South Coast Nursing Homes Limited

Manor Hall 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?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Manor Hall Nursing Home provides nursing and personal care for up to 44 people. There were 34 people living at the home at the time of the inspection. They had a range of complex health care needs which included people who have multiple sclerosis, stroke and diabetes. Some people had a degree of memory loss associated with their age and physical health conditions. Most people required help and support from two members of staff in relation to their mobility and personal care needs. Accommodation was provided over three floors with a passenger lift that provided level access to all parts of the home.

This was an unannounced inspection which meant the provider and staff did not know we were coming. It took place on 24 and 25 August 2016.

There is a registered manager at the home. 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.

There were not enough staff on duty to meet people's needs. Staffing levels were based on the number of people living at the home. People's individual needs had not been considered when determining staffing levels.

Staff had a good understanding of the risks associated with caring for people at the home and risk assessments were in place. Where people had health related conditions there was appropriate guidance in place which ensured people received the care they required. However, risks associated with managing people's pressure areas and fire evacuation procedures required review. We made a recommendation about this.

People were supported by kind and caring staff. Staff knew people well and had good relationships with them. However, the delivery of care was task based rather than person centred. Care plans lacked information about people's holistic needs. There was a lack of meaningful activities and people spent long periods of time isolated and unstimulated in the lounge. The quality assurance systems were in place but had not identified all the shortfalls we found.

Staff maintained people's privacy and understood the importance of confidentiality.
Relatives were able to visit the home whenever they wished and were made to feel welcome.

The registered manager was aware of the Mental Capacity Act 2005 and DoLS and how to involve appropriate people, such as relatives and professionals, in the decision making process.
Relevant guidelines were available within the home for all staff to reference.

Staff received regular training and updates to enable them to meet people's needs. Staff had regular

supervision where they were able to discuss any concerns and identify any training or support needs.

People were supported to maintain good healthcare and were able to access healthcare professionals when needed. When people's health needs changed the nurses ensured people were referred to the appropriate healthcare professionals. People were provided with a choice of food and drink that met their individual needs and preferences. This supported them to maintain a healthy diet.

The management and storage of medicines was safe, and people received their medicines as prescribed. Staff had received training on safeguarding adults and were confident they could recognise abuse and knew how to report it. Recruitment records demonstrated there were systems in place to ensure staff were suitable to work at the home.

There was a complaints policy in place. People told us they were happy to raise any concerns. People spoke highly of the registered manager. She was a visible presence at the home and knew people and staff well.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Manor Hall Nursing Home was not consistently safe.

There were not enough staff on duty to meet people's needs. Assessment of people's needs had not taken place to determine staffing levels.

Staff had a good understanding of the risks associated with caring for people at the home. However, risks associated with managing people's pressure areas and fire evacuation procedures required review.

The management and storage of medicines was safe, and people received their medicines as prescribed.

Staff understood the procedures in place to safeguard people from abuse.

Is the service effective?

Good

Manor Hall Nursing Home was effective.

Staff were suitably trained and supported to deliver care in a way that responded to people's changing needs.

Staff ensured people had access to external healthcare professionals when they needed it.

The registered manager was aware of the Mental Capacity Act 2005 and DoLS and how to involve appropriate people, such as relatives and professionals, in the decision making process.

Staff monitored people's nutritional needs and people had access to food and drink that met their needs and preferences.

Is the service caring?

Good

Manor Hall Nursing Home was caring.

People were supported by kind and caring staff. Staff knew people well and had good relationships with them.

Staff maintained people's privacy and understood the importance of confidentiality.

Relatives were able to visit at any time, and were made to feel very welcome.

Is the service responsive?

Requires Improvement

Manor Hall Nursing Home was not consistently responsive.

Although people were able to make some choices the care they received was task based and not person-centred due to constraints on staff time.

People did not always receive the care they needed. Some people spent a considerable amount of time in the lounge without any interaction or stimulation from staff.

A complaints policy was in place and complaints were handled appropriately.

Is the service well-led?

Requires Improvement

Manor Hall Nursing Home was not consistently well-led.

