

Bupa Care Homes (CFChomes) Limited

Elm Grove Nursing Home

Inspection report

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Requires improvement



Is the service caring?

Good



Is the service responsive?

Requires improvement



Is the service well-led?

Good



Overall summary

This unannounced inspection took place on 7, 11 and 12 May 2015.

Elm Grove Nursing Home provides residential and nursing care for up to 60 older people. Adjacent to the main house, in the same grounds, there is a specialist unit for people living with dementia, the Chesnut Unit, which is separately staffed.

There was a registered manager in post at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Sometimes there was insufficient staff and people waited too long for assistance. Staff told us there were times when they had to manage with less staff and people didn't go out much but those who were able used the garden. Three relatives told us the dementia unit was short staffed. There was a shortage of activity staff when we visited, which the registered manager was aware of. This has required improvement.

Summary of findings

People's dietary requirements and food preferences were not fully met for their well-being. People in the dementia care unit had a limited choice of nutritious snack food when they refused main meals. Catering staff were unaware of people's dietary requirements and preferences and improvements were required. Most people told us they enjoyed their meals and relatives sometimes dined with them. One relative said "The food is super".

Regular checks were made to ensure the service was safe and well maintained. The quality of care was monitored by the provider and staff evaluated care plans monthly. People were involved with planning their care and made decisions in their daily life. Where people were assessed as not being able to make decisions best interest meetings were held with those that knew them well and healthcare professionals. People's medicines were managed safely and regular checks were made to monitor staff practice.

People were supported by well trained staff who knew people well. Staff had the skills and knowledge to safeguard people and maintain their health and wellbeing. People were treated with dignity and respect. A member of staff described respect and dignity as, "How I would like to be cared for". Staff spoke about people with compassion during daily meetings between senior staff which highlighted where people required additional professional support. Any concerns raised were addressed. Weekly clinical meetings looked at people's individual conditions, the treatment and their progress.

A range of activities people enjoyed were provided and included music, quizzes, craft making and trips out to local cafés and garden centres. Relatives and people in the community were invited to planned events during the year.

Concerns were listened to at residents/relative meetings, where all aspects of the service were discussed. Complaints were taken seriously and acted upon. The registered manager welcomed comments at any time from people, their supporters and staff. A relative said the staff were, "Absolutely marvellous and can't do enough for people".

People and their relatives were asked views about the care and how the home was run. They completed an annual survey about the service and their judgements and comments lead to improvements. A monthly newsletter informed people about changes and planned events. Regular audit of systems and review of procedures were completed. There was continuous quality monitoring throughout the year. Staff meetings provided information and training to staff to ensure improvements were completed. The vision and values of the service were to be the best provider of care, where staff were happy to work. This was discussed at staff meetings.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

This service was not consistently safe.

There were times when there was insufficient staff which meant people sometimes waited for assistance.

People were safeguarded as staff were trained to recognise abuse and to report any abuse.

People's medicines were given, managed safely and kept under review to ensure people were receiving appropriate medicines.

People were protected by thorough recruitment practices.

Requires improvement



Is the service effective?

This service was not consistently effective.

People's dietary requirements and food preferences had not been fully met for their well-being.

The staff were well trained and were able to look after people effectively.

People had access to healthcare professionals and had ongoing healthcare support.

Requires improvement



Is the service caring?

The service was caring.

People were treated with compassion, dignity and respect.

Staff treated people as individuals and interacted with them positively.

People were involved in making decisions about their care and supported and encouraged to be independent.

Good



Is the service responsive?

The service was not consistently responsive.

People received the care and support they needed and were involved in decisions about their care when possible.

Staff knew people well and how they liked to be cared for.

People took part in activities and went out in the community. However there was insufficient staff to engage with people, particularly at weekends.

Complaints were taken seriously but not all outcomes for people were recorded.

Requires improvement



Summary of findings

Is the service well-led?

