Sandylane Limited

Regent Hotel

Inspection report

11 North Marine Drive
Bridlington
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Tel: 01262673338

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 19 May 2016 and was unannounced. At our last inspection of the service on 22 April 2014, the registered provider was compliant with all of the regulations in force at that time.

The Regent Hotel is a care home that is registered to provide care and accommodation for up to 29 older people. It is situated on the sea front in Bridlington, in the East Riding of Yorkshire. Accommodation is located over three floors and had a passenger lift. It has mainly single bedrooms. The home also has assisted bathrooms and shower rooms. There is a large communal room and a separate dining room.

The registered provider is required to have a registered manager in post and on the day of the inspection, there was a manager in place, although they were not registered with the Care Quality Commission (CQC) and had not yet submitted an application for registration as they had only been in post for four weeks. A registered manager is a person who has registered with the CQC 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.

We found that staff had received an induction prior to starting work within the home; however, this did not always provide staff with the required skills to carry out their roles effectively. We also found that a high number of staff had not completed refresher training in a variety of topics and they lacked some knowledge in relation to the Mental Capacity Act 2005 (MCA). This was a breach of Regulation 18. You can see what action we told the provider to take at the back of the full version of the report.

We found that people's health needs were not always met. One person living in the home had experienced a sustained period of weight loss and although we saw that their weight was regularly monitored, no action had been taken to address the weight loss and there had been no contact made with any other professionals in relation to this. This was a breach of Regulation 14. You can see what action we told the provider to take at the back of the full version of the report.

We found the quality assurance systems in place had failed to detect issues of concern in relation to care planning, medication, staff training, the condition of some areas of the home and the monitoring of people's weights. Record keeping within the service also needed to improve. This was a breach of Regulation 17. You can see what action we told the provider to take at the back of the full version of the report.
We found that the premises were not properly maintained. This was a breach of a Regulation 15. You can see what action we told the provider to take at the back of the full version of the report.

We found that staff had a good knowledge of how to keep people safe from harm and there were enough staff to meet people's assessed needs. Staff had been employed following appropriate recruitment and selection processes.

We found that the administration of medicines was being managed appropriately at the service, although we identified some issues with the recording of medication.

The manager understood the Deprivation of Liberty Safeguards (DoLS) and we found that the Mental Capacity Act 2005 (MCA) guidelines had been followed. Staff did not use restraint, and this was confirmed during conversations with staff.

People told us they enjoyed the food and most people had enough to eat and drink. We saw people enjoyed a good choice of food and drink and were provided with snacks and refreshments throughout the day.

People told us they were well cared for. We found that staff were knowledgeable about the people they cared for and saw they interacted positively with people living in the home. People were able to make choices and decisions regarding their care.

People were offered a variety of different activities and were supported to go out of the home to access facilities in the local community, although people did indicate they would like more outings.

People's comments and complaints were responded to appropriately and there were systems in place to seek feedback from people and their relatives about the service provided. We saw that any comments, suggestions or complaints were recorded and acted upon when necessary.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff displayed a good understanding of the different types of abuse and could explain how to recognise and respond to signs of abuse to keep people safe from harm.

Staff had been recruited safely and there were sufficient numbers of staff employed to ensure people received a safe and effective service.

Risk assessments were in place and reviewed regularly, which meant they reflected the needs of people living in the home.

The home had a system in place for ordering, administering, storing and disposing of medication. However, we found some issues in relation to the recording of people's medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received the required training within the time scales identified by the registered provider.

The manager was able to show they had an understanding of Deprivation of Liberty Safeguards (DoLS) and we found the Mental Capacity Act 2005 (MCA) guidelines were being followed.

We saw most people's nutritional needs were met and that when people required support to eat and drink this was provided. People enjoyed the food and told us they had a choice at mealtimes.

People's health needs were not always met. Most people who used the service received, where required, additional treatment from healthcare professionals, however we found one instance where this had not happened.