The quality assurance systems to assess the quality of the service provided were not always effective.

There was an open culture at the home and the registered manager was well thought of. People, visitors and staff told us they could discuss concerns with her at any time.

Manor Hall 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 was an unannounced inspection on 24 and 25 August 2016. It was undertaken by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we reviewed the records of the home. These included staff training records staff files including staff recruitment, training and supervision records, medicine records complaint records , accidents and incidents, quality audits and policies and procedures along with information in regards to the upkeep of the premises.

We also looked at five care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at the home. This is when we looked at their care documentation in depth and obtained their views on their life at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection, we spoke with nine people who lived at the home, four visiting relatives, and eleven staff members including the registered manager and a visiting healthcare professional.

We met with people who lived at Manor Hall Nursing Home; we observed the care which was delivered in communal areas to get a view of care and support provided across all areas. This included the lunchtime

meals. As some people had difficulties in verbal communication the inspection team spent time sitting and observing people in areas throughout the home and were able to see the interaction between people and staff. This helped us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at the home. Comments included, "We've got security here," "There are people around and I do know people can't get in without permission." People told us they received their medicines when they needed them, they told us if they needed pain killers they could ask for them whenever they liked. One person said, "I just request it and the nurse gives it to me." Visitors we spoke with told us their relatives were safe at the home.

We found some aspects of the service were not always safe. People told us they had to wait for staff to attend to them. One person said, "Sometimes when you've got to go to the toilet you have to wait ages, they could do with more nurses for that sort of thing."

We found not everyone's needs and choices had been taken into account when determining staffing levels. Staffing levels were stable. Two nurses worked each day and one at night. One day nurse commenced work an hour earlier than the second nurse to ensure the morning medicines were given in a timely manner. There were nine care staff in the morning, one of who came on duty an hour early to assist one person who liked to get up early. There were six care staff in the afternoon and four at night. There was an activities co-ordinator on duty between 10am and 4pm six days a week. In addition to providing care for people the care staff were responsible for preparing and serving breakfast and hot drinks each morning and afternoon. Staff were constantly busy throughout the day. At the time of the inspection 30 people required support from two staff with their mobility needs. This meant if four people required support at the same time other people would be required to wait. We observed call bells were ringing constantly throughout the day. These were answered quickly however people told us their needs were not always addressed at that time. One person said, "If I call, staff come to me quite quickly but they don't always attend to me then. They explain they are busy and will come to me as soon as they can." The person went on to say they would often have to wait up to 30 minutes to be attended to. Another person told us, "If you're lucky you get someone." People told us there was no social company at the home. One person said, Sometimes they (staff) talk but they don't sit down, they're always rushing around."

Staff were focussed on the work they had to do but people did not always receive the care they needed. Care plans informed staff how often people should have their position changed and staff recorded on people's room charts when this had happened. Where people remained in bed we saw their position was changed in accordance with their care plans. However, people who spent time in the lounge did not always have their position changed in accordance with their care plan. For example one person who required their position to be changed two to four hourly had their position changed whilst in bed. However, we saw this person had not had their position changed during the afternoon during the first day of our inspection. The records showed they had not had their position changed for seven hours. The records from the day before our inspection showed the person's position had not been altered for six hours.

Staff told us they were busy and had little time to spend with people except when providing their care. One person told us they would like to get up at 9am but it would be anytime between 9 and 11am depending on staff availability. One staff member said, "If we could have someone do the hot drinks it would give us more

time to spend with people." Two staff members told us they had asked for more staff. One staff member said, "We have been told there needs to be 40 people living at the home before staffing levels are increased." Records of staff meetings showed staffing levels were based on how many people lived at the home and did not reflect people's individual needs. The staffing levels were not flexible and had not been reviewed to ensure staff could meet people's needs.