The service was well led.

The home was managed well and regular quality checks ensured that people were safe and improvements were made.

The registered manager was accessible to staff and people and knew what the visions for the service were.

Regular resident and staff meetings enabled everyone to have their say about how the home was run.

Good



Elm Grove Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 7, 11 and 12 May 2015 and was unannounced. The inspection team consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert had experience in caring for people living with dementia.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A

notification is information about important events which the service is required to send us by law. We did not have a Provider Information Return (PIR) this time. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to assess how the service was performing and to ensure we addressed any potential areas of concern.

We spoke with the registered manager, quality manager, six care staff, six nursing staff, the trainer, one of the activity co-ordinators and a member of the catering staff. We spoke with seven people who use the service, nine relatives/friends and a district nurse. We looked at information in 12 care records, three recruitment records, the staff duty roster, quality assurance. We checked some procedures which included, medicines, end of life and safeguarding adults. We also contacted a GP practice and healthcare professionals that visited the service to obtain their view of the service.

Is the service safe?

Our findings

When we completed the inspection there were 50 people accommodated in four units which included the separate residential dementia care unit. Two nurses and six care staff were employed in the three nursing units each morning and this reduced to five care staff in the afternoons until 20.00 hrs to care for 31 people. During the night there was five staff on duty. A monthly rota for the nursing units indicated there were 11 days when the care staffing levels fell short by one care staff.

In the dementia unit 19 people were accommodated. There were four care staff in the morning and this reduced to three in the afternoons until 20.00 hrs, then two night staff on duty until 08.00 hrs. The dementia care unit was short of staff on six mornings in May 2015. Three relatives in the dementia care unit told us the unit was short staffed. We observed that the dementia care unit was calm and people were engaged with staff when we visited. Staff told us there were times when they had to manage with less staff and people didn't go out much but used the garden. There was a shortage of activity staff when we visited, which the registered manager was aware of.

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

The registered manager told us people's care dependency determined the staffing levels. The registered manager relied on information during the daily morning meetings with senior staff to discuss any concerns for additional staff when people's care needs increased. The homes 'bank staff' were used when necessary and agency staff were rarely used. The registered manager used a staffing tool to calculate permanent staff requirements but temporary staff could be used when needed.

Staff recorded when people waited for more than four minutes for their call bell to be answered. We found 13 calls that were answered after four minutes on one day. The maintenance staff checked call bells were working monthly to exclude any faults. The registered manager had not audited call bell information to look at trends and assess staffing levels and deployment of staff.

There was a safeguarding adult's policy and procedure and all staff completed safeguarding training during their induction and refresher training annually. Staff had

completed a safeguarding training booklet. Staff in the dementia care unit told us what they would do to keep people safe when there was a negative interaction between them. The staff knew who to inform if they suspected any abuse and when to 'whistle blow' if staff were involved. We looked at safeguarding records where staff had taken appropriate action by contacting the local safeguarding team and had involved health and social care professionals.

A person told us they felt safe and the staff were very good. They did not have any complaints about the service. A relative in the dementia care unit told us his mother felt very safe. He said this was confirmed as his mother never reacted to any of the carers when they came close and she was always happy to see them.

Medication administration records demonstrated people's medicines were being managed safely. There were policies and procedures in the safe handling and administration of medicines. Protocols for medicine prescribed 'as required' were clear. Daily, weekly and monthly audits of medicines were completed to check the management of medicines. Staff completed an annual medicine management test paper and visual competency assessment for medicine management.

Recruitment procedures were completed thoroughly and made sure suitable staff were recruited to keep people safe

Accident and incidents were recorded by staff and reviewed by the registered manager. We were unable to see the accidents and incidents prior to May 2015 as the information was archived. There was no audit of all accidents and incidents to identify trends and the actions taken to prevent further occurrences. The provider had begun a new pilot of falls in April 2015, tracking where and when they occurred and any reoccurrence.

