Care Quality Commission

Bupa Care Homes (ANS) Limited

The Harefield Nursing Centre

Inspection report

Hill End Road
Harefield
Middlesex
UB9 6UX
Tel: 01895825750
Website: www.bupa.co.uk

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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?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on 1 September 2015 and was unannounced.

The Harefield Nursing Centre is a care home with nursing for up to 40 older people. At the time of our inspection 38 people were living at the home. Some people living at the home were living with dementia. The home was run and managed by Bupa Care Homes (ANS) Limited. There was a registered manager in post, however she was on extended leave at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The home was being managed in her absence by an acting deputy manager who was supported by senior staff from Bupa who visited the home at least twice a week. The registered manager was due to return to work in October 2015.

Summary of findings

People's needs were not always met because there were sometimes not enough staff and the staff were not always deployed in a way to meet these needs.

People's capacity to consent had not always been recorded and their written consent had not always been obtained.

The staff did not always treat people respectfully. For example they did not always respect their privacy, offer them choices or use their names when referring to them.

People did not always receive care and treatment which reflected their individual needs and preferences.

Records were not always accurately maintained or up to date.

The service was being managed by an acting deputy manager. The registered manager was not working at the home at the time of the inspection.

The provider had systems to monitor the quality of the service, including audits of the service. However, these did not always mitigate the risks to people.

There were appropriate procedures for safeguarding adults and the staff were aware of these.

The risks people were exposed to had been assessed and there were plans to minimise risks.

People received their medicines in a safe way.

The staff received the training and support they needed to undertake their roles.

People's health care and nutritional needs were assessed, recorded and met.

Some of the staff did treat people with respect. We saw kind and caring interactions and people told us the staff were kind and caring. Individual care plans were in place.

The provider had an appropriate complaints procedure and people felt their complaints were acted upon.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

People's needs were not always met because there were sometimes not enough staff and the staff were not always deployed in a way which effectively met these needs.

There were appropriate procedures for safeguarding adults and the staff were aware of these.

The risks people were exposed to had been assessed and there were plans to minimise risks.

People received their medicines in a safe way.

Requires improvement

Is the service effective?
The service was not always effective.

People's capacity to consent had not always been recorded and their written consent had not always been obtained.

The staff received the training and support they needed to undertake their roles.

People's health care and nutritional needs were assessed, recorded and met.

Requires improvement

Is the service caring?
The service was not always caring.

The staff did not always treat people respectfully. For example they did not always respect their privacy, offer them choices or use their names when referring to them.

However, some of the staff did treat people with respect. We saw some kind and caring interactions and people told us the staff were kind and caring.

Requires improvement

Is the service responsive?
The service was not always responsive.

People did not always receive care and treatment which reflected their individual needs and preferences.

Individual care plans were in place.

The provider had an appropriate complaints procedure and people felt their complaints were acted upon.

Requires improvement

Is the service well-led?
The service was not always well-led.

Requires improvement

Summary of findings

Records were not always accurately maintained or up to date.

The service was being managed by an acting deputy manager. The registered manager was not working at the home at the time of the inspection.

The provider had systems to monitor the quality of the service, including audits of the service. However, these did not always mitigate the risks to people.

The Harefield Nursing Centre

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider 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 took place on 1 September 2015 and was unannounced.

The inspection team included two inspectors, a pharmacy special 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. The expert-by-experience on this inspection had personal experience of caring for people who had dementia.

Before the inspection we looked at all the information we had about the provider. This included notifications of significant events, concerns and safeguarding alerts.

During the inspection visit we spoke with ten people who used the service, six of their relatives who were visiting and staff on duty who included the acting deputy manager, nurses and health care assistants. We also spoke with the regional director who was visiting the home on the day of our inspection.

We looked at the environment and observed how people were being cared for. We looked at the care records for six people who lived at the home, how medicines were managed, staff recruitment, training and supervision records for five members of staff and the provider's records of complaints, accidents and incidents and quality monitoring.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe at the home and with the staff. Some of the things they said were, ‘’I am safe and happy’’, ‘’I am safe and have my medicines on time’’, ‘’the environment is safe and people are kept safe by the staff who seem experienced’’, “Safe! Gosh yes, I feel safe with the staff, happy go lucky lot, I like them” and “I feel safe and the staff are very good, very understanding and very patient.”

