GCH (Harrow) Limited

Kent House

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

Kent House is part of Gold Care Homes Limited and provides accommodation and support with personal care for up to 36 older people, some of whom have dementia. At this inspection there were 35 people using the service.

This was an unannounced inspection. The service was last inspected in March 2014, and was found to be meeting the regulations we inspected.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider carried out audits to monitor the quality of the service but this did not lead to improvements in people's care. Prior to this inspection, the provider had undertaken audits, including on accident and incidents, medicines, care plans and infection control but there were no improvements made after each audit cycle.

Summary of findings

Care plans were not regularly updated to reflect people's changing care needs so that people received care that was appropriate and safe.

We saw some people's records about care, treatment and support were not clear, factual and accurate. This meant people's care records were unreliable and exposed people to the risk of receiving the wrong care and treatment.

The provider failed to ensure people receiving care were protected against the risks associated with unsafe use and management of medicines. People did not always have their medicines at times they needed them, and in a safe way. There were no appropriate arrangements for recording, storage and safe administration of medicines.

There were no appropriate steps to ensure that there were sufficient numbers of suitably qualified, skilled and experienced staff at all times. People's safety was at risk through the lack of supervision for those who were at high risk of falls, lack of procedure in place for last minute absences and staff shortages and the failure of the provider to assess the needs of people when determining the number of staff required on duty.

Staff did not always ensure that people were eating and drinking enough to keep them healthy.

People using the service were not protected against identifiable risks of acquiring infections by means of the effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of infection.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this 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?

Inadequate

The service was not safe. People receiving care were not protected against the risks associated with unsafe use and management of medicines. People did not always have their medicines at times they needed them, and in a safe way. There were no appropriate arrangements for recording, storage and safe administration of medicines.

The provider did not have sufficient numbers of suitably qualified, skilled and experienced staff at all times.

The home did not have a system in place to regularly assess and monitor the quality of the service or manage risks to people's health, welfare and safety.

Is the service effective?

Inadequate

The service was not effective. Care plans were not detailed and did not always reflect people's changing needs.

Staff did not always ensure that people were eating and drinking enough to keep them healthy.

Staff did not receive regular supervision and appraisals. Most staff staff were overdue their refresher training on all the mandatory training, including safeguarding, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Is the service caring?

Requires Improvement

The service was not caring. In some cases we saw people were not treated with dignity and respect. During the night, all people wore incontinence pads, regardless of their incontinence status.

People told us staff were kind and respected their privacy and dignity. They told us that staff provided them with the assistance they needed.

We found people had access to the equipment they needed to promote their independence. For example, people used walking frames and wheelchairs to enable them to move freely within the home.

Is the service responsive?

Inadequate

The service was not responsive. The service was not always responsive to people's individual social needs as we found some people did not have the opportunity to participate in any planned meaningful activities.

People's needs were not always assessed and appropriately reflected in their care records. Largely, people's needs had not been reassessed when their needs had changed.

People participated in surveys but their feedback did not always lead to service improvements.

Summary of findings

Is the service well-led?

The service was not well-led. There were systems in place to monitor the quality of the service. However, audits, surveys and feedback did not lead to improvements in care.

Staff spoke positively about the registered manager. However, staff felt she did not receive sufficient support from senior management.

Staff told us that they were supported and felt able to express their views about the service.

Inadequate

Kent House

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.

This unannounced inspection was carried out on 9 and 10 November 2014 by three 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. A pharmacist inspector also carried out an unannounced inspection on 10 November 2014.

During the inspection visit we spoke with 14 people using the service, eight staff members, two members of the provider's management team, a healthcare professional, and two relatives. We observed how staff interacted with the people who used the service. We looked at twelve people's care records to see how their care was planned, seven staff personnel files and records relating to the management of the service including quality audits.

Some people had complex needs so we used the Short Observational Framework for Inspection (SOFI) to observe the way they were cared for and supported. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Before the inspection the provider completed a Provider Information Return (PIR). 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 reviewed the information included in the PIR along with other information we held about the home.

Inadequate

Is the service safe?

