Totalwest Limited

Lower Bowshaw View Nursing Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on 15 and 19 October 2015 and was unannounced which meant no one at the service knew we would be attending.

The service was last inspected in November 2013 and was found to be meeting the requirements of the regulations we inspected at that time.

Lower Bowshaw View Nursing Home accommodates up to 40 older people that require nursing or personal care. At the time of our inspection there were 36 people living at the service.

There was a registered manager in post at the service. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers,

Summary of findings

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

We found that some people had no risk assessments and care plans in place that detailed what support they needed . We saw that some people's individual risks had not been appropriately managed to maximise their safety.

There were current vacancies for nurses which meant the service had to use agency staff at times. Staff said they felt the staffing levels in place were satisfactory. We saw that deployment of staff required improvement at times as we saw examples of when there was a lack of trained staff to support people.

People were administered their medicines in accordance with safe administration however information in records did not always show why people did not have medicines if these were not administered. There was no guidance in place to direct staff when people needed medicines to be taken 'as and when required'.

Staff were aware of the need to report abuse and what procedures to follow and there were policies in place for staff to follow. Staff had regular supervisions and appraisals and said they felt supported by management. Training was provided for staff so they had the skills for their roles and staff were encouraged to pursue further development. Team meetings took place regularly.

There was guidance and training in place for the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). No one at the service had a current DoLS authorisation in place. We saw an example of where the MCA was followed for one person however we saw examples of where consent was not appropriately obtained for people.

People spoke positively about the food and we saw people had access to, and input from, a number of health professionals where required. Staff were able to describe people's personalised needs and we did see evidence of person centred detailed care plans in place for some people. However a lack of information in the majority of records we looked at did not always show what care people needed and what care they had received in accordance with any needs.

People and relatives spoke positively about the staff and the care they received. We saw positive interactions and communication from staff towards people when providing support. People told us, and observations showed, that people's privacy and dignity was maintained.

There was a varied activities schedule in place and we saw differing activities take place which people enjoyed. Meetings took place so that people had opportunities to feedback their views of the service and suggest improvements. There was a complaints procedure in place and people said they would feel comfortable in raising any issues.

The registered manager had an internal audit system in place to identify areas for improvement. Although incidents were monitored, the system was not robust enough to effectively identify patterns and trends with a view to reduce risk.

Feedback from people, relatives and staff was positive about the registered manager. Quality assurance surveys were completed with a view to improve the service and there was evidence of actions taken.

We found four 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?

Inadequate

The service was not always safe. Individual risks to people were not suitably assessed and managed to maximise their safety.

Staffing levels were suitable to meet people's needs but we saw that deployment of staff needed improvement at times.

Medicines were not always managed in a safe way to prevent people being exposed to risks associated with medicines. Staff were aware of the need to report abuse and what procedures to follow.

Is the service effective?

Requires improvement

The service was not always effective. Consent was not always sought in accordance with the service's consent policy and the Mental Capacity Act 2005.

Staff had regular supervisions and appraisals and said they felt supported. Training was provided for staff so they had the skills for their roles.

People spoke positively about the food and we saw people had access to, and input from, a number of health professionals where required.

Is the service caring?

Good

The service was caring. People gave positive comments about staff, the care they received and how they were cared for.

We saw positive interactions and communication from staff towards people when providing support.

People felt, and observations showed, that privacy and dignity was maintained.

Is the service responsive?

Requires improvement

The service was not always responsive. Care records did not always reflect people's needs and were not always regularly reviewed.

There was a varied activities schedule in place and we saw differing activities take place which people enjoyed.

Resident meetings took place so that had opportunities to feedback about the service and suggest improvements. There was a complaints procedure in place and people said they would feel comfortable in raising any issues.

Is the service well-led?

Requires improvement

The service was not always well-led. There was a lack of records in respect of people who lived there about what care they required and received.

Summary of findings

An internal audit system was in place to identify areas for improvement. Incident monitoring was not robust enough to effectively identify patterns and trends.

Feedback from people, relatives and staff was positive about the registered manager. Team meetings took place regularly. Quality assurance surveys were completed with a view to improve the service.

Lower Bowshaw View 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 15 and 19 October 2014 and was unannounced.