The relatives we spoke with also felt people were kept safe. However they were concerned that there were not always enough staff on duty to meet people’s needs.

Some of the people who lived at the home also told us there did not always seem to be enough staff. Some of the things they said were, ‘’there are not enough staff’’, ‘’they are rushed off their feet’’ and ‘’it worries me that some people need extra help and they do not get it, for example help to eat.’’ One person told us the staff were sometimes too busy to answer their call bell and they had to ‘’shout if I want help.’’ Another person told us the staff were ''never available'' to do anything with people and therefore they were ‘’bored’’ and ‘’just slept because there is nothing else to do.’’

People gave us examples of when they had waited for care and support. One person showed us that their relative was still in bed at 11.30am on the day of our inspection. They told us this was not their choice, it was that the staff had not had time to support them to get up. People also told us they had to wait a long time for meals. On the day of our inspection we saw that some people who required support to eat their meal were not given this support until 1.30pm, an hour after the stated time for lunch and when others had started to receive support. One person was seated at a dining table with others who were eating for 35 minutes before they were served their meal.

Throughout our inspection we saw people who remained in bed and people who were left seated in communal areas for long periods of time without staff support. Some of the people at the home had complex needs due to their dementia or mobility and required two members of staff to support them with physical care. We observed that people received support to meet physical care needs but that the staff did not spend time interacting with people or attending to their social and emotional needs. Where people were able to manage part of their own care, for example eat their meals without assistance, the staff brought them their food and took their empty plates away but did not spend time supporting the person to have a positive mealtime experience. We observed the staff supporting people to come into the communal areas but they left them there without anything to do, or interacting with them apart from brief acknowledgements. The staff appeared focussed on the physical tasks they were attending to and we heard them discussing their next task with other members of staff before they completed what they were doing with one person.

The staff told us they did not think there were enough of them. They said that they could not give everyone the support they needed when they needed it. They told us that in one unit 10 people required support to eat meals and nine people required some support to move safely from one place to another, with six people requiring the support of two members of staff for this. They told us there were four health care assistants working in this unit and 20 people in total to care for. In the other unit there were three health care assistants on duty in the day, one person was expected to remain in the communal lounge at all times leaving two health care assistants to attend to everyone in their rooms including meeting personal care needs. On the day of our inspection there were only three people in the lounge for over an hour, although some people were attending an organised activity in the other unit, the majority of people remained in their bedrooms for the morning. The staff said that it was not possible to make sure everyone was supported out of bed or to eat their meals in a timely manner. One member of staff told us it regularly took two hours for each meal time to make sure everyone received the support they needed. The nurses told us they did not have enough time to read care plans and to update these. One care plan we saw was incomplete and the nurse on duty told us they had not had an opportunity to write the plan.

Some of the staff told us there was a high reliance on agency (temporary) staff and a high turn-over of staff. They said that this made it harder for them to complete all the work they needed as they were expected to show the agency and new staff what they needed to do. One nurse who had been appointed shortly before our inspection told us they were still shadowing experienced nurses and did not yet know the home. They told us they had been asked to take a lead role one night because the other nurse on duty was an agency member of staff and was not familiar

with the home. They told us they did not believe this was safe as they were also unfamiliar with the home. The care staff told us that only one health care assistant had been at the home the previous night, leaving three members of staff (two nurses and one health care assistant) to care for 38 people for almost 12 hours. The acting deputy manager confirmed this had been the case because they had been unable to cover short notice staff absences.

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

The acting deputy manager and the regional director told us they had recognised that staffing levels at the home needed to be reviewed as there had been an increase in the dependency needs of people living there. They told us the provider was meeting shortly after the inspection to discuss increasing staffing levels.

Following our inspection visit the provider wrote to us and told us that staff recruitment was on-going and that they were recruiting additional care and nursing staff.

The provider had a procedure for safeguarding adults and the staff were trained in this. The staff were able to explain about different types of abuse and what they would do if they suspected someone was being abused. The acting deputy manager spoke about safeguarding alerts which had been made at the home. She had a good knowledge of these and was able to explain what action had been taken to investigate concerns. The provider had notified the relevant people, including people's next of kin, the local safeguarding authority and the Care Quality Commission. There were records of safeguarding alerts and investigations, including the outcome of these and any actions for the provider. The provider had worked with the local authority safeguarding team where needed.