Health and safety information included risk assessments for all areas, equipment and products used. Safety issues identified by staff were dated and it was clear when maintenance issues were completed and checked monthly by the registered manager. The maintenance staff had completed health and safety training. The provider visited every six months to check safe working practices. Fire safety checks and staff fire training were up to date.

Is the service safe?

Individual risk assessments in people's care plans were clear and identified how to reduce risks for people. There was a business continuity plan to guide staff should there be any disruption to the service.

There were infection control procedures for staff to follow and they were trained to prevent cross infection. Staff used personal protective equipment and disposed of soiled linen appropriately. All areas were clean and there were no offensive odours.

Is the service effective?

Our findings

We observed a meal time experience for people in the nursing units and the dementia care unit. In the dementia care unit people were respectfully helped when required. There was a lack of food choice for people as they were unable to visually choose at each meal. At lunch no choice was offered to people they were told it was beef casserole today and people were served their meal of beef casserole with broccoli, carrots, peas and mashed potato. People had chosen meals the day before but there were no visual menu cards to show them. A set number of meals were allocated for each meal and there was limited flexibility should someone refuse a meal. If people wanted something different they could only have it by ordering directly from the kitchen while they sat at the dining table. There were snacks available but staff said that nutritious finger food for people who may not eat their meals was limited. A choice of drink was available. As a result of our feedback to the registered manager on the final day of our three day inspection people in the dementia unit were able to choose from two different meals offered to them on plates. The staff wanted to continue to help people choose their meals this way.

Some people in the nursing unit dining room waited 30 minutes for their meal and were unhappy. Two staff served people with vegetables but they served people who had just arrived first and were unaware that some people had waited a long time. There was a menu card on each table and people could choose from two main courses and two desserts. People had a choice of drinks. Adaptations were used to assist people at meal times for example; different table heights and plate guards. People said they enjoyed their meal, one person said, "If I don't like the food I leave it" and another person said the food is "alright". A relative told us, "The food is super and they provide a tray for my husband as he likes to eat in his bedroom". We were told that BUPA had the same winter and summer menus in all their homes irrespective of people's personal preferences.

Green tabards were used to protect people's clothes when requested but this looked institutionalised. Catering staff were unaware of people's dietary needs. They had requested information about people's food preferences and diets but had not received this information.

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

Handover record sheets prepared to inform staff before each shift about changes were not accurately updated. We were told that the same sheet was used until the information had changed. However information had changed and this could be confusing and potentially unsafe. The registered manager told us they were updated weekly or sooner. Staff record daily changes in handover sheets from people's care record. Staff had signed that the handover record was complete and they had read it. Team leaders from each unit joined handover sessions and care staff saw every person they were responsible for, usually six or seven people, before they began their shift. This informed staff what time each person must have contact, for example to change their position to prevent pressure ulcers.

People were supported by staff with the appropriate skills, experience and knowledge to meet their needs. We spoke with staff about their training and supervision. They told us there was annual mandatory training for example; moving and handling, safeguarding adults and fire safety. There was also the opportunity for specialist training. Staff told us they were offered training during supervision. They told us the training was very good and they appreciated being able to add to their skills, for example, defibrillator use, end of life care and dementia care training. Staff told us training was completed by a combination of in house, e-learning by computer and outside agency provision.

The trainer told us about induction training completed with other local BUPA care homes. They were responsible for training staff in three care homes and told us this was an effective use of resources. There was a four day induction programme, which included the provider's mandatory courses. Staff were unable to care for people until the induction training was completed. Training was recorded using a colour coded system to ensure that staff completed it when required. The trainer asked the manager and nursing staff for feedback and staff completed test papers to check the effectiveness of training. The aim was for all care staff to start an NVQ qualification after a six months probationary training. Nurses had the clinical training they requested for example, catheterisation and tissue viability.