We found that the premises were not properly maintained. Some carpets in people's bedroom's were poorly fitted, one room had a damp patch on the ceiling and wallpaper was coming away

from the walls.

Is the service caring?

Good

The service was caring.

We observed good interactions between people who used the service and the care staff throughout the inspection.

People were treated with respect and staff were knowledgeable about people's support needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had their health and social care needs assessed and plans of care were developed to guide staff in how to support people. However, these plans were not always reflective of people's current needs.

We saw people were encouraged and supported to take part in a range of activities.

There was a complaints procedure in place and people knew how to make a complaint if they were dissatisfied with the service provided.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service did not have effective systems in place to monitor and improve the quality of the service.

Staff and people who visited the service told us they found the manager to be supportive and felt able to approach them if they needed to.

There were sufficient opportunities for people who used the service and their relatives to express their views about the care and the quality of the service provided.

Regent Hotel

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 registered 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 was carried out on 19 May 2016 and was unannounced. One Adult Social Care (ASC) inspector carried out this inspection.

Before this inspection, we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authorities that commissioned a service from the home. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they had with the home.

The registered provider was asked to submit a Provider Information Return (PIR) prior to the inspection, as this was a planned inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The registered provider submitted their PIR in the agreed timescale.

During the inspection, we spoke with three members of staff, the manager, the cook, a member of domestic staff, two people who used the service and two relatives. We spent time observing the interaction between people who lived at the home, the staff and any visitors.

We looked at all areas of the home, including bedrooms (with people's permission) and office accommodation. We also spent time looking at records, which included the care records for three people, medication records for six people, handover records, supervision and training records for three members of staff and quality assurance audits and action plans.

Good

Is the service safe?

Our findings

The service had policies and procedures in place to guide staff in safeguarding people from abuse. We saw the manager used the local authorities safeguarding tool to decide when they needed to inform the safeguarding team of an incident, accident or an allegation of abuse. We saw that safeguarding concerns were recorded and submitted to both the local safeguarding team and the Care Quality Commission (CQC) as part of the registered provider's statutory duty to report these types of incidents.

We spoke with three members of staff about safeguarding; we asked how they would identify abuse and the steps they would take if they witnessed abuse. We asked staff to tell us about their understanding of the safeguarding process. Staff gave us appropriate responses and told us they would initially report any incidents to the manager or the senior care worker on shift and they knew how to take it further if needed. One member of staff told us, "I would report anything of concern to the senior on shift or the manager. If I needed to I would contact the CQC directly." Another told us, "I'd have no qualms about reporting anybody."

We saw the home had systems in place to ensure that risks were minimised. Care plans contained risk assessments that were individual to each person's specific needs. This included an assessment of risk for falls, pressure care, mobility and nutritional status. Staff told us they continually worked to minimise the risks that people using the service were exposed to. For example, one staff member said, "Some people get up during the night and this makes them more at risk of falls, we have sensor mats in place to warn us when they get up. If people are up and they don't want to go back to bed, I make them a cup of tea and bring them downstairs so we can keep an eye on them." Another told us, "We check to make sure the food is at the right texture for people, we check the wheelchairs to make sure they are safe and always keep an eye on people as things can happened in the blink of an eye."

We saw Personal Emergency Evacuation Plans (PEEP) were in place for all of the people living at the service. The purpose of a PEEP is to provide staff and emergency workers with the necessary information they need to assist people to evacuate the premises safely during an emergency. We also saw that people were required to sign in and out of the home, which created a record of visitors and ensured that people could be safely evacuated in the event of an emergency. This showed the manager had taken steps to reduce the level of risk people were exposed to.

Accidents and incidents were recorded and audited on a monthly basis. The audits identified the number of incidents and accidents, the severity of the incident, whether emergency assistance was required, if the person was admitted to hospital, whether CQC had been notified and whether a RIDDOR notification was required. When an injury had occurred or was suspected, body maps identifying the location of the injury and 72-hour observation checks were put in place. This provided prompts for the staff to carry out increased observations and notify the appropriate health care professional should the person experience any deterioration in health or a change in their usual behaviour. We also saw that the accident and incident file contained guidance for staff regarding head injuries and the protocol to follow should this occur.