The inspection team consisted of one adult social care inspector and a specialist advisor who was a registered nurse with experience of nursing care of older people.

Prior to our inspection, the provider had 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 information we held about the service which included statutory notifications of deaths and incidents. We reviewed information from commissioners of the service, the local authority safeguarding team and the local Healthwatch, for any relevant information they held. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with 13 people, and two relatives of people, who lived at the home. We undertook informal observations and spent time with people in communal areas to observe the care and support being provided.

We spoke with the registered manager, the clinical team leader, a registered nurse, five care workers, the cook, the administrator and an activities co-ordinator.

We viewed a range of records about people's care and how the home was managed. These included the care and medication records for eleven people, recruitment records for five members of staff members, policies and procedures, audits and meeting minutes.

Inadequate

Is the service safe?

Our findings

People told us they felt safe at the home. One person said, "It's very safe. I wouldn't stay here if not." Another comment was, "I'm not worried about anything here." Another person said they felt safe to a "certain extent" and went on to explain they didn't like the dark but staff had put a night light up for them which had reassured them. No one we spoke with expressed any concerns with their safety.

We saw a staffing policy in place at the home which set out numbers of staff required for differing occupancy levels at the home. The registered manager told us she did not complete any formal dependency assessment but nurses would assess people's individual dependency. If there was a requirement for more staff, or levels in place were not suitable for people's needs, the registered manager said she could discuss this with the provider to look at whether any resource changes were needed.

Staff we spoke with felt staffing levels were suitable to meet people's needs. The service had care workers employed on a bank basis who were able to cover absences. The registered manager told us that the biggest challenge with regards to staffing was recruiting nurses. There were two nurse vacancies at the time of our inspection and the registered manager was in the process of interviewing and sourcing staff to fill these posts. As a consequence, the home had to rely on agency workers at times. An agency nurse was working on the second day of our inspection.

We observed some periods where there was lack of suitable staff presence. We spent some time in the dining room one afternoon. Four people were present and one person was sat in an adjoining conservatory. A care worker and a work experience trainee who was additional to the staffing complement were sat with the people in the dining room. One person requested assistance to use the toilet and the care worker left the dining room with the person to support them. For 15 minutes the trainee was left alone with the people. People were making requests for drinks and biscuits. The person in the conservatory also shouted several times for assistance. The trainee tried their best but was unsure how to manage and we told them we would find a staff member. We found the registered manager who told us the trainee should not have been left unsupervised and that the same situation had also occurred earlier that day. The registered manager told us she would speak with staff to ensure this did not happen again. Following our inspection, the registered manager told us she would no longer be using trainee staff.

Staff we spoke with had safeguarding training and knew about different types of abuse and the procedure to follow to report any concerns. There were policies in place for safeguarding and whistleblowing. Whistleblowing is where a worker reports any wrongdoing at work. This showed that there were processes in place for staff to follow to minimise the risk of abuse occurring.

We saw one recent incident documented where a person living at the home had made an allegation of abuse. This had been brought to the attention of the registered manager who showed us how this had been investigated. Although the investigation by the registered manager had not substantiated the allegation, it had not been referred to the local authority safeguarding team at the time it was made. The registered manager, at our request, discussed this with the safeguarding team during our inspection and they advised they did not require a retrospective referral. The registered manager told us she would ensure any similar allegations in future were referred appropriately to the local authority in line with safeguarding procedures.

Out of 11 people's care records we looked at, we saw that seven people had no risk assessments in place. Some of these people had been at the service for a number of weeks and months. This included a lack of risk assessments to be able to identify people at risk in key areas such as malnutrition and pressure sores. Polices in place at the service stated that these risk assessments were to be completed as part of the admissions process.

We saw the records of one person who had been admitted into the home in September 2015. The person had a history of falls as documented on a pre admission assessment as well as other health related conditions that could impact on their mobility. Daily records documented that the person could become agitated which led to the person attempting to climb out of bed several times. There was no falls risk assessment and care plan to advise how the person was to be supported to manage this risk and what interventions were needed to reduce it. In October 2015, an accident report recorded that the person had fallen on the floor. We spoke with the nurse who said they knew the person had a fall and confirmed that no risk assessment was carried out following the fall. We asked if the home

used sensor mats which can be either for beds or chairs to alert staff that someone is moving around. The nurse said one was one in place for this person. However, when we checked we saw there was no sensor mat in place.