We found the provider had not ensured there were sufficient numbers of staff deployed to meet people's individual care needs. This is a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were a number of fire checks and a fire risk assessment had taken place. Personal emergency evacuation plans (PEEPs) were in place to ensure staff and emergency services are aware of people's individual needs and the assistance required in the event of an emergency evacuation. However, in the event of a fire or other emergency when people would be unable to use the passenger lifts there was no equipment available for staff to evacuate people. Most people were dependant on two staff for their mobility needs and would not be able to use the stairs. There were a range of environmental and individual risk assessments in place for example in relation to people's mobility, risk of falls and skin integrity. Staff we spoke with had a good understanding of the risks associated with supporting people. Risk assessments had identified people were at risk of pressure area damage. There was information in care plans about the support people required to maintain their pressure areas. This included information about position change and pressure relieving equipment such as air mattresses or cushions. There was information about the pressure settings in people's room charts however we found not all the mattresses had been set correctly. Care plans informed staff whether people required bed rails to be used but this information had not been recorded in people's room charts. Room charts were completed to say bed rails were in the correct position but there was no information to show what the 'correct position' was. We raised this with the registered manager and nurses who ensured this was addressed promptly. We recommend the provider reviews procedures at the home to ensure people are safe at all times.

People's risks in relation to their health related conditions were managed safely. Some people required care in relation to a health related condition such as diabetes, epilepsy, wound or catheter care. Care plans contained appropriate guidance to ensure people's health needs were met appropriately. For people who were living with diabetes there was information about the medicines they had been prescribed, when their blood sugar levels should be checked, what were normal levels for each individual and what action staff should take if the levels were too high or too low. Incident and accident forms had been completed when required and information was used to update the care plans and risk assessments. Staff had a good understanding of the risks associated with supporting people at the home.

People were protected, as far as possible, by a safe recruitment system. Appropriate checks were undertaken before staff began work to ensure they were of suitable character to work at the home. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). Records showed there was a full employment history and any gaps in employment had been recorded. There were copies of other relevant documentation including references, interview notes and Nursing and Midwifery Council (NMC) registration documentation in staff files. There were regular checks in place to ensure nurses who worked at the home had maintained their registration which allowed them to work as a nurse.

Medicines were managed safely. Medicines trollies were locked when left unattended. Staff did not sign Medicines Administration Records (MAR) charts until medicines had been taken by the person. These had been completed to show when medicines had been given or why they had been omitted. MAR charts contained relevant information about the administration of certain drugs, for example in the management

of anti-coagulant drugs, such as warfarin. Medicines were ordered, stored and disposed of safely. The nurses received regular training and there was regular checking of their competency to administer medicines. There were regular audits of medicines to ensure safe practice was maintained.

Some people had been prescribed 'as required' (PRN) medicines, such as pain killers. There were protocols in place however the nurses told us these were currently being reviewed to ensure they were individual and contained all the information staff required. For example the reason for the medicines used, the maximum dose and the minimum time between doses. The nurses had a good understanding about the medicines people had been prescribed and why they may need them. Some people had medicines administered covertly. Covert is the term used when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in a drink. There was evidence this had been discussed with the
person's GP and other relevant people. Mental Capacity assessments were in place to demonstrate why this was appropriate for the person.

Some people required topical creams to be applied. Some of these were to maintain good skin health for example to prevent skin becoming dry. Others had been prescribed for a specific health need such as a skin infection. Creams that had been prescribed to maintain good skin health were stored in people's bedrooms. There were body maps in place to show where to apply the cream and care staff recorded when this had been done. Nurses and care staff told us they were confident the creams had been applied correctly however the charts were not always fully completed. Nurses told us they were currently working with care staff to ensure they were fully completed. The nurses received annual medicine training updates and competency checks.

Staff received safeguarding training and regular updates. They told us about steps they would take if they believed people were at risk of abuse or harm. Care staff told us they would report to their senior on duty and escalate their concerns through the company if they felt issues had not been addressed. Staff were aware of their responsibilities to report any concerns and were aware of the external organisations they could report to if their concerns had not been addressed appropriately. They were aware where they could access relevant telephone numbers for external organisations. All concerns had been referred appropriately to the local safeguarding team.