We confirmed that checks of the building and equipment were carried out to ensure people's health and

safety was protected. We saw documentation and certificates to show that relevant checks had been carried out on the electrical circuits, gas safety, fire extinguishers, emergency lighting, passenger lift, nurse call system, weighing scales and all lifting equipment including hoists. We saw that a suitable fire risk assessment was in place and regular checks of the fire alarm were carried out to ensure that it was in safe working order. We also saw that regular fire drills took place to ensure that staff knew how to respond in the event of an emergency. This showed that the registered provider had taken appropriate steps to protect people who used the service against the risks of unsafe or unsuitable premises.

We spoke with the manager about how they ensured there was enough staff on duty to safely meet people's needs. The manager told us, "We adjust the number of staff based on the dependency of people in the home. You could have the same number of people but with higher needs and they would obviously need more staff." On the day of this inspection, there was the manager, one senior care worker, two care workers, a cook, a kitchen assistant and a member of domestic staff on duty. We checked rotas and found that on a night there were two members of care staff on duty. Our observations confirmed there were sufficient levels of staff to meet the needs of the people using the service.

We looked at the recruitment records for three staff members. We found the recruitment process was robust and all employment checks had been completed. Application forms were completed, references obtained and checks made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and ensured that people who used the service were not exposed to staff that were barred from working with vulnerable adults. Interviews were carried out and staff were provided with job descriptions, terms and conditions of employment and policies and procedures (including whistleblowing, confidentiality and the disciplinary procedures). This helped to ensure staff knew what was expected of them.

We were told that only the management team and seniors carers were currently trained in the administration of medication and checks of the training records confirmed this. However, the manager told us they had also started to provide medication training for some of the more experienced care staff. It was hoped that this would ensure that people could access medication 24 hours per day without the need to rely on on-call managerial or senior care staff during the night.

We observed a medication round and saw that this was completed in a non-obtrusive and respectful manner. We saw the member of staff wore a tabard to indicate that they were carrying out a medication round so should not be disturbed. This enabled them to remain focused on the task. We saw the medication cabinet was locked each time it was left unattended; this prevented people accessing other people's medication. We also saw that the member of staff waited until the person had taken the medication before they signed the person's medication administration records (MARs). One person using the service told us, "I always get my medication on time."

We found the service used a monitored dosage system supplied by a local pharmacy. This is a monthly measured amount of medication that is provided by the pharmacist in individual packages and divided into the required number of daily doses, as prescribed by the GP. It allows for simple administration of medication at each dosage time without the need for staff to count tablets or decide which ones need to be taken and when.

We looked at how medicines were managed within the home and checked a selection of people's MARs. We found that medicines were obtained in a timely way so that people did not run out of their medication, administered on time, stored safely and disposed of appropriately. There were facilities available to store

controlled drugs (CD's). These are medicines that have strict legal controls to govern how they are prescribed, stored and administered. We carried out a stock check of six of the CD's stored at the service and found that the records tallied with the amount of medication in stock.

However, we found that there were issues with the recording of medication. For example, we saw that when one person's GP had made changes to the amount of medication the person was required to take, this had been transcribed on to the MAR chart. However, the person transcribing had not signed to identify who they were, nor had they sought a second signature in line with best practice. We found protocols were in place for 'as and when required' (PRN) medication, however one person's protocol did not include the name of the medication to be given. We also found issues with the stock control of PRN medication, as the amount of medication brought into the home had been incorrectly recorded making it impossible to tally the amount of medication that remained in stock. We found that although weekly medication audits had taken place they had failed to detect the issues identified. However, following a stock take on the day we were satisfied that the amount of medication on the premises was correct and that it had been administered as required. We have addressed the issue of poor recording in the Well-led section of this report.

