view before this was from 2007. If meetings do not occur regularly or are not recorded it means that information is not always communicated effectively to staff members and items raised are not always actioned or addressed. For example, a serious accident or a safeguarding incident.

Daily information was communicated to staff. Messages and appointments were conveyed through a diary and the handover record. A written and verbal handover took place at the start of each shift so staff were kept informed of people's current support needs.

Relatives said they had not been kept well informed about the changes in the ownership of the home. A meeting had been held the previous week and relatives said this had provided further information. Relatives told us they could speak to any staff at the home to discuss how their family member was. We found records of contact with relatives in people's care records were not always kept up to date. For example, we reviewed one person's records where the last entry was February 2015 and contact had been made since.

The provider had completed and returned the PIR within the timeframe allocated and explained what the home was doing well. The new provider had set out where improvements were needed and how these would be addressed.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents Regulation 18(2) (c) The provider had failed to notify the Commission, as required of a notification

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 (1) The provider had not ensured that practice to obtain consent for care and treatment was in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (2) (b) The provider had not ensured that all reasonable steps had been taken to mitigate risks as the management of incidents and accidents was not effective, risk assessments were not regularly reviewed and individual emergency plans were not in place or had not been regularly reviewed.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 13 HSCA RA Regulations 2014

personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Safeguarding service users from abuse and improper treatment Regulation 13 (1) (2) The provider had not ensured people were protected from abuse as systems and processes were not effective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Regulation 16 (2) The provider did not have effective systems in place to ensure that complaints were responded to.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (2) (a) The provider had not ensured that staff had fully completed an induction programme or had sufficient and regular training to be effective in their role.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures	Regulation 17 (3) (b) & 17 (1) (2) (a)
Treatment of disease, disorder or injury	The provider had not submitted an action plan as required following the inspection in September 2015. The provider did not consistently operate effective systems to monitor and improve the quality of care provided.

The enforcement action we took:

We served a warning notice.