The registered manager planned to complete six supervision sessions with all staff annually but they told us

Is the service effective?

not all had been completed to date. Clinical Supervision was provided by the deputy manager and annual appraisals were completed by the registered manager or the deputy manager. A staff member couldn't remember her last supervision session but told us if they wanted to discuss something they could go to the office on an informal basis to speak to a manager. Other staff told us they had completed formal supervision.

Staff had completed or were soon to complete Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training. The MCA provides a legal framework for those acting on behalf of people who lack capacity to make their own decisions. The registered manager had a good awareness and understanding of DoLS. DoLS provides a lawful way to deprive someone of their liberty in the least restrictive way, provided it is in their best interests or is necessary to keep them from harm. Staff described the principles of the MCA and gave examples of how this was put into practice. They told us about 'best interest' meetings where people did not have the capacity to make a decision and family and professionals met to decide the best plan for them. They also described how people chose to live their life each day by making some decisions. Staff told us 17 DoLS had been applied for those in the dementia care unit. Two applications had been assessed and granted with reviews due in 2016. CQC had been informed of the DoLS in place for people.

Care records had clear mental capacity assessments where all daily living tasks were assessed. We saw an example for one person where a relative was present and the record indicated whether the person had mental capacity or whether capacity was lacking or variable for each 15 daily living interactions. Evidence of how the assessor judged the capacity was recorded, for example, the person 'doesn't know the safety factor of not using a walking frame'. There was a 'best interest' record for all care interactions because most were identified as the person lacked mental capacity. The doctor was involved in mental capacity assessments

where necessary for example, when do not attempt resuscitation decisions were made. One person had an advanced directive in place not to receive any blood products with regard to their religion.

People had access to health and social care professionals. We contacted health and mental healthcare professionals about the service and spoke with a visiting professional during the inspection. They were positive about the care people received and had seen improvements in the last 12 months. They said staff listened to advice and acted promptly. They described the care of a person as 'good' with regard to support with emotional distress as care staff had recorded detailed information about people and knew their life history. The care plans recorded visits by health and social care professionals and the advice and action required to support people's changing needs. Community mental health professionals supported people in the dementia care unit and staff maintained regular contact with them for advice.

Care records had risk assessments for malnutrition and weights were monitored. A malnutrition universal screening tool (MUST) was used which assessed people's weight and identified anyone at risk from malnutrition. Daily records recorded how much people had eaten which included snacks where there was a risk of malnutrition. Staff described how food was made available throughout the day and the benefits of snacks when people were reluctant to eat. Food diaries and weight charts were maintained when people were at risk. Staff described the use of thickening agents to prevent people from choking and how people receiving palliative care were supported with eating and drinking.

The premises had been refurbished and most areas were well presented and met people's needs. The dementia unit had little personalisation on the bare walls in peoples rooms. Staff told us there had been personal pictures on the wall prior to redecoration but they did not know why these had not been replaced.

Is the service caring?

Our findings

People told us, “The staff are very good, I have no complaints”, “I am so happy here it’s good”, and “My keyworker is kind but not all the staff are kind”. The person told us the keyworker often did additional things and spent more time with them. A keyworker’s role was to organise appointments and make sure people had everything they needed. A healthcare professional told us staff were very helpful and spoke to people nicely, they had no concerns about the care provided. Relatives told us they were very happy with care in the dementia unit and said staff were always in the dining room ready to help people if they needed it. They also said staff were always smiling, very helpful and ready to give people a cuddle for reassurance. When we asked if there was anything they would change they told us there wasn’t.

In the dementia care unit we observed good interaction between people and staff. Staff were sat with people going through magazines, looking at the pages and talking with them. One member of staff got down on their knees so that they were at the same level to talk to people. There was music on in the background but it was not too loud and didn’t stop people communicating. Staff helped people with their lunch but always asked for their consent before they started and encouraged independence until assistance was necessary. People were offered salt and pepper and asked if there was anything else they wanted during lunch.