The staff had developed risk assessments for people where there were identified risks. For example, for people moving safely around the home, the risks of developing pressure sores and nutritional risks. These assessments were comprehensive and included plans to minimise risks and harm. For example where people were considered at risk of developing pressure sores, there was special equipment to relieve pressure areas, regular repositioning and daily checks of the person's skin. Records showed that these checks and actions had taken place and that staff checked the equipment to make sure this was working. Risk assessments had been reviewed monthly, and more often when needed. Where people were considered at risk because they were resistant to the care which had been planned, there were clearly recorded practical steps for staff to take to help to reassure and support the person.

The provider had made regular checks on the environment and the safety of the building. There was a maintenance person employed to attend to repairs and we saw that these had been addressed as required. There was a risk assessment for the environment and another for fire safety. These had been regularly updated. The staff had been trained to use equipment at the home and what to do in event of a fire. There had been regular fire drills and the records of these showed what action the staff had taken.

People' received their medicines as prescribed and planned. The provider had an appropriate procedure regarding medicines. The staff had received regular medicines management training and their competency to administer medicines had been assessed annually. There were records of these. The provider undertook audits of medicines management and we saw that these identified any areas of concern, which had then been put right. The provider had changed pharmacy supplier shortly before the inspection. The acting deputy manager told us that there had been some problems with this but they were regularly meeting with the pharmacy to remedy these.

Medicines were stored securely and at appropriate temperatures. There were regular checks on storage and to make sure medicines were safe. The medicine administration records were completed accurately, with the exception of one error which the provider had addressed. We audited a sample of medicines and found that the correct amounts were stored and had been recorded, although two records were not clear and had not included amounts of stock medicines. Pain assessments were in place, along with protocols for administering pain relief. Where people were prescribed PRN (as required) medicines, there were plans for when these should be used and records to say when and why they had been administered.

There were appropriate procedures for the recruitment of staff. These included checks on their suitability to work, for example reference checks and checks on their criminal records. Staff were required to complete application forms which included details of their previous employment. Their

Requires improvement

Is the service safe?

identification and permission to work in the UK were checked and recorded. Nurses' professional pin numbers were obtained. The staff recruitment files we viewed were complete.

All staff were required to wear a uniform and name badges which included their designation.

The environment was clean and appropriately maintained. The cleaning staff had schedules to ensure that deep cleaning of the environment and equipment took place.

Requires improvement

Is the service effective?

Our findings

There was no evidence of consent from some people to their care and treatment in their care plans. Some care plans included assessments of their capacity to make decisions, although not all the care plans we viewed included this information. Where people had been considered to have capacity there was not always evidence they had consented to their care plan. Some care plans included evidence of consultation with families and those with Lasting Power of Attorney for health and care decisions. However, other care plans did not include evidence of family involvement. Some people's next of kin had signed agreement to Do Not Attempt Resuscitation documents, which meant that it had been considered in the person's best interest that if they stopped breathing the staff should not attempt to resuscitate them. These forms had also been agreed and signed by the GP. However, one form we viewed had not been signed and the information in this was incomplete.

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

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. The acting deputy manager demonstrated a good understanding of their responsibilities in respect of this. They had liaised with the local authority and had started to make applications where restrictions applied, for example for people who were unable to safely leave the home without an escort. The staff had received training in the Mental Capacity Act 2005.

People told us they though the staff were skilled and appropriately trained.

New staff were expected to complete an induction into the home, including training and shadowing experienced members of staff. Their knowledge and competencies were assessed and recorded. The provider made sure all staff had regular updates in training. The staff confirmed they had received training in health and safety, safeguarding adults, manual handling, infection control and first aid. They told us they had also received training about caring for people who had dementia. The nurses told us they kept their professional training up to date and that the provider had offered training in specific interventions, such as the use of syringe drivers. The staff told us they found the induction process and training useful.

The acting deputy manager told us all staff had taken part in individual supervision meetings to discuss their work. We saw evidence of recent meetings for all staff, however some staff had not received individual supervision meeting support for some time before this. The acting deputy manager had started to appraise all staff and these meetings were recorded. The majority of staff told us they felt supported and had opportunities to discuss their work and ask for additional support and training. However, two members of staff told us they did not always feel they were consulted about decisions involving their work. The majority of staff told us they worked well as a team and all the staff we spoke with told us they liked their job and working at the home.