During the inspection, we found the home to be clean, tidy and free from odour. Infection control audits were completed on a monthly basis and we saw that there was detailed information available for staff on hand washing and what to do in the event of an outbreak or suspected outbreak of an infectious disease within the home. Cleaning schedules included daily, weekly and deep cleaning tasks that required completing by the domestic and night staff. The domestic staff confirmed they had sufficient equipment and cleaning products available and they always ordered in advance to ensure they did not run out. This showed us that the manager had considered the impact of infection for people in the home and had put interventions in place to minimise this risk. However, we did note that in one of the upstairs bathrooms that contained a bath and a toilet there were no facilities for the effective washing of hands. We discussed this with the manager and they agreed to ensure that hand soap and paper towels were immediately put in place.

Requires Improvement

Is the service effective?

Our findings

The service had an induction in place for new starters to complete prior to starting work in the home. The induction covered a range of topics including the company's philosophy, code of conduct, health and safety and also more practical training such as supporting people with personal care, moving and handling, pressure area care, assisting people to eat, bathing, denture care, use of hoists and customer service. We were told that as part of the induction staff had the opportunity to shadow more experienced members of staff before they were included on the rota. A new member of staff said, "All the staff have been very helpful, supporting me to settle in and get used to all the different jobs I have to do."

We spoke with one member of staff to ask what training they had received prior to starting in their role as a care worker. They told us that they had completed the registered provider's induction and shadowed staff for four shifts before they were included on the rota, but had not received any formal training prior to starting. They told us they had recently completed moving and handling training, were booked on the safeguarding of vulnerable adults training and were in the process of working through the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. We discussed this with the manager who said that they would not ask staff to perform any tasks they were not trained in, and had arranged formal training in moving and handling and safeguarding at the earliest available opportunity.

The staff we spoke with told us they had received training, but acknowledged that some of it was ready for renewal. One staff member told us, "I've had training in the past, but it's been a while now." Another told us, "I've had loads of training, but they are currently updating all of our training. If I'm lacking anything then I will just tell the manager and they book it." We viewed the services training records and found that the system to record training was under development; it was therefore submitted to us following the inspection. The registered provider had identified areas of training which they deemed mandatory, including moving and handling, safeguarding, health and safety, fire safety and infection control and the expectation was that these would be completed annually. We saw that other training including dementia awareness, first aid, food hygiene and medication training was expected to be completed every three years. However, when we viewed the training record provided we saw that a number of staff had not completed the mandatory training within the stated period.

The manager explained they had inherited a staff team with a backlog of out of date training and that with support they had started to develop a system that would effectively record what training staff had completed and what training was needed to ensure the staff team had the necessary skills to perform their roles effectively.

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

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation, which is designed

to ensure that the human rights of people who may lack capacity to make decisions are protected.

The 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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that one person was subject to a DoLS authorisation at the time of this inspection and the manager had notified the CQC about this as required.

As part of the admission process people were asked to sign to state they were happy with the content of their care plan and if they consented to being photographed. When people were assessed as lacking the capacity to make their own decisions, a family member or representative had signed on their behalf. We found that staff were able to explain how they ensured that people consented to care interventions, by asking their permission, or by explaining each step of the intervention they were carrying out. However, we found that some lacked the appropriate level of knowledge of MCA for their role, although we did not see any practice that contradicted MCA guidelines. When we viewed the training records, we saw that only a few of the staff had completed MCA training.

People told us they enjoyed the food. Comments included, "We have a soup for starter, it's always lovely", "The food is always nice", "It is always tasty", "I couldn't grumble about the food" and "We get a choice." A visiting relative told us, "[Name of relative] always eats well; they eat better here than they did at home."

We were told that a choice of meals and drinks were offered and that people could have a glass of wine with their meals if they chose to. The cook told us that they offered people a choice and that alternatives were available if people did not want either of the choices available. One member of staff told us, "When we ask people what they want to eat, sometimes they can only remember the last option we told them, I always repeat the choices to make sure they are happy with what they have chosen."