A relative said the staff were, “absolutely marvellous” and “can’t do enough for people”. The examples given were when a person’s own hairdresser came and used the homes salon at no cost. Also staff had persuaded the person to join in with activities and the relative told us it was lovely to see they were so much better. The relative told us the manager had said they could visit any time of day even if it’s 07.00 in the morning. A visitor told us they had enjoyed meals with their relative.

People had personal profiles in their care plans about their preferences and a map of their life with basic information which could be expanded on. Families were relied upon to provide more detailed information for some people living with dementia. There were daily routines recorded for people called ‘who I am’ which provided clear information to guide staff when people were unable to tell them their preferences.

The activity co-ordinator told us they attended resident/relatives meetings so they knew what changes people wanted. People and their relatives were listened to at the meetings and changes were made. Examples were, people had requested more call bell pendants to wear and these were provided and the use of an iPad computer was working well to send emails, photographs and videos to some relatives.

There was a general atmosphere of calm and friendliness. At handover meetings staff spoke about people with compassion. Staff said, “I like working here and really like the residents”. They described how they treated people with dignity and respect by being polite and addressing people in a way which they preferred, taking into account cultural/religious backgrounds and beliefs. Staff said they treated people as individuals and learnt how they wanted things done. One staff member described how they knew one person really well having built up a relationship and communicated with their family who lived abroad. Another staff member said they respected people’s knowledge, age, experience and their needs and wishes.

Staff described a good relationship with one person they had known for many years. They exchanged news about their families and had a common interest in literature. They said they felt part of one another’s lives. Staff told us it was their role to make people feel happy and safe. Positive communication between staff was seen by them as essential to people’s wellbeing.

Staff told us people had a place in the community as local groups visited and people went out to local parks and shops.

People’s wishes were respected about their end of life care. A member of staff described respect and dignity as, “How I would like to be cared for”. Each person had a plan completed with information about their funeral arrangements and wishes when the time came. One person’s end of life care plan had a ‘do not resuscitate’ record as part of their advanced decision and staff were aware of this. A health professional told us they supported the staff with care for people near the end of their lives and relatives had described the care at Elm Grove to them as ‘very good’ every time. A letter of compliment from a relative for end of life care said, ‘staff were unfailingly

Is the service caring?

dedicated, happy, and sympathetic, we were treated with dignity under sometimes difficult conditions'. The trainer told us staff had received specialised training for end of life care.

Is the service responsive?

Our findings

Pre-admission assessments were completed before people moved in. We looked at a person's care plan who was receiving short stay respite care. They had 'what a normal day looks like' to enable staff to quickly identify their preferences. There was a record of what the person can do and what they need support with. There was good detail about night time support when the person became more anxious. The service had deactivated the light sensor in the ensuite toilet so that the light would remain on all night for comfort and to enable the person to find their way. Risk assessments included moving about and a low risk of falls was recorded when the person used stairs. Daily records had a lot of detail about what the person chose to do all day.

Care records provided staff with information to provide people with the correct care and measure their progress. A skin care plan had a risk assessment completed for developing a pressure ulcer. The type of pressure relieving mattress used and the person's ability to change their position in bed without help was recorded. The wound care record included a photograph, description and measurement of the wound and the type of dressing used.

The service was changing systems for recording people's care to a more person centred system called 'My Day, My Life' which included information about a person's life. The new system referred to, professional visits and referrals log, daily notes, risk assessments, senses and communication, choice and decisions over care, lifestyle, healthy happier life, safety, moving around, skin care, going to the toilet, eating and drinking, breathing and circulation, mental health and wellbeing, washing and dressing and future decisions. In an emergency relevant care plans were copied for the emergency services to take with them.