Another person had had seven falls in the first two months since their admission to the home. We saw that this person had an initial falls risk assessment in place but it did not provide any information about the overall level of risk and had not been reviewed. There was a care plan in place for the person being at risk of falls but, like the risk assessment, it had not been updated in response to the falls the person had. This showed that the person's risks had not been suitably assessed to maximise the person's safety.

People told us they received their medicines from staff with no problems noted. We observed occasions of people being administered their medicines and saw that staff stayed with people and followed safe practice for administration.

Controlled drugs are medicines which must be stored and administered under strict guidelines and legislation, due to their harmful effects if not managed correctly. We saw the service's controlled drugs were stored in accordance with legislation. The temperature of the treatment room where medicines were kept and the drugs fridge was checked daily. The fridge was within the accepted range however we saw the treatment room was recorded above safe range several times, and on the first day of our inspection. We found that the drugs fridge was not locked and staff were not aware of where the key was which meant refrigerated medicines could not be stored securely. We saw that the treatment room was kept locked when not in use.

We looked at a sample of people's medication administration records (MARS). We saw that photographs were not in place for all the people living at the service to help ensure correct medicines are given to the correct person. On MARs we saw the use of a particular code with no explanation of what it meant. The MAR said that when this code was used, the staff member had to give an explanation as to why the medicine was not administered. We saw one person was prescribed eye drops twice a day but the MAR only recorded these as being administered once for three consecutive days. One's person's MAR included an anticoagulant to be taken 'as directed'. It had not been administered and the lack of guidelines in place for 'as directed' medicines meant it was not clear when this would be required. A nurse and the registered manager informed us that this medicine was not administered by staff at the home and should not be on the MAR. There was a risk that unfamiliar staff such as agency nurses, may not be aware of this which could led to the medicine being wrongly administered. The registered manager told us she would ensure this medication was removed from the MAR.

We found risks to the health and safety of people were not assessed to ensure care and treatment was provided in a safe way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We saw that all nurses employed at the service had current registration with the Nursing and Midwifery Council (NMC) and this was checked by the registered manager. We looked at the recruitment files of five members of staff and saw these contained application forms, details of previous employment history and references. However, some references did not correspond as being from referees stated on the application forms and it was not always clear what relationship the referee had with the applicant. There was no evidence to support that referees had been verified where the source of these were not identifiable.

The service's recruitment policy stated that an enhanced DBS (Disclosure and Barring Service) check had to be completed and satisfactorily returned prior to employees commencing employment. DBS checks help employers to make safer recruitment decisions. Two of the staff files showed that DBS checks had not been obtained for the employee until several months after they had already started working at the service. Two employees were working currently without yet having had a DBS check returned. The registered manager told us these had been applied for and said they would now ensure that until these were returned, the staff were not working unsupervised.

The registered manager told us that voluntary work experience trainees undertook placements at the service. There was a 'volunteer' policy which stated all unpaid people working at the service were subject to the same recruitment procedures as paid staff. The registered manager confirmed she did not undertake any DBS or reference requests for these people. No risk assessments were undertaken and no checks made to ensure the suitability of these trainees. Following our inspection, the registered manager told us she had ceased this practice and would no longer be accepting these placements.

Inadequate

Is the service safe?

Our findings demonstrated that recruitment procedures were not operated effectively to ensure people were suitable to work at the service. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

A maintenance person was employed at the service who had responsibility for regular checks to maintain the safety of the premises and equipment. We saw regular checks of fire alarms and equipment were undertaken. A current fire risk assessment was in place with details about what support each person would need in the event of an emergency.

Requires improvement

Is the service effective?

Our findings

People told us they felt looked after and that staff supported their needs. Staff said they were kept updated about changes to people's health and that information was passed on at handover between shifts. They told us any concerns with a person's health would be passed on to nurses or the registered manager. We saw evidence of involvement from other professionals with people's care, including doctors, specialist nurses, opticians and dentists. This showed that people were supported with their health needs where required.