The home was clean and tidy throughout with evidence of good attention to detail. Regular health and safety checks took place. These included environmental and maintenance checks. There was regular servicing for gas and electrical installations and lift and hoist servicing. Equipment required to maintain people's safety and well-being for example suction machines and syringe drivers were regularly checked by the nurses and ensured to be in good working order. Water temperature and legionella checks took place regularly. The home was staffed 24 hours a day with an on-call system for management support and guidance.

Good

Is the service effective?

Our findings

People told us food was very good. One person said, "There's always a choice, it's served hot and I'm putting on weight." A visitor told us they often joined their relative for a meal and "food was good." People told us staff were skilled and knew how to look after them. One person said, "'We have a nice set of nurses they are very good."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to 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 and hospitals 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. DoLS applications for people who did not have capacity and were under constant supervision by staff had been submitted. There were mental capacity assessments in care plans. These informed staff that people were not always able to make choices.

Mental capacity assessments had been undertaken and 'best interests' decisions made, with all relevant people and professionals involved in the process. For example some people had bedrails in place. This was consistent with the law and the provider's policy. Staff had an understanding of the Mental Capacity Act (MCA) (2005). Staff had undertaken recent training in this area and had an understanding of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. We observed staff asking people's consent prior to offering care and support throughout the inspection. There was no information about whether people had a power of attorney in place and what this covered. The registered manager told us she had identified this and was currently gathering the appropriate information.

Staff received appropriate training and support to enable them to meet people's needs. When staff commenced work they completed an induction which introduced them to the policies and procedures of the service and included moving and handling training. They said this was, "Intense and to the point." One staff member explained, "The training really focuses on the care people here need, it's specific to their needs." Staff spent time shadowing other staff prior to working unsupervised. Staff also undertook the Skills for Life Care Certificate training. This familiarises staff with an identified set of standards that health and social care workers adhere to in their daily working life. We spoke with staff about their experiences of induction they said this provided them with the knowledge they needed to support people. One staff member said, "We always work in pairs, so there's always support."

Staff received regular training and updates in subjects relevant to the care needs of people they were supporting. This included safeguarding, dementia, moving and handling, mental capacity and infection control. In addition staff were able to undertake further training for example the diploma in health and

social care at various levels. Staff told us they identified further training during supervision to support them in their roles. Nurses received regular clinical training and updates, this included wound care, diabetes and emergency situations. Staff competencies were regularly checked this included moving and handling and practical skills for nurses. We were told there had been a new appointment to the training team and this person had been focussing on clinical nursing skills and developing nurses knowledge. Nurses told us if they had any clinical concerns or identified areas they needed support or further training this would be provided. Nurses were supported by the training team in meeting the new requirements relating to nurse's continued registration. These requirements ensure registered nurses meet a certain standard in order to continue to practice.

There was an ongoing supervision programme and staff told us they received this regularly. Staff told us they found this useful it gave them an opportunity to discuss any issues and if possible solve problems. Staff said they could discuss concerns with the registered manager or senior staff at any time.

People were supported to maintain good health and received on-going healthcare support. Records confirmed that staff liaised with a wide variety of health care professionals who were accessed regularly. This included the Tissue viability nurses, speech and language therapists, GP and chiropodist. The nurses maintained good contact with the GP's, they regularly contacted them for advice for example regarding people's medication or change in health. Staff enabled people to maintain close and effective links with health care professionals. For example, a staff member accompanied one person to a hospital appointment. A health professional we spoke with told us staff knew people well, they referred people to them appropriately and acted on the advice given. People told us they were supported to see their GP, dentist and chiropodist when they needed to. One person said, "The doctor comes here and they (staff) take me to the dentist."

People's nutritional needs had been assessed and regularly reviewed and they were supported to maintain a balanced and nutritious diet. When risks were identified these were reflected within care documentation. There was also information in the kitchen and people's bedrooms. This included people who required a specialist diet such as pureed, diabetic or fortified. The cook and staff had a good understanding of people's dietary needs and choices. Food was freshly cooked daily and people were offered a choice at each meal. Hot and cold drinks were served regularly throughout the day. At the time of the inspection there was a heatwave warning in place. Staff were reminded to offer people extra drinks throughout the day and jugs of juice were available. We observed the activity staff reminding people to drink and ensuring cups were topped up.