There were clear records regarding the support from healthcare professionals particularly for people living with dementia when medicine changed and there were protocols for administration. One person's reassurance and support care plan included a detailed record of when they became anxious to try and recognise what the cause may be. There was evaluation of one incident to see where improvements could be made. The noise level in the dining room was identified as a possible trigger to causing anxiety and changes were made. Staff told us they had a very good

relationship with GPs some of whom do regular visits and others call as necessary. They said all GP practices were very good at giving telephone advice and reviews so that responses were made quickly

The care plans we looked at gave enough information to adequately care for people. The care plans were evaluated monthly. When families supported people to make some decisions this was recorded. Additional care plans were used, for example, when people had specific care to reduce pain.

Managers and senior staff communicated daily at the 'Take 10 meetings' held between 10 -11 each morning, usually only taking a short time to ensure all departments were aware of any ongoing concerns or progress that day. We noted staff communicated who had a visit from or an appointment with a healthcare professional, what activities were planned for the day and any staff changes.

Activity events were planned and organised using a six monthly events planner given to people and their families which included visiting singers and special celebrations. People also had a weekly plan with daily details of activities planned for each morning and afternoon, for example, quizzes, crafts, decorating small cakes and pamper sessions. There were no planned activities during the weekend but sometimes there were live entertainers and the activity staff came in to help as care staff had little time to help. The home employed two activity co-ordinators. On one of the days we visited there was only one activity person looking after groups of people and they were very busy. The registered manager was aware there was a shortage of activity staff. The activity person had been well trained and told us, "I love my job". People told us they enjoyed the activities provided. A person in the nursing unit told us they would like to go out more with the staff.

We observed people enjoying a singing session and people living with dementia sang throughout and used the correct actions. Everyone really enjoyed themselves and were seen happy and smiling. The general atmosphere was good. We saw people were enjoying the well planned gardens, where they walked safely and securely. There were examples of arts and crafts completed by people and videos were taken of people dancing and handling reptiles and birds, which were sent to some relatives.

We were shown 'memory boxes' outside each person's room in the dementia care unit and families were

Is the service responsive?

encouraged to fill them with significant things to help people remember their life and identify their bedroom. The staff discussed with families unable to help with this if they could add to the boxes for them to support people with remembering which room was their bedroom.

We looked at an example of a person's personal profile which told staff they liked to play dominos. The staff tried to play dominoes as often as they could with them. We were told new activities were tried all the time and people made suggestions during their meetings. Some people had individual activities with staff but staff told us it was difficult to see everyone. People's reaction to each activity they completed was recorded in a weekly log. The log was reviewed monthly by the activity staff and highlighted who may need more input from them. Two different people were taken out each Friday to local shops and gardens centres and people in the community had visited the homes. The service had held garden parties, strawberry cream teas and bonfire night events for example.

People knew how to raise concerns and there was a complaints procedure. One person said they would speak to the registered manager if they had any concerns. Residents/relatives meetings were held regularly and people had raised concerns there. The concerns log showed that the service had taken appropriate action. Complaints were taken seriously but it was difficult to access all the complaint information because the provider had dealt with some complaints and had not informed the registered manager of the outcome and action taken. One complaint we looked at was investigated thoroughly by the service and the registered manager held an immediate staff meeting to ensure the actions taken were completed and reviewed. The registered manager told us there was no current requirement to provide an advocacy service for any individuals.

Is the service well-led?

Our findings

An annual quality audit was completed by the quality manager and area manager in January 2015 and the improvement plan was due for review in September 2015. However the area manager completed monthly provider reviews to monitor progress with the improvement plan. We looked at a recent monthly provider review completed at the beginning of April 2015. The quality of care and records were looked at in detail and practice was scrutinised. Recommendations for improvements were recorded to follow up the next month. The area manager attended a weekly clinical review meeting during the monthly check. Nurses and team leaders had discussed people at risk nutritionally and the importance of tracking weight loss. To track any weight loss was one of the improvement actions.