We observed the serving of lunch and although people received their meals in a timely manner and clearly enjoyed the food, we felt that improvements could be made to the dining experience. We saw that people were helped to their seat just before lunchtime so they did not have to wait long for their meal to be served. We saw that aprons were offered to protect people's clothing from any spillages and that tables were set with tablecloths, placemats, napkins and cutlery. However, condiments were not provided and this meant people had to ask for these.

There were sufficient numbers of staff to support people during mealtimes and we saw that when people required assistance with eating that this was provided by staff who offered reassurance, prompts and checked the person had eaten as much as they wanted. However, we saw one member of staff chose to squat down next to the person they were assisting. It would have been a more relaxed experience for both if the staff member sat in a chair, either alongside the person or opposite them during this intervention.

We saw that the kitchen had cleaning schedules in place and that the temperature of fridges and food was taken daily. The home had achieved a rating of three following a food hygiene inspection undertaken by the

local authority Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. One is the lowest score and five is the highest score achievable.

People were weighed on a regular basis and this information was recorded in their care plan. We saw they had their dietary needs assessed and plans were put in place to help the service meet these needs. However, we found that plans were not always followed, for example, one person was diabetic and had a risk assessment in place, which clearly stated that they needed to eat regularly to reduce the risks associated with hypoglycaemia. From our observations, we found that they were allowed to sleep for long periods throughout the day and although the person had been offered a cup of tea, they had not been offered any food between breakfast and mid-afternoon. We could see from records that the person had been weighed on three occasions between January 2016 and May 2016. During this period, they had experienced a weight loss equating to 11% of their total body weight. This person had not been referred to the GP or a dietician for a full nutritional assessment. We discussed this with the manager who assured us that the person did receive regular meals, but as there was no food and fluid chart in place, we were unable to verify this.

We found that some people using the service did have food and fluid charts in place and these recorded the amount and type of food and fluid consumed on a daily basis. However, we saw that these were not always accurately completed. Fluids were not always totalled at the end of the day and there was also no information or advice included to indicate how much fluid should be consumed daily and how staff should respond if a person's fluid intake fell below a certain level. The food charts we viewed were inconsistent and did not include a reason why the person had not eaten a meal. This made it difficult to determine whether a meal had been offered and the person had not eaten it or whether they had eaten and the chart had simply not been completed.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people who were at risk of developing pressure sores had repositioning charts in place to ensure they were repositioned within a specific timeframe to alleviate pressure on areas of fragile skin. However, we saw that these charts were not accurately completed, did not always contain the required information and on occasions were left blank or recorded that the person had only been turned once. For example, we saw one person's chart did not inform the care staff how frequently they needed to be repositioned. We discussed this with the staff and the manager who informed us that the person was turned on a regular basis. However, they acknowledged that the recording of the positional changes needed to improve. We saw notes from the district nurse that stated there were no concerns in relation to the persons pressure sores, which indicated the correct regime was been followed.

We saw when people had attended meetings or appointments, or a health or social care professional had visited, this was recorded in the persons care file. However, we saw that the recording of this was inconsistent. For example, we saw one person had attended an 'eye check' but there was no detail regarding the outcome of the check. We saw another entry simply stated 'Social worker visited today', without any further detail recorded. Including additional detail would help the staff develop a better understanding of how the needs of people were changing and whether any amendments needed to be made to people's care plans. The manager told us that the quality of recording in the home had been addressed with staff and the minutes of a recent meeting confirmed this.

The home had a traditional, but homely feel to it and was for the most part in reasonable condition, albeit a little dated. We saw that people were able to personalise their rooms with pictures, photographs and ornaments and other items of sentimental value. One person using the service preferred to spend time in

their room and had a large model train set in situ to help occupy their time. However, we noted that some areas of the home required some immediate attention. One of the bedrooms we viewed had an ill-fitting carpet that moved underfoot, a damp patch on the ceiling, a chipped and dated sink unit and the wallpaper had started peeling off one of the walls. We also saw that one of the baths was worn to the enamel base and the bath panels required replacing to ensure effective cleaning could take place. The manager acknowledged there were areas of the home that required attention and assured us that these would be addressed.