At the end of our inspection visit we discussed some of our findings with the acting deputy manager and regional director. Where we raised concerns about some of the practices we had observed, the regional director acknowledged a need for additional training and support for some staff. She discussed her plans for this which included some bespoke training for the staff at the home.

There were regular staff meetings. The acting deputy manager told us she had introduced a new system for handing over information when staff changed over. The new meetings involved all staff. She had also introduced regular clinical risk meetings which included senior health care assistants as well as nurses. She told us this meant that there was a better awareness amongst all staff and the staff shared information with each other in a clearer way.

People's opinion about the food varied. Some of the things people told us were, ''food is somewhat disappointing'', ''the ingredients of the meals and the variety of the vegetables are good but the cooking of them could be better'', ''the food is ok'', ''I have a choice and plenty to drink'', ''food is lovely and I have a choice'' and ''the food is very nice.'' One visitor told us their relative often refused meals and their appetite had reduced. The said, ''the staff make sure they offer her food throughout the day if she has not eaten at meal times.''

Requires improvement

Is the service effective?

People's nutritional needs had been assessed and where they were considered at risk of malnutrition a plan had been created to help maintain their weight, including dietary supplements. People had been referred to specialists where needed. The staff recorded and monitored food and fluid intake where people were considered at risk. People were weighed regularly, although the records of this were not always clear and did not always identify if someone's weight had changed. Where people required a special diet for health, lifestyle or cultural reasons this had been recorded.

People were offered hot and cold drinks throughout our inspection. They were given a choice of meals at lunch time and the food looked fresh and well prepared. Menus were displayed in communal areas and people were offered alternatives where they did not want one of the main meal choices.

People told us their health care needs were met. The manager and staff were able to tell us about how some people's health care needs had improved and one person told us, ''my family say I have never looked better.'' People said they were able to see a doctor and other health care professionals as needed. Nursing staff were employed at the home throughout the day and night. They demonstrated a good awareness of people's health needs.

People's health needs had been assessed and care plans for specific needs were in place. We saw that where people had a wound or a particular health need this was recorded. There was regular evaluation of the need and care had been altered to meet changing health needs. However, records of health care professional involvement were not always up to date.

Requires improvement

Is the service caring?

Our findings

The majority of people told us the staff were kind and caring. They said they had positive relationships with them. Some of the things people said were, ''the carers are very good indeed'', ''they look after me'', '' that is the right name, carers, they seem to like their work. I also think that a lot of residents take it for granted, they don't say thank you enough; I also think that they know me as a person'', '' My carers are very good, gentle and kind; they tell me they like looking after me'', "I can bring my own personal things in – they never moan, they encourage me'', '' If you ask a carer to do something they will always try to do it, they are good'', '' The carers run it here, they do a good job'', '' Some staff are exceptionally good'', ''there are two or three fabulous carers'' and ''carers have got to have that sort of caring nature to do the job and they treat me as I would want to be treated.''

Some other people felt that the staff were not always caring. One person said, ''they are often too rushed to talk to me.'' Another person told us, ''it depends on how busy they are.'' One person told us the staff did not always knock on their door and sometimes walked in on them when they were using the toilet.

Care plans were stored in an unlocked cupboard in a reception area between the two units. Books containing personal information about people, including a handover book, information for the GP and records of people's weights were stored on a shelf in this area. This meant that visitors and others could access confidential personal information. We discussed this with the regional director and acting deputy manager who agreed to store the documents more securely and told us that this had taken place following our visit.

Interactions between staff and the people they were caring for were limited and often task based. The staff often gave the impression that they did not have time to talk to people. In one example we saw someone striking up a conversation with a member of staff and asking them about what was happening during the day. The member of staff did not look at the person and just said, ''nothing is happening'' and then walked away. At the mealtime, with the exception of one member of staff, they did not engage with people as they brought them their food. One person asked a member of staff what something on their plate was. The member of staff gave them the wrong answer and walked away leaving the person asking again to which no one answered. Some people waiting for their food started conversations with passing staff, but the staff did not respond. The staff supporting people to eat their meals did not talk with them apart from interactions such as, ''open up'' and ''here is some food.''

The staff did not always appear to be thinking about the perspective of the people they were caring for. For example one member of staff woke a sleeping person at 12.30pm saying, ''wake up its lunch time.'' The staff member then walked away to attend to other tasks. The person did not receive their meal for another 20 minutes and the staff member did not engage with them at all whilst they were waiting. The staff put protective aprons on people before they had their meals, but did not always ask if this was what the person wanted or explain what they were doing. People were brought in wheelchairs to the communal areas and repositioned by staff who did not explain what they were doing or ask the person's permission.