Weekly clinical review meetings with nursing and senior staff looked at pre-admission decisions, new people admitted, treatment of wounds, prevention of pressure ulcers, people's safety, people at risk nutritionally, behaviours that may challenge staff and medical conditions that may require specialist support. We looked at two clinical review meeting records and they provided staff with a detailed action plan of people's clinical issues each week. Health and safety meeting were held quarterly.

The registered manager told us they visited all units daily. Some people knew the registered manager by name and told us they had seen her walking around the home. A person told us their family mostly spoke with the manager and they were happy with the situation. A relative told us they had no reason to think the home was not well led and said, "There is always a nice buffet and cake for resident's birthdays". Another relative said their initial visit to look at the home had been unannounced but they were encouraged to look around and felt completely comfortable with Chesnut Lodge, the dementia care unit. They said the manager of Chesnut Lodge did an assessment at their home prior to admission and they were fully involved.

Staff in the dementia care unit told us the registered manager was supportive and often visited the dementia care unit and came whenever they were needed. Staff there felt the dementia unit was very well supported by all managers and nursing staff.

An annual resident/relatives' survey had been completed in May 2015. The results told us the areas of strength were, the staff, the quality of care and that relatives were reassured by the service. Areas for improvement were the promptness of staff attending to people and the environment. Comments received were, 'My aunt says she is well looked after and content' and 'My sister who is bed bound is always clean and comfortable and as she can do nothing for herself the staff must be doing it for her'. The registered manager informed us staff had been allocated to each person to improve promptness. The refurbishment had been completed with new soft furnishing and bathroom cabinets. Seven compliments were received from relatives in March 2015.

The registered manager had notified CQC about events and we used the information to monitor the service and ensure they responded appropriately to keep people safe. The service encouraged an open communication with people, their relatives and staff. Resident/relative and staff meetings were held regularly and monthly newsletters informed people of forthcoming events and news. The resident/relative meeting minutes for April 2015 indicated that people's concerns and suggestions were listened too. The registered manager told us about the improvements made since the meeting, for example people's post was put in a safe container in their wardrobe. There was also a discussion about people in the nursing unit knowing the code to the front door. This was essential information as the receptionist was not always available. A newsletter we looked at told people about the new care plans which would involve everyone.

We looked at recent meeting minutes for care staff, heads of department and nurses where a variety of topics were discussed and the registered manager said their door was always open if anyone needed to see them. It was unclear from the minutes who had the responsibility to complete actions required before the next meeting, which would help track progress made. Staff had been open and honest during meeting discussions and a recent complaint was evaluated and improvements suggested. Staff commented that meetings did not include the night staff.

The objectives of the provider were discussed during one staff meeting. The objectives were; to reach millions more people, be the best provider in the country, people love working for BUPA and equipment is used wisely to avoid waste. Staff were reminded that the provider offered a free

Is the service well-led?

service to help keep them fit, for example free physiotherapy after an injury. All staff were entitled to a free hot meal every day. The registered manager told us about plans for the future. The service wanted to provide more respite care for people, improve the standard of food and the dining experience with matching crockery.

Some policies and procedures were difficult to find and the procedures we looked at required a review or additional information. The quality manager informed us some policies were under review and amended procedures were available on the provider's intranet. The trainer told us nurses completed their professional development and asked for the training they required to keep up to date with clinical governance.

Audits were completed and information was provided in a six monthly Quality Metric Report. The report measured the outcome of care delivered in relation to key themes. The themes for example included numbers of, pressure ulcers, significant weight loss, GP reviews of medicines, complaints, chest and urinary infections and how many plans care had been reviewed. There was no comment recorded for action taken but we looked at a monthly medicine audit where five records were checked as 90% completed and action had been identified for improvement.

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

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

There were insufficient numbers of suitable staff to keep people safe and meet their needs. Regulation 18 - (1)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

People's dietary requirements and food preferences had not been fully met for their well-being. Regulation 9 - (1) and (3) (I)