People were weighed regularly to ensure they were adequately nourished. When people had lost weight they were referred to the GP or dietician. Some people required their food and fluid monitored, we saw records in place to demonstrate this. At handover staff were reminded about people who needed to be encouraged with their meals. The nurse told care staff about one person who had lost weight, they were reminded to prompt the person to eat and encourage them to drink more. Staff were informed this person needed to be weighed at the end of the week and if they had not gained weight they would be referred to the GP for further assessment.

Good

Is the service caring?

Our findings

People we spoke with told us staff were kind and caring. One person said, "They're very nice I'm well looked after." Another person said, "Staff are really kind and lovely." One visitor told us staff were very caring they said, "They're (staff) lovely, I can't speak highly enough of them." Another visitor said their relative was well looked after.

Staff were busy and not able to spend as much time as they wished with people which left people isolated for long periods of time throughout the day. However, we observed staff treating people with kindness and care. Staff worked at people's own pace. They did not hurry people and were patient. We observed staff talking with people as they undertook care. One staff member said, "We chat with people when we're giving them care and when we're in their rooms with them." Another staff member told us about the hourly 'comfort checks' for people. They said, "That is their (people's) time. We don't just look at them to check, we talk to them, we make sure they have everything they need, we offer them drinks, put their TV on whatever they want."

We observed one staff member providing a meal for a person who remained in their bedroom. The staff member supported the person to eat their food, they sat with the person, maintained eye contact and chatted with the person throughout the meal. We observed similar practice when staff were attending to people who were less able to communicate verbally. Staff knew people well. One staff member said, "People communicate through eye contact, facial expressions and little connections like that. That's how we know what people need."

It was clear from observing staff that they knew people well, they were able to tell us about people the care they needed their likes and dislikes and how they liked their care provided. Staff spoke quietly with people making eye to eye contact, using their preferred name and taking time to listen to them. People were treated with respect and staff protected people's privacy and dignity when they assisted them with personal care. One staff member told us, "We treat people with dignity by listening to them, abiding by their wishes and making sure doors and curtains are closed when we are giving personal care." Arrangements were in place to ensure that people's records were stored securely and that their personal information remained confidential. Staff did not discuss personal information in communal areas of the service.

People and their families where appropriate, were involved in their day to day care. People's care plans and risk assessments showed they had been consulted on their views of their care and asked what was important to them. There were care plans in place to reflect people's end of life wishes. Relatives told us they were kept informed about people and involved in decisions about their care. One relative told us, "They always involve me in any decisions." Throughout the inspection we observed staff contacting people's relatives to inform them of changes and giving them updates about people's health and care needs. We saw visitors were welcome to visit the home at any time.

People were treated with kindness and compassion by staff who cared about the people they were looking after. We observed staff assisting people into chairs. They ensured people were comfortable for example

readjusting one person's clothing to ensure it was not twisted and ensuring they had their drink and call bell nearby. We saw staff did not leave people until they were satisfied the person was comfortable.

People's bedrooms were personalised with their own belongings such as photographs and other memorabilia. People were dressed in clothes of their own choices and were well presented. Staff told us they supported people to choose what clothes they wanted to wear each day. Staff understood the importance of ensuring people were clean and well presented in a way that suited the individual.

Requires Improvement

Is the service responsive?

Our findings

We found aspects of the service were not responsive. People told us they received the care they needed however some people's choices were not always respected. One person said, I go to bed at 6-6.30pm because you have to wait a long time and staff might not be available if I wait later." Some people told us they did not have enough to do during the day. One person said, "I wish there was more opportunity for conversation with staff."

Pre-assessments took place before people moved into the home. People and where appropriate their representatives were involved in developing their care plans. Although staff offered people choices throughout the day for example in relation to where they wanted to spend their day, what they wanted to eat or what they wanted to wear, the care they received was not person-centred but task based. This was because of the constraints on staff time. Staff assisted people to get up but this was dependant on their availability not on people's individual choices. One person told us they would like to get up at 9am but it would be anytime between 9 and 11am depending on staff availability. We observed one person had been brought into the lounge as lunch was being served. Staff explained they had only just got this person up as they had been busy all the morning.