Staff told us they received lots of training for their roles with a majority of this training provided in house by the registered manager and clinical team leader. Staff spoke positively about the training they received and said they were encouraged to undertake additional training and further courses. They told us about an eight week induction they undertook when they started their employment which they said had been very useful. On one day of our visit, staff were undertaking training about the new 'care certificate' that had been recently implemented which showed the service aimed to keep updated with staff skills. On the second day we spoke with a training assessor who was assessing staff undertaking vocational qualifications. They told us the registered manager was very keen to encourage training and progression for staff. The assessor said staff were knowledgeable about their roles and skills and demonstrated a good understanding of people's needs and observed staff putting their training into practice.

Supervisions are meetings designed to support, motivate and enable the development of good practice for individual staff members. Appraisals are meetings involving the review of a staff member's performance, goals and objectives over a period of time, usually annually. Staff told us they received regular supervisions and appraisals. They said these would be with either a nurse of the registered manager and they received a lot of support in their roles. One staff member gave an example of a supervision which had incorporated a practical demonstration of a certain task which had been beneficial to improve their own practice. Staff said they could seek support whenever they needed. We found that staff received appropriate support, development and supervision in their roles.

We asked people about the meals at the home and views were mainly positive. Comments included, "Beautiful meals, you couldn't get better in a restaurant", "Meals are lovely. You get a choice from a menu, they come round every day. We get plenty", "Foods very good", "Food's alright. Dinner was nice", "Meals are pretty good. Can have a cooked breakfast but not every day. I would have one a day if I could. Dinner is best meal of the day. Plenty for me", "Not bad food here", "Meals are ok. Depends if you're choosy." People said they would be able to have alternatives. We saw each person had a jug of water in their room which they said they got fresh each day. We saw people often with hot drinks and refreshments throughout the day.

We spoke with the cook who showed us menus for a four week period which gave a varied choice and offered balanced meals. A menu board displayed the different choices available to people that day. The cook said that at times they spoke with people about their preferences and nurses would provide dietary information for new people. There was a wipe board in the kitchen where specialised diets were documented.

We undertook periods of observation at breakfast and dinner time. Tables were neatly set, napkins and condiments were available on each table and music played low in the background. People mainly sat in small groups. Although people had chosen their meals prior to the lunch service, staff did not always explain and confirm to people what the meal was when it was served to ensure this suited their preference. Staff did not rush people and we saw people were supported to eat where they required assistance and were offered encouragement.

The Mental Capacity Act 2005 (MCA 2005) is legislation designed to protect people who are unable to make decisions for themselves, and to ensure that any decisions are made in people's best interests. The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

Staff we spoke with told us they had training in MCA and DoLS however their knowledge of this legislation was variable. Care plans did not evidence where people had consented to residing at the home and the registered manager told us she believed some people did not have

Requires improvement

Is the service effective?

capacity to make that decision. We saw the records of one person who did express actions of wanting to leave the home. Staff used techniques to manage this but no consideration had been given as to whether the person would require a DoLS authorisation to ensure they were not subject to any unlawful restrictions. The registered manager told us she would review whether any people at the home met the criteria as requiring a DoLS authorisation.

Our observations showed that when staff interacted with people, they asked people for permission to do things and would seek their consent first. We saw one example where a specific decision had been made in a person's best interests where they had lacked capacity. Information and the rationale for this was recorded in the person's care plan. The consent policy in place stipulated that no one else could give consent on a person's behalf. However, we saw that some care interventions were in place which people had not consented to. For example, we saw that bed rails were in use for a number of people in the home. There was a lack of information to show that people had consented to these, or where they were not able to consent, that the use of these were in the person's best interests. There was no information to show that less restrictive measures had been considered. Consent forms had been signed by people's family members with no explanation as to why the person had not signed themselves. We spoke with one person who told us they had never been asked whether they wanted bed rails to be in place. The person had a signed consent in place for the rails which had been signed by their spouse. They told us, "I don't really mind either way about them [bedside rails] but I wasn't given a choice."