This was a breach of Regulation 15 of the Health and Social Care Act 200 (Regulated Activities) Regulations 2014.

Good

Is the service caring?

Our findings

We found there was a friendly, relaxed and homely feel to the service. On arrival, we found that some people were up and had already eaten breakfast and were either watching television or reading the daily newspaper in the lounge. Small groups of people who lived in the home were chatting and discussing how they were feeling and it was clear they had developed friendships with the people they lived with.

We spent time observing people who used the service and saw how they interacted with staff and other people living in the home. We saw that most people appeared to be relaxed, happy and engaged in their environment. We saw people were comfortable in the company of staff and were able to share a laugh and a joke. People using the service were happy to approach staff and ask for support and staff knew how to respond. One person, however, chose to spend most of the day sat away from the rest of the group and would occasionally shout out. We saw that staff were generally quick to respond to this person and some were able to swiftly determine what the person wanted or needed to help them settle.

People told us they were given a choice about how their care was provided. They told us they could choose what time they got up and what time they went to bed, they were given a choice of meals and we saw they could choose where they sat and whom they spent their time with. They also said they were able to decide what activities they wanted to join in with and we saw that on their bedroom doors it identified whether the person would rather have a male or a female carer or whether they had no preference. Staff told us they tried to provide people with as much choice as possible regarding the care they received. One member of staff told us, "I always ask people what they would like to wear, whether they would like to come downstairs, what they would like to eat and drink and let them decide how they want to spend their day." One person who used the service told us, "When I first moved here, I wasn't happy, but I requested this room and since moving in I haven't looked back."

Staff told us they promoted the independence of people using the service. One member of staff told us, "I encourage people to do things for themselves as much as possible. This could be anything, like today I got one lady to walk five steps, which was a big achievement for her" and "I'll always ask people if they want to try and do something for themselves before I do it, especially with their personal care." However, one person who lives at the home felt that sometimes staff expected too much from them saying, "Sometimes they expect me to do something for myself and I just can't, but I tell them."

People were treated with dignity and respect. We saw that staff knocked on people's doors before entering, called people by their preferred name and ensured bathroom doors were closed quickly if they needed to enter or exit, so that people were not seen in an undignified situation. We observed staff supporting a person to move from their dining chair into their wheelchair with the aid of a hoist. Staff talked them through the process explaining where they were positioned and what they needed to do next to help the staff safely complete the manoeuvre. We saw that staff ensured that the person's dignity was protected throughout by ensuring their dress was appropriately placed to avoid any embarrassment.

A relative told us "Over the years I've seen good and bad, but the staff are really good with [Name of relative],

they all get on with her and she seems to like them" and "[Name of person] needed to go to hospital and two of the girls came in on their day off and took her, they really care." A member of staff told us, "I love the resident's and I love my job. The residents are really vulnerable and I work to make sure that there time here is the best it can be."

Relatives and visitors were welcomed at the home and were free to come and go as they pleased and stay as long as they liked. One relative told said, "I can ring and call in whenever I want, although I usually visit in the morning." Another said, "I come as often as I can and normally visit in the evening." Some family members and friends chose to spend time in the home with their relatives, whilst others liked to take people out for lunch, a drink in a local cafe or to do some shopping in the town.

There was information about advocacy services available to people who lived at the home. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them.

Discussion with the staff revealed there were no people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that some people had religious needs, but these were adequately provided for within people's own family and spiritual circles. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Requires Improvement

Is the service responsive?

Our findings

The manager told us that it was their intention to complete pre-admission assessments themselves, to ensure that they were fully satisfied that the service was able to meet the needs of any person moving to the home. They said this would also allow them to assess the impact of any new admissions on the people already living in the home. Following the pre-admission assessment, interim care plans were developed to ensure that staff knew how to manage the needs of people with whom they were unfamiliar. The information they collated during this initial period was then used to develop a comprehensive care plan covering all the assessed needs.