The staff did not always use people's names when speaking about the people they were caring for. For example we heard a number of staff refer to people as ''feeders'' meaning someone who required support at meal times. The staff talked about ''feeding people'' rather than supporting them.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, we observed some of the staff being kind and gentle. For example, we saw some staff explaining what they were doing and reassuring people when they were helping them use a hoist. We overheard one member of staff telling someone ''you look beautiful'' whilst they helped them to brush their hair. The staff called people by their preferred names when speaking with them and we saw them knocking on doors and waiting for an answer before entering. We saw one member of staff explaining to one person about the food they had served them, they checked the person understood and repeated things that the person had not clearly heard.

The provider told us that they were organising bespoke training for the staff regarding dignity and respect.

Relatives were able to visit whenever they liked and to help with caring for someone if this was their choice. We saw relatives supporting people at mealtimes and spending

Requires improvement

Is the service caring?

time with them throughout the day. The staff were polite and welcoming to visitors. The visitors told us the staff were always welcoming and gave them information they needed and included them in discussions.

Requires improvement

Is the service responsive?

Our findings

People's individual needs were not always met. Some people told us they thought this was because the staff did not have enough time or there were not enough staff. One relative told us, ''my relative cannot eat or drink on his own, he needs care and he can sometimes wait for up to an hour.'' Another relative told us that the staff did not always shave their relative and he was used to being clean shaven. People told us there was ''nothing to do.'' Some people said they liked the organised activities but apart from these there was no entertainment or anything to do.

During our inspection people were not supported to move around the house or garden for leisure. During the morning in one lounge people had nothing to do. A staff member gave one person a book and one person a magazine but then left them to look at these without support. Neither person showed an interest in the item they were given. Music was playing but people were not given a choice of this and when the staff member chose to change the music they did not ask people about this or talk to them. People were seated in the dining area and lounge for an hour before they were given lunch. They were not given anything to do or offered any activities. The staff told us people liked to go to the village and to use the garden, but some staff said they did not have time to support people to do this. One person told us, ''I am supposed to go for a walk every day and the staff try to, but I don't always go.'' Another person told us, ''The weakest thing is Saturdays and Sundays, there is nothing to do, nothing to keep my brainbox working.'' One relative we spoke with told us people were ''bored'' they said, ''the staff never do anything with anyone.''

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

The provider told us that they had introduced a system of ''resident of the day'' where each person had their needs reviewed, had individual time with the activities coordinator and received any ''special treatment'' which met their needs and wishes on that day.

The provider employed an activities coordinator who organised social activities during the week. People like her and said they liked the activities. One person said, ''she is a treasure.'' There was a notice board of planned activities on display. There were boxes of games, books, puzzles and toys. However, people were not offered these and the planned activity for the day did not take place. Shortly before the inspection there had been a fete at the home and the staff said people had enjoyed this. People told us they liked the garden and there was a lot of wildlife that visited the garden. Some people had helped with the home's planting and gardening. The activity coordinator kept a record of people's interests and the activities they had participated in. However outside these organised activities people told us there was not enough to do.

Following the inspection the provider told us that they had organised for staff training around meeting the needs of people who had dementia and they had also ordered additional sensory equipment for people who were unable to leave their beds. The provider also told us they were looking at the possibility of introducing additional staff to support activities.

People's needs had been recorded in care plans. These included information on their preferences, likes and dislikes. The staff recorded the care they had given people and any changes in their needs. Care plans included background information about the person, although this varied in detail. Pre-admission assessments had been carried out by nursing staff and included information on specific health care needs.

There was an appropriate complaints procedure. People told us they knew what to do if they had a complaint. They felt their complaints and concerns were responded to appropriately. The provider kept a record of all complaints and how these had been investigated and responded to. Information from complaints was used as part of the provider's quality monitoring and action plans for improvements.

Requires improvement

Is the service well-led?