Our findings

We got mixed responses from people regarding how safe they viewed the care and treatment they received. One person told us, "I have known this home for a long time, and I do feel safe. I have never seen anything like abuse here or cruelty from the staff." However, some people expressed concerns about insufficient staffing. One person told us, "Staff have too much to do and no time to do it" and another person said "Sometimes you have to fit in at certain times because they are short of staff."

The provider did not undertake comprehensive risk assessments for people's specific complex needs. For example, in one file, we saw that the blood glucose levels of a person with diabetes varied considerably within a 24 hour period, from 5mmols to 21mmols but there was no care plan, risk assessment or guidance of the action staff would take if the person became hypo-glycaemic (low-blood sugar) or hyper-glycaemic (high-blood sugar).

The same person did not have a diabetes care plan, including a nutritional plan. The Diabetes UK, "Good clinical practice guidelines for care home residents with diabetes", dated January 2010 states, "Every person with diabetes should have an individualised nutritional care plan in place." A diabetes care plan is important in order to identify key roles and responsibilities, targets and outcome measures, annual review procedures, and what arrangements are in place for specialist review.

In another file, we noted a moving and handling assessment of one person raised concerns about their skin integrity. The plan stated the person's skin was delicate and at risk of tearing. This person was unable to walk unaided and could not change position independently. At this inspection, we saw that this person had been seated in an armchair by 10.30am. We visited the person in their room throughout the day from 10.30am to 8pm and we did not observe staff changing this person's position. Staff spoken with were not aware if this person had been moved. Records did not show if this person had been moved or turned. The National Institute for Health and Clinical Excellence (NICE) CG29 "Pressure ulcers: The management of pressure ulcers in primary and secondary care" dated September 2005 states that one of the best ways of preventing a pressure ulcer is to reduce or relieve pressure on areas that are vulnerable to pressure ulcers by repositioning or moving.

In another file, we read that a person's mental health had deteriorated. On following this up with staff, they told us that the person had started displaying aggressive behaviours. However, there were no risk assessments or management strategies around this person's behaviour.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicines were not stored and administered safely. The provider did not ensure access to the Controlled Drug (CD) cabinet was limited to authorised persons. Although the room housing the CD cabinet was locked, the actual CD cabinet was not locked. The keys of the room housing the CD cabinet were in a desk drawer in an accessible office. This office was accessible to all staff, including staff who were not authorised to access the CD cabinet.

We also saw that keys to drug trolleys were not kept in an appropriate and secure location. Medicines trolleys were locked in a separate walk-in cupboard. However, keys to this cupboard were kept in a desk in an accessible office. The keys to one trolley were attached to it, which meant even when the trolley was locked when in use during a medicines round it was insecure and accessible to people in the service and unauthorised staff.

People on medicines prescribed to be used 'as required' or prn did not have protocols to support staff in their use. It was also not clear whether the medicines were given as prescribed. For example, in one case, we saw 15 gaps on medication administration record (MAR) out of a possible 30 administrations. In another example, there was an advice for prescribed antibiotics to be taken twice a day for 10 days and advice that any remaining liquid was to be discarded. However, we saw from the MAR sheet that medicine was signed as given for 13 days.

We also saw that the printed MAR sheets showed times 8:30am, 12pm, 5pm, 8:30pm for the administration of paracetamol. The times indicated on the MAR sheets did not give sufficient time between paracetamol doses if they were adhered to. Paracetamol must be taken at least on a four hourly interval.

We found the same lack of clarity in the administration of other PRN medicines. This meant that people may not have received their medicines when they needed them.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service safe?

The provider did not manage infection prevention and control (IPC) well. The provider did not have Department of Health's publication: The Code of Practice for Health and adult social care on the prevention and control of infections and related any related guidance (hereafter referred to as, The Code). The Code sets out what registered providers of health and adult social care services need to do to ensure compliance with the Care Quality Commission (CQC) registration requirements for IPC. This is important to ensure staff follow policies and procedures that meet current and relevant national guidance.