Our findings showed that care and treatment was not always provided with consent of the person, and in accordance with the MCA 2005, where a person lacked capacity. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We observed that there was a lack of signage around the home and points of interest to assist people with orientation. People did not have easily identifiable information on their bedroom doors, such as pictures or memorable objects. Names on doors where these were in place were written in small print and difficult to see. This meant the environment could be difficult to navigate around for people living with dementia. The registered manager told us her intention as part of the redecoration scheme was to incorporate designs and signage to make the home more 'dementia friendly'.

Good

Is the service caring?

Our findings

We asked people their views of the service and the staff who supported them. Comments included, "They're very kind here", "I like it here. They are nice girls. I torment the lives out of them, we have a laugh. They're very good", "Staff are very friendly. They talk to you in a nice way", "I'm happy here. I like it", "It's very friendly", "I like it here. It's as good as I'm going to get. Staff are ok", "I get on ok with staff", "It's not bad here", "I'd sooner be at home but staff are very good." One person told us they liked to have their door open and said, "Staff always shout in to ask if I'm ok. Sometime they come and chat."

Two relatives we spoke with were complimentary about the home. One told us, "I can't recommend the place enough. Superb care, first class. All staff are great, fabulous". They told us their family member had passed away some time previously but they still came back to the home to play music for the people there. They said, "I wouldn't come back if I didn't like it." The second relative was very happy with the staff at the home and said they were very caring. A training assessor who was at the home on one of our visits said that staff interacted well with people at the home.

We saw a recent letter from the family of a person who lived at the service who had recently passed away. It was very positive and praised the staff and the service for the "love and impeccable care" they had shown to their family member. They had bought a rose for the garden at the service to be named in memory of their family member.

Healthwatch provided feedback they had received from a source which said the person did not find the staff caring in nature. The person did comment that the activities were good.

We observed mainly positive interactions between staff and people. Staff communicated with people in a way to suit people's needs, such as speaking slowly and clearly where people had hearing difficulties and bending down to the persons' level when speaking with them. The staff were polite and courteous with people although we saw there were sometimes limited opportunities for staff to engage with people other than when providing support. However, staff told us at quieter periods they were able to spend more time with people. Where touch was used, this was appropriate, for reassurance and at the preference of the person. We saw one person who liked to walk along the corridors was accompanied by a staff member holding their hand which the person had initiated. Another person kissed a staff member on the cheek and there was good natured banter between staff and people.

We saw that people's rooms were personalised and contained their own items such as pictures, ornaments and furniture. One person told us, "I've got a unit coming from home soon to go in the corner of my room. I like my own ornaments and I can put them on." Several people commented that they had a nice room.

People told us it was their own choice of when they chose to get up and go to bed. One person told us they liked to have showers as opposed to baths and staff supported them with their choice. We saw that people were offered choice of what they wanted to do and where they wanted to go. People spent their time around the home wherever they chose. Several people we spoke with told us they preferred to spend time in their rooms and eat their meals in there. One person said, "Generally I go to the dining room or sometimes eat in here (my room), depends how I feel at the time."

People gave examples of how they were treated with dignity and respect by staff. One person said, "They always knock on my door do staff. I think it's very nice of them." All people we asked said staff knocked first and we observed this in practice. People told us, "They [staff] respect my privacy." In the dining room we observed one person with visual problems who requested assistance from staff to wipe their eyes which were troubling them. A staff member asked the person if they wanted to go somewhere more private to receive assistance.

Staff received training in equality and diversity, and dignity and were able to give examples of how they promoted people's dignity in their work. A dignity board was in display in reception with photos of staff and people who were part of a 'dignity committee'. 'Dignity meetings' took place on a regular basis which included staff and people from the committee and these covered discussions around dignity in relation to facilities, housekeeping, food, and activities.

Although we saw examples where staff demonstrated knowledge of people's pasts, care records we looked at did not contain information about people's life histories or past. The registered manager told us that work had begun on compiling and putting in place this information in place

Good

Is the service caring?

for people. Information about people outside of their care needs is valuable to provide knowledge for staff in order to understand a person and know how best to support them. This is especially important for staff that may be unfamiliar with the people, such as new staff or new people using the service.

Requires improvement

Is the service responsive?