Some people told us they didn't have enough to do during the day. One person said, "All I ever do is sit down," another person told us, "I spend the day just sitting in my chair, it's dead boring." Someone else said, I go to bed after tea because I have had enough of sitting and looking at nothing." There was an activity programme in place however this was not person centred and did not include meaningful activities for people who were less able to participate in group activities. Care staff told us people needed more to do during the day. One staff member said, "I see people sitting there doing nothing. If I have time I will stop and talk but I don't often have time. Activities co-ordinators were responsible for providing activities at the home. There was an activity co-ordinator on duty six days a week. People in the lounge spent long periods of time with no stimulation or interaction from staff. People were not offered anything to do, for example magazines or books to read. There were books available in the lounge but these were out of reach of people. On the first day of the inspection the activity co-ordinator was painting some people's fingernails but there was no activity for other people. On the second day a musical entertainer visited the home, people had asked to be informed what tune was being played but this did not happen. Following the playing of one tune people commented they had enjoyed that particular genre of music, other people agreed but this was not pursued to ensure people listened to the music of their choice.

Social and activity care plans were in place but these were not personalised. The Dementia In-Reach Team had introduced the Pool Activity Level (PAL) assessment. This is a framework for providing activity-based care for people who are living with dementia. The PAL assessment identifies a person's ability to engage in activities which are then developed for each individual. This should include a detailed life-history and information about people's specific hobbies and interests. We observed one person had been assessed as requiring the 'reflex' level of activity. This meant the person was living with advanced dementia and maybe unaware of their environment or their own body. The PAL assessment advises not to over stimulate or use multiple stimuli at one time as the person would not be able to process the information. It recommends

using touch, a warm, reassuring tone and volume of voice and positive facial expressions to engage with the person. The social care plan did not reflect this assessed level of engagement. It stated the person liked to watch TV and listen to music. This did not reflect the person's assessed ability to engage. We saw similar discrepancies in other care plans. There was no information for staff about how they should engage with this person and support them to engage in appropriate activities. The activity co-ordinator told us they had not received training to understand the PAL assessment approach to activity and did not use that information when developing activities.

The meal aspect of the service had not been adapted to meet people's individual needs. There was no dining room at the home however there was a table available in the lounge where people could eat their meal if they wished to. Some people ate their meals in their bedrooms others sat at individual tables in the lounge. These tables were not set for a meal and there was no visual stimulus that would have promoted it as being a mealtime for example glasses or napkins for people. There was salt and pepper but these were in paper sachets and we did not see anybody being asked if they would like to use them. People who were living with a dementia type illness may not recognise these sachets as condiments. One person told us about the mealtime experience. They said, "I don't think there is anything wrong with the food but there is a lot of rushing around because a lot of people in their rooms." Another person told us, "I don't think they (mealtimes) are social occasions."

Some people required support to make choices due to living with a dementia type illness. People were asked to make meal choices the day before however there were no picture menus or alternative ways of offering people choices. There was no menu on display in areas that people accessed for example in people's bedrooms or the lounge. People who did not require support at mealtimes were provided with their meals first, staff then supported people who were less able. We observed one person who required specialist equipment to eat their meal had this in place but staff had placed this in the wrong position. The person struggled to eat for some time before staff intervened.

People did not always receive the care they wished for or required. Care was task based rather than responsive to individual needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite these concerns we did see some evidence of responsive care being provided. Where people were able to make their own choices they were supported to do so. Some people who remained in their bedrooms told us they had enough to do during the day. One person told us they enjoyed watching television and reading. Another person told us they enjoyed going out with staff to the park. Where people's health and care needs had changed staff identified this and ensured people received the appropriate care they needed.

The provider had a complaints policy and procedure and complaints were recorded and responded to appropriately. We saw complaints had been investigated and the person responded to appropriately. Where a complaint was upheld they had apologised to the complainant and described the action taken to put things right and improve the service for the future. People told us they would make a complaint if they needed to and knew they would be listened to.