Our findings

Some people told us they had not had contact with the managers and some felt the lack of permanent manager at the service had a negative impact. Some of the things people said were, '' I have never come into contact with any of the management'', ''I have not been asked about what I think of the service yet'' and ''with the manager away nothing gets done and nothing changes, people have nothing to do.'' However, some people felt the service was well run. They told us, ''the management is fine'', ''we had a residents meeting two weeks ago'', ''the managers are always talking to me'', ''the person in charge at the moment is very nice and very pleasant'' and "I feel this is my home, well it is my home; there is nothing to grumble about and if you need anything they will get it for you, my little friends."

The registered manager had been on extended leave for a number of months and was due to return to the home in October 2015. The deputy manager, who had been managing the service in her absence, had left the home. At the time of our inspection the clinical lead had been appointed as acting deputy manager and was managing the service. A registered manager from another home was visiting twice a week to offer support. The acting deputy manager told us that the regional manager and area manager also offered support. However, the provider had not appointed a new deputy manager or clinical lead and this meant the person was carrying out three different roles at the home. She told us that on one occasion in the previous week she had to work as the only nurse on one unit in addition to managing the home. This arrangement was due to come to an end when the registered manager returned to her post a month after our inspection. Some of the relatives of people living at the home and some staff told us that they felt the arrangement had a negative impact on the service.

The provider's systems for monitoring the quality of the service had not always been operated effectively because they had not always mitigated risks or made improvements where there were breaches of Regulation. For example, promoting a person centred approach to care and maintaining accurate and complete records of the care planned and provided to people.

Some of the care plans we looked at were not complete. For example, one care record for a person who had lived at the home for approximately two months did not contain information on all their care needs, their strengths and the plan for staff to support them. Some of the information was also inaccurate, for example the plan stated that the person did not require bed rails, there was no assessment for the use of these and no evidence of consultation about the use of these with the person or their family. However, we observed the person was in bed with rails throughout our inspection. Another person's care plan identified a risk of malnutrition and there was evidence the person had been referred to an appropriate professional. However, there was no information following this about how the person should be supported to meet this need. They were identified as needing to be weighed weekly. However, records about their weight had not been kept each week. The records of other people's weight were also unclear as they did not always identify when there had been a change in the person's weight. In some cases it was not clear if anomalies which differed significantly to the person's normal weight had been followed up because there was no record of this. Some other care plans varied in the amount of information. For example, some of the care plans did not contain any information about GP or other health care professional involvement. Five of the six care plans we viewed had no record of baths or showers. The care plans for some of these people indicated they liked to have showers. One of the nurses told us they did not think they had time to check and complete care plans. The acting deputy manager told us they had introduced a new system where a different care plan was reviewed and updated each day. The staff told us this did not always happen and sometimes information was not updated.

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

The provider had systems to monitor and assess the quality of the service. These included audits of medicines management, accidents and incidents, infections, deaths and other significant events. There was evidence the provider analysed these and acted on any concerns or trends. The acting deputy manager completed a report for the provider which included action taken and plans for improvement. The area manager carried out monthly audits of the home and completed a report of these. The report included an action plan and each month progress on this was checked.

Requires improvement

Is the service well-led?

The provider held regular meetings for people living at the home and their relatives. We saw the minutes of these. People had been informed about things that affected the home, such as the changes in management, and were also asked about their views, activities, décor and food. The provider sent out annual satisfaction surveys to people living at the home and other stakeholders.

People living at the home and staff spoke positively about the acting deputy manager. Everyone we spoke with and their visitors said that there was a positive culture and atmosphere at the home, although some visitors said that the staff were rushed and did not have enough time to care for or engage with people. Most of the staff told us they liked working at the home, they said they enjoyed their roles. However, some staff told us there was a high turnover and this meant they were often having to work with new staff getting to know the home. Most of the staff told us they thought there werenot enough of them and that they were too rushed to do their jobs effectively. Some of the staff told us there needed to be improvements with team work and staff communication. The regional director told us the provider was reviewing staffing levels at the service and considering whether these met people's needs.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person did not always deploy suitably qualified, competent, skilled and experienced staff to meet the needs of service users.** Regulation 18(1)

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 **The registered person had not always obtained the consent of the relevant person to provide care and treatment to service users.** Regulation 11

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **The registered person did not always ensure service users were treated with dignity and respect.** Regulation 10

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered person did not ensure care and treatment of service users met their needs and reflected their preferences.** Regulation 9

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not always assess, monitor and mitigate the risks to service users. The registered person did not always maintain an accurate and complete record of the care planned and provided to each service user. Regulation 17(2)(b) and (c)