The care plans we viewed were written in a person centred way and contained information including the person's life history, one page profiles, daily routines and likes and dislikes. This information enabled staff to develop a better understanding of the person they were supporting and helped them to target conversations on subjects the person was interested in. People told us that either they or a representative was involved in the initial planning of their care. One relative told us, "Yes, they involved me at the beginning to make sure they knew what they needed to know about [Name of relative]."

Care plans were reviewed on a monthly basis and updated based on the information shared during handovers, the information recorded in people's daily records and information received from health and social care professionals. However, we found that some of the care files contained contradictory information and advice for staff to follow, or in some cases did not provide clear guidance on how to effectively meet people's needs. For example, one person's health had deteriorated and they were now cared for in bed. However, we found that an interim care plan developed in April 2016 stated that the person should get up and out of bed each day. We discussed this with the manager and staff and they told us that the person had continued to deteriorate so were now cared for in bed.

We also saw that one person had spent a significant amount of the day asleep in the lounge. We monitored the interaction with this person and found that they were allowed to sleep for long periods without staff waking them. We discussed this with the manager and care staff and they told us that when woken the person could be agitated and at times verbally abusive. We viewed the persons care plan and saw that there was no plan in place to advise staff how to effectively manage this type of behaviour.

We found that there was a lack of accurate care records in place and have reported on this further under Regulation 17.

The home employed an activity coordinator and they carried out a variety of activities within the home, arranged for entertainers to visit the service and took people out into the local community when they requested this. On the day of this inspection, the activity coordinator was on leave; however, we discussed what activities normally took place within the service with people living there. People told us there were a variety of activities available to them including quizzes, bingo, arts and crafts, movement to music, foot massage, snakes and ladders, memory games, dominoes, nail care and a library service. One person also attended a local day centre.

One person using the service told us, "[Name of activity coordinator] is great, they keep us all going and we can have a laugh" and "You can go in the garden if you want, you just have to ask." Another said, "I can't do the exercises, but I like the bingo" and "I spend some of the time downstairs but after dinner I come to my room and watch TV or read my book." One visiting relative told us, "Yes, there always seems to be things going on, they bring entertainers in and [Name of relative] has been out with the activity coordinator." Another said, "They send me pictures through when they have taken [Name of relative] out, it is reassuring to know they are getting out and about" but also mentioned, "Although they take [Name of relative] out, they are unable to sit out anywhere."

The activity co-ordinator produced a monthly newsletter that outlined any upcoming events that were taking place in the home. We saw that there were a number of people coming into the home to provide entertainment for people using the service. These include local singers and children from a local nursery who were going to sing for people. The newsletter also reminded people of the dates when the hairdresser was attending, when the 'sweet man' was visiting and announced any special events including people's birthdays.

The service had policies and procedures in place to effectively manage any complaints that they received. We found that the service did not receive many complaints but the complaints and compliments they did receive were recorded correctly. We saw that complaints were fully
investigated and that the complainant always received a response, although we noted there was no documentation available to indicate that people were happy with the outcome. The complaints record showed us appropriate action had been taken in response to any complaints received. For example, one person complained that staff were banging doors during the night. This issue was discussed with the staff on duty to ensure they were more considerate about how they moved around the building at night time in order not to disturb people.

A copy of the complaints procedure was available in the reception area of the home. All of the people we spoke with said that if they had any concerns they would speak to either the manager or a member staff. One visiting relative told us, "If I had any issues then I would speak with the staff, if it was something serious I would speak to the manager." From our discussions with staff, we found they knew how to support people to make a complaint if they needed to.