People's views were sought and listened to. There were six monthly resident and relative meetings. The registered manager had identified not many relatives had attended and arrangements had been made for the next meeting to be better advertised. Records showed people were asked about their view of the food and issues about laundry were discussed. People and relatives were also introduced to new staff at the home. Minutes of the meeting were discussed with people who had not attended.

The service sent a series of annual questionnaires to people's relatives or representatives to gather their views on the care and support provided, activities, the food, the environment and management. The last survey indicated people were satisfied with the support they received.

Requires Improvement

Is the service well-led?

Our findings

People told us there was a nice atmosphere at the home. One person said, "It's quite nice they (staff) get on well together." Another person told us, "It's very good, everyone is happy and kind, they are kind that is the main thing." They told us staff were approachable. Staff told us the registered manager and senior staff within the organisation were open and approachable. However, we found aspects of the service were not well-led.

There was a quality assurance system in place and a series of audits took place. However, where some shortfalls had been identified for example at staff meetings in relation to staffing levels no formal analysis of people's needs or action had been taken to determine appropriate staffing levels. Some shortfalls in relation to person-centred care, the risk of social isolation and records had not been identified. There were no audits of people's room charts to identify the issues we found.

Accurate and complete records about the care required had not always been maintained. The care plan records were task focused and did not provide sufficient information about people's holistic needs to ensure a personalised service was consistently provided. For example one care plan stated the person found it difficult to communicate, understand and respond due to living with dementia but there was no detailed guidance about how staff could communicate with this person. Another care plan stated the person may display behaviours that challenged themselves or others when they received personal care but there was no guidance about how staff could support the person. A number of people were deemed not to have capacity but there was no information in the care plans about how they were able to make day to day choices for example what to eat or what to wear. However, staff knew people well and were able to tell us how people communicated with them and made choices but this information had not been recorded in their care plan to ensure it was used to provide a consistently personalised service.

Activity records were not individual. They focussed on the activity provided, who wished to attend and who declined. There was no evidence these were based on what people would chose to do and they were not linked to the PAL assessment. Where people had attended an activity there was no information about whether they had participated or enjoyed themselves. Some people went out for walks with staff but there was no information about why some people went out and others did not. One person told us they would like the opportunity to go out however staff told us this person declined to go out if offered.

The quality assurance framework was ineffective because the provider failed to have effective systems and processes to assess and monitor the quality of the services provided and ensure people's records were accurate and complete. This was a breach of Regulation 17(1)(2)(a)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager took an active role with the running of the home and had good knowledge of the staff and the people who lived there. Staff told us they felt well supported by her. She provided clear and confident leadership for the service. There were clear lines of responsibility and accountability within the management structure. There was a thorough handover at the start of each shift. The registered manager,

nurses and all care staff attended which meant they were aware of people's needs and any changes. Staff were regularly updated by colleagues throughout the day. The service had notified us of all significant events which had occurred in line with their legal obligations.

Staff had opportunities to develop and improve the service. Care staff and nurses discussed ways to ensure air mattress settings should be recorded and checked in a way that was clear for everybody. We saw staff were listening to and respecting other colleague's points of view.

There were regular staff meetings to provide a forum for open communication. Meeting minutes showed staff were always thanked for their hard work. Meetings were used as an opportunity to update staff about changes at the home, forthcoming training and reminders about training they had completed. Staff told us they were able to bring up new ideas and suggestions. If suggestions made could not be implemented, staff confirmed feedback was provided. For example, one staff member told us they had brought up issues about the staffing levels and were told why these could not be increased. They said; "We were listened to, they can't do anything at the moment but I felt listened to and they know how we feel."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive the care they wished for or required. Care was task based rather than responsive to individual needs. 9(1)(a)(b)(c)

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 quality assurance framework was ineffective because the provider failed to have effective systems and processes to assess and monitor the quality of the services provided and ensure people's records were accurate and complete. 17(1)(2)(a)(c)

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 We found the registered provider had not safeguarded the health, safety and welfare of people living in the home by ensuring there were sufficient numbers of staff deployed. 18(1)