The provider did not have a written policy that detailed the roles and responsibilities of staff in respect of IPC, including roles and responsibilities for the management of outbreaks and incidents of infection. When we asked the registered manager and the deputy manager they were not clear who was responsible for IPC. A written policy that details roles and responsibilities is important to ensure staff understand their role and responsibilities for maintaining high standards of cleanliness and hygiene.

The provider did not ensure the risks from cross-contamination were minimised. In one example, a person with MRSA did not have a care plan in place. This was important to identify this person's infection status, including risks and how these were to be minimised. Equally, this was important because there were people receiving care with leg ulcers, catheters, diabetes, and some who were on courses of antibiotics. These groups are most at risk of MRSA infection. However, there was no infection control advice that was being followed in respect of this person. Criterion 5 of The Code sets out guidance to registered providers to ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people. Similarly**,** criterion 5.2 of The Code, states that arrangements to prevent and control infection should demonstrate that responsibility for IPC is effectively devolved to all groups in the organisation involved in delivering care. In this case, the provider did not meet both criteria.

In another example, the provider did not use correct cleaning colour coding system. This is recommended in The Code. We spoke with three members of staff who were not aware of the correct colour code system. Equally, personal protective equipment (PPE) was not used effectively. We observed that staff did not always remove gloves after each care activity for which they were worn and before attending to other people or contact with other items such as door handles. We also observed that at times aprons were not discarded on completion of a task. Similarly, we saw that hoist slings were shared between people. Department of Health's publication: Prevention and control of infection in care homes – an information resource, dated February 2013 states, "Slings should be laundered in hottest wash cycle allowable according to the manufacturers' instructions and not shared between residents."

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were not enough staff with the right experience or training to meet the needs of the people living in the home. Although the registered manager told us that the staffing numbers and skill mix were set with regard to people's dependency needs, there was no system in place that showed this. The staff allocation sheets that were used on both days of this inspection did not reflect the dependency needs of people.

At night from 9pm and 12am, the three waking staff spent almost three hours working on the first floor. During this time, some people were seated in the lounge without supervision. Staff told us if people wanted support they would ring call bells. We were concerned this was not safe partly because, from the incident log we saw that in July 2014 there had been 8 falls in the home; 6 in August 2014, 11 in September 2014 and 10 in October 2014. We also noted that 18 of these had not been witnessed by staff. People were at risk of having a fall or other incident without staff supervision.

During mealtimes staff were particularly busy supporting a considerable number of people with their meals and other care needs, which meant that mealtimes lasted an hour and a half or more. Some people had to wait a significant amount of time before being provided with their meal whilst staff were providing care and support to others. Lunch started at about 12.45pm. At 1pm people were still being seated, whilst some people were having soup and some were on their main course. A person who stayed in their room was served lunch at 1.30pm. During all this time, there was little communication between staff and people; staff were very much task orientated.

Inadequate

Is the service safe?

We looked at the care plans of four people who lived on the ground floor. It was indicated they were on two hourly observations. At this inspection, none of the four people we checked between 9pm and 12am were observed because all the three staff on duty were attending to people on the first floor.

We asked the registered manager what system the home had in place for emergency absences, late sick leave, and other instances which resulted in a shortage of staff. The manager said they would ask staff to work extra shifts because they did not use any agency. Staff told us if no staff were available to work extra shifts, they worked short-staffed.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service had a safeguarding policy and procedure. Staff had received training in safeguarding adults. We spoke with seven staff and they knew and were able to tell us about signs of abuse, including relevant reporting procedures, such as reporting concerns to their manager or where appropriate, the local authority or CQC.

Inadequate

Is the service effective?

Our findings

We received mixed feedback about the quality of food and choices available. One person, a vegetarian was happy with their choice, told us, "I think they are very good with the food." Another person said, "We get a menu and choose from that." However, other people were not as complimentary. Commenting on food choices, one person told us, "Some days you get a choice others you don't" and on being asked if they could ask for something that was not on the menu, this person remarked, "Oh no! That's beyond the limit."