Other opportunities were available for people to offer feedback on the service they were receiving. Meetings for people using the service and their relatives took place and we saw the last one was held on the 18 May 2016. One person said, "I attend the meetings, I have my say." The issues discussed included quality of care, care staff, mealtimes and food, activities and any complaints. It was clear from the comments that people felt comfortable raising any issues or making requests. For example, we saw that people had stated that although most of the staff were very good, some were grumpy. We also saw that they had requested some additional activities other than singers, such as people with animals visiting the home. Although this information had been recorded and collated by the home, there were no actions agreed at the meeting to indicate what the service was going to do in response to the requests and comments. We discussed this with the manager and they agreed to amend how the meeting was recorded to clearly evidence what action had been taken in response to any suggestions.

Requires Improvement

Is the service well-led?

Our findings

We found there was a quality monitoring system in place that consisted of daily, weekly, monthly and annual audit checks, meetings, questionnaires and the analysis of the information collated from these. However, we saw that the quality assurance system was not always effective and required improvement. We found the systems in place had failed to detect issues of concern in relation to care planning, medication, staff training, the condition of some areas of the home and the monitoring of people's weights. Where concerns had been raised there was no clear action plan, to record what the registered provider was doing in response.

The service kept records on people that used the service, staff and the running of the business that were in line with the requirements of the regulations and we saw that they were appropriately maintained, up-to-date and securely held. This meant that people's personal and private information remained confidential.

However, some record keeping within the service needed to improve. We saw evidence that medicine records, care plans, repositioning charts and food and fluid charts were not always accurate or up to date. This meant that staff did not have access to complete and contemporaneous records in respect of each person using the service, which potentially put people at risk of harm.

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

The home is required to have a registered manager in post. A registered manager is a person who has registered with CQC 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. On the day of the inspection, there was a manager in post. However, they were not currently registered with the CQC. They told us that they had previously worked as the deputy manager of the home and had agreed to take over as manager following the departure of the previous manager. They were currently being 'coached' by a previous registered manager and the registered manager from another of the registered provider's services. They planned to apply for registration in near the future.

Services such as Regent Hotel that provide health and social care to people are required to inform the CQC of important events that happen in the service. The manager of the service had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

Staff received support from the manager, which included appraisals, team meetings, regular face-to-face conversations and formal supervision. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to its staff. It is important staff receive regular supervision as this provides an opportunity to discuss people's care needs, identify any training or development opportunities and address any concerns or issues regarding practice. Staff told us they were able to approach the manager with any concerns at any time and they felt they had sufficient support when they needed it most. One member of

staff said, "The new manager…they're approachable, I can go to them with anything." Another said, "They've been brilliant, no problems, I can approach them and I know they will act on any issues that are raised" and "I've noticed that there have been some improvements already, things like the general upkeep of the home have got better."

People told us that the communication within the home was generally good and that staff kept family members and people's representatives up to date with any changes to a person's needs, whether they had any health appointments and if they were unwell or had been involved in an accident or incident. One relative told us, "No problems with communication, the staff always ring straight away." Another said, "I can call them whenever I want for an update and they always call if anything has happened."

Regular meetings took place for people who lived at the home, relatives and staff. This ensured that people had an opportunity to feedback any concerns, compliments or complaints. We saw that these were well attended and that meetings were always a two way process that enabled people to talk openly about any issues or improvements they would like to see. However, we found that any agreed actions were not always recorded, making it difficult to assess how the service had responded to do the requests and comments received.

We discussed the key challenges the manager felt they faced. The manager informed us that they were looking forward to the challenges ahead. They told us they were in the process of developing an action plan to ensure that areas identified as requiring improvement were addressed as a priority.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not always ensure that people using the service had their nutritional and hydration needs adequately met. Regulation 14 (1)(2)(a)(i)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who use the service were not protected against the risks associated with premises that were not properly maintained and unsafe or unsuitable equipment because of inadequate maintenance. Regulation 15 (1)(c)(e)

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 in place effective systems to assess, monitor and improve the quality and safety of the services provided in the carrying out of the regulated activity. Regulation 17 (1)(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People who use the service were not protected from the risks associated with receiving care from staff who were not properly trained to

carry out the duties they are employed to perform. Regulation 18 (1)(2)(a)