Staff did not always ensure that people were eating and drinking enough to keep them healthy. We saw that one person who was admitted a few weeks prior to this inspection did not have a care plan in place. The weight charts of this person showed significant weight loss between September 2014 and October 2014. Screening for malnutrition had not been carried out on admission as recommended by NICE guidance dated February 2006, "Nutrition support in adults: Oral nutrition support, enteral tube feeding and parenteral nutrition." A Malnutrition Universal Screening Tool (MUST) had not been used for this individual. 'MUST' is a screening tool to identify adults, who are malnourished, or at risk of malnutrition. Furthermore, the provider had not sought input from healthcare professionals who are skilled and trained in nutritional requirements for this person. This person's fluid and food intake records did not always make it clear how much they had eaten or drunk. With significant weight loss a care plan should have been in place to direct staff on what to do.

One other person had two separate Nutritional Risk Assessment Charts for 2014. In one chart the monthly recording covered July 2014 to October 2014 and showed the person had no weight problem. However, the weight chart for August showed the person had lost 2.05 kg. In view of the discrepancy and inaccuracy of the records in these two documents, the nutritional risk assessment made was unreliable and exposed this person to the risk of receiving the wrong care and treatment.

Another person's 'nutritional Needs' care plan did not reflect their current needs, which included loss of appetite and weight loss. The monthly weight charts for this person showed erratic weight gain and weight loss. However, the care plan of this person did not reflect the weight loss problem and did not mention the Ensure supplement drink that had been prescribed.

The menu plan was not presented in a format that could easily be understood by all the people using the service, such as the use of pictures or visual aids to help people make a choice. When we highlighted this to a member of staff, we were told, "We normally make choice for those who can't read or talk."

There was a choice of the main dish on the menu plan, however staff did not offer people a choice for which vegetables they would like to eat or if people would like to eat something lighter such as salad.There was a choice of one pudding and we observed no fruit was offered to people.

This was a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us and records confirmed they did not receive regular supervision and appraisal. The provider's supervision policy stated, "All care and nursing staff should have at least one formal supervision session of at least one hour duration every two months." This was not happening consistently.

This was a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff training records showed staff had received up to date training in key aspects of their role such as dementia care, moving and handling, health and safety and safeguarding. However, we found that most staff were overdue their refresher training. We saw that there was a plan for all staff who were overdue to be booked for training.

Most staff we spoke with did not understand the requirements of the Mental Capacity Act 2005. Equally, most staff did not understand their responsibilities in relation to Deprivation of Liberty Safeguards (DoLS). There was a lack of awareness of its implications for a significant number of people living in the home who with regard to their safety were always accompanied when out and were not free to go out into the community alone.

The registered manager had a good understanding of their responsibilities in relation to MCA and DoLS and had applied for authorisation to deprive four people of their liberty as part of keeping them safe. We saw examples of

Inadequate

Is the service effective?

when the provider acted in people's best interests when they did not have capacity to consent. The provider had consulted with their family and professionals where appropriate. We saw records in some care plans we viewed in respect of MCA assessments. Do not attempt Resuscitation (DNAR) forms seen in the care records of three people showed that DNAR had been discussed with GP and family members. Details of who was not for resuscitation were clearly recorded in the night staff file.

The provider did not provide a supportive and enabling environment for people with dementia. The provider supported 12 people who were diagnosed with dementia. NICE guidelines, 'Dementia: Supporting people with dementia and their carers in health and social care', dated November 2006, states that care home placements for people with dementia should ensure that 'built environments are enabling and aid orientation.' We observed that the environment had not been adapted for people with dementia. In the lounge area the calendar was still showing the month of October 2014. There were few calendars in the rooms and several clocks, which were incorrect. The environment did not provide landmarks to help people find their way around the indoor environment. This is recommended in the stated guideline.

We observed in the morning the television was on mute, with subtitles and a CD was playing. One person was evidently frustrated at the level of noise and another remarked, "What a row. It is terrible just sitting here with that racket on." It was difficult to communicate with the background noise and the CD playing. NICE guidance also recommend simplified environments and moderate levels of environmental stimulation.

Requires Improvement

Is the service caring?

Our findings

Some people fed back that staff treated them with respect; they felt the staff maintained their privacy when providing them with care in their rooms by knocking and closing the door. The staff knew the likes and dislikes of the people and addressed them by name. Some people told us the assistance they received from staff was appropriate to their needs. We saw staff knock on people's bedroom doors. Doors were closed when staff supported people with their personal care. Comments from people who used the service included, "Staff are pretty kind. I would say something if they weren't" and "I think staff are very kind. They look after me very carefully, I'm very grateful."

We saw staff and people who lived in the home interacting well but people who were quiet or preferred to stay in their rooms were given very little attention. Throughout the day, as we observed the routine care for two people in their bedrooms on the second floor, we did not see any member of staff spending some social time with them or interacting with them. The two people were not engaged in social activities or therapeutic stimulation for the whole day. We checked the activity monthly record sheets for July 2014 to November 2014 for one of them. The recurrent theme almost daily was 'watching television'. During this period, the records showed that there had been no one-to-one activity, except on 25 July 2014. There were entries for 'librarian visit'; once a month, 'hair done'; once or twice a month, and 'family visit'; once or twice a month.

We observed the care that was given to a person who spent the whole day in their bedroom. The person was not able to hold a cup and using a straw at the same time due to a complex condition. The person told us they would need a member of staff to help them to drink and eat. Staff told us this person was able to hold a cup if it had two holders. At 1pm we saw three cups of drink that had been served to this person had not been drunk since breakfast. Two of the cups did not have two holders, which meant the person could not have drunk unaided. Staff did not show concern for this person's wellbeing in a caring and meaningful way.

We saw staff focussed on tasks rather than individual personalised care. In particular, during lunch time some staff who assisted people with their meals did not interact with them. We observed positive engagement between people and staff was limited and generally task orientated when staff were transferring them or giving them drinks.

We observed during the night that all people wore incontinence pads, regardless of whether they needed them or not. The night staff told us some people were not incontinent. On the contrary, the manager had told us all people had been assessed as incontinent, and so were given incontinent pads "To make sure they were comfortable and dry." However, we established that 13 people had not been assessed as incontinent, which meant by giving them incontinent pads, the provider was not treating them with dignity and respect.

In terms of dignity, we observed that people had tea and coffee in plastic mugs and not cups; including not being provided with plates for their biscuits. Also, we noticed that large bibs were placed on people during the lunch service instead of napkins to use.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found people had access to the equipment they needed to promote their independence. For example, people used walking frames and wheelchairs to enable them to move freely within the home.

Representatives of other faiths regularly visited the home to support people with their spiritual needs.

Inadequate

Is the service responsive?

Our findings

The provider did not maintain accurate records in respect of care and treatment of people who used the service.

The care plans we checked had not been kept up to date as the contents did not always reflect the current status of people's care needs. The printed care plans for each person did not have a date to indicate when it had been written and there was no record of the author. We could not find evidence of people being consulted or involved in decision making following the review of care plans by staff. These plans contained limited reference to the person as an individual. We asked one person about knowledge of their care plan and they were unclear as to what this was. Another person was also unsure and could not indicate any involvement in it.

One person's records about care, treatment and support were not clear, factual and accurate. The admission notes indicated this person was admitted on a specified date, but a different admission date was indicated within the same records. A food and fluid intake chart showed this person had a ceratin amount of fluid intake, when in fact this person had not drunk the stated drinks. Also, the care records of this person indicated they had diabetes type 1 and diabetes type 2, when in fact this person had type 1 diabetes.

We looked at the nutritional needs care plan of another person. This recommended the person should have two litres of fluid daily. On following up the food and fluid charts from 1 November 2014 to 10 November 2014, we saw all charts except two did not have totals recorded. Without accurate information it was difficult to identify if the person had drunk two litres of fluid per day as stated in their care plan.

In a monthly review of another person's care, the author had recorded in the person's review form that this person had lost 2.25 kg and had a Body Mass Index (BMI) of 14, but on the weight chart the weight loss for the same date, was given as 2.05 kg and their BMI as 15. We saw further discrepancies, including inaccurate BMI calculations for the same person when we analysed the information on the 'Monthly Weigh-in' form for 2014.

In another example, staff had told us a person receiving care was able to call for assistance using a call bell. However, we established the person was unable to press the bell because of a physical disability. This aspect of the person's disability was not reflected in their care plan.

People were at risk of receiving care and treatment that did not meet their needs because the provider lacked proper information about them by means of the maintenance of an accurate record in respect of their care and treatment.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There were two activities taking place during our second visit; a quiz in the morning and bingo in the afternoon. The hairdresser was in as well. However, 9 out of 19 people who were present during the quiz had their eyes closed. We saw that engagement between people and staff was limited and generally task driven. There were no attempt to get people who spent time in their bedrooms, involved in any meaningful activity.

Staff knew how to respond to complaints and understood the complaints procedure. People also told us they knew how to raise concerns. People told us they would raise concerns with a staff member. We saw that people had folders containing service user guide, including information on how to make a complaint.

The service held regular meetings with people that used the service in order to get their views on the service provided. We saw that people who used the service and their relatives were involved in giving feedback about the service. However, their feedback was not always used to improve the service.

Inadequate

Is the service well-led?

Our findings

The systems in place to monitor the quality of service were not effective . We found, although the registered manager and senior management undertook audits and surveys, largely this did not lead to improvements. An audit, as defined by Healthcare Quality Improvement Partnership and endorsed by NICE, is: '…. a quality improvement process that seeks to improve [people's] care and outcomes through systematic review of care and the implementation of change.'. Prior to this inspection, the provider had undertaken audits, including on accident and incidents, medicines, care plans and infection control but there was no recorded evidence of improvements to care made after each audit cycle.

A general audit of the service was undertaken by the service Operations Director in July 2014. However, the results of this audit had not been fed back to the service or actioned. This demonstrated that audits were not used as a tool to improve the service.

We found evidence of an audit of medicine management carried out 26 October 2014. Areas of non-compliance had been identified, including signing for topical creams to indicate that they had been applied; appropriate coding for non-administration of medicine at the back of the MAR sheets; ensuring medicines trolleys were secured to the wall when not in use and signing for PRN medicines when applied. However, there was no improvement plan to address these issues.

We looked at records of accidents and incidents contained in an accident file and a subsequent analysis of the data. We found this data was not subjected to a robust analysis in order to identify patterns and trends in order to inform an improvement plan. For example, a person using the service had three falls in July 2014. This was recorded as having occurred 'walking - witnessed - public area'. Under 'action to reduce high incidence of falls', the action plan stated this person was 'now under the mental health team and on medication". This was not an adequate action plan to guide staff on how to reduce risk of falls to this person.

The provider had a system of audit in relation to surveys undertaken on people using the service, professionals and visitors. We looked at the surveys that were carried out in 2014. The provider received six responses from professionals. In their responses to the question, "Are you aware of the complaints procedure", five of them indicated they did not know. The provider's action plan was to implement a flowchart of the complaint system by end of May 2014. However, this was not in place at this inspection. A 'relatives survey' found that relatives were unfamiliar with the formal procedure of making complaints. The provider's action plan stated they would have a flowchart of the complaints procedure available for relatives by May 2014. However, this was not in place at this inspection. Similarly a 'residents survey' did not have an associated action plan on areas of concern.

NICE recommends that once the results of an audit and recommendations for change have been communicated, an action plan should be produced to monitor implementation of these recommendations.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Healthcare professionals told us they had a good working relationship with the registered manager and were satisfied with the service provided by the home. A healthcare professional told us they received positive feedback from people using the service that they were safe.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs Where food and hydration are provided to service users as a component of the carrying on of the regulated activity, the registered person must ensure that service users are protected from the risks of inadequate nutrition and dehydration. Regulation 14 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The registered person must ensure that service users are protected against the risk of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of accurate records in respect of each service user. Regulation 21 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person did not make suitable arrangements to ensure people's dignity. The registered person did not make sure service users participated in decisions relating to their treatment and care. Regulation 17 (1) (a) (b) (2) (a) (b) (c) (d) (e) (h) (g)