Our findings

Discussions with staff showed they were knowledgeable about people's personalised needs. However, care plans did not always capture this information about people. Two people with complex needs did have care plans which were very detailed in place for these. Staff were able to tell us information which corresponded to the information within them. Where care plans were in place for other people's records we looked at, updates of these were not consistent. We spoke with a nurse who had responsibility for care plan updates who told us they were aware of the lack of information and reviews and they were trying to work through this.

On both of our visits we found occasions where people did not have access to call bells, or call bells leads in place. One person's care plan said that staff needed to ensure they had their call bell to hand at all times but there was no call bell lead in place on our first visit. On our second visit we saw three people's rooms, out of eight we checked on the first floor, had no call bell lead in place. The registered manager confirmed these should have been present and could not account for why they were not there. She replaced these during our visit and informed us she would implement measures to make sure call bell leads were in place in future.

We asked people if they felt staff responded to their needs. One person said, "Got a call bell. They [staff] come. Sometimes quite a while but as a rule they're generally good." One person said, "You only have to ask staff and they'll get you what you want". Most people we asked said staff accommodated their requests however one person told us that at times they felt it was "Too much trouble for the staff" if they asked for something.

We observed examples of staff responding to people's needs. For example, one person accessed a smoking room that had to be opened by a senior staff member. They told us they would like to go outside for a cigarette and we passed this on to the staff member who immediately supported the person outside. However, during busier periods, people's requests were not always responded to. We observed one person at dinner ask staff over a period of over 25 minutes to go to the toilet. Three staff members told the person they would have to wait until dinner was served and would go to "the top of the list" after dinner. The person kept repeating her request. Eventually a staff member did assist the person to use the toilet.

Two activities co-ordinators were employed at the home. We asked one of the co-ordinators about the different activities that took place. They told us these included games and reminiscence, brain training, arts and crafts, parties, newspaper discussions and music. Trips out of the home also took place such as regular trips to the local church. Some people at the home had recently become part of a choir group at the church. A mobile library visited regularly and we were told about befrienders who came to visit and chat with people. A quarterly leaflet was produced which detailed upcoming events, and regular activities.

We observed lots of activity taking place at the home. These took place in a lounge on the ground floor. The activities were enjoyed by a number of people and some people from the first floor regularly came down to the ground floor to join in. During our visits we saw people taking part in a quiz, and people singing and dancing. We saw people were practising for a pantomime they were writing and performing in and we saw that people looked happy and were participating . The activities workers actively tried to encourage and engage all people present. The atmosphere was lively and we heard lots of laughter from people.

The activities co-ordinator and registered manager told us an aromatherapist attended regularly to see people one to one in their rooms and provide hand massage. They also said they were looking to set up a portable sensory trolley which could include items to take round to people in their rooms where people preferred one to one activities or were unable to attend the activities lounge. One person told us of a recent trip to the church where they had looked at picture of the local areas from years ago. They said, "It was lovely to see. Beautiful pictures." They told us they liked to knit and make beads and showed us some items they were in the process of making in their room.

There was a complaints procedure on display in reception which provided details of how to make a complaint and other organisations people could contact with concerns. We looked at the latest complaints that had been submitted formally. We saw that the complaints had been investigated with the findings documented and outcomes fed back in writing to the complainant.

Requires improvement

Is the service responsive?

People told us they would feel comfortable to raise any concerns with staff and/or the registered manager. No one we spoke with at the home had any complaints to make at the time of our inspection. 'Residents' meetings took place which the activities co-ordinators chaired and we saw minutes of. These contained themes for discussion which included what activities people would like and idea for trips out. This showed there were opportunities for people to influence the service and how it ran.

Requires improvement

Is the service well-led?

Our findings

A registered manager was in place. The provider information return referred to the recruitment of a deputy manager to assist with the running of the service. The registered manager told us a deputy was not in place but this post was still being actively recruited to. They told us past appointments to the post had not been successful.

People told us they were happy with how the home ran. One person said, "I think it's ideal for anyone like me. I'm not unhappy with anything." Another person said, "I would recommend it here."

Some of the people we asked were new to the service and were not always clear who the registered manager was but those who did know spoke positively about her. One new person said of the registered manager had, "She is very nice. Told me all about the place when I came." The registered manager explained that she introduced herself to new people and told them about the service. Relatives we spoke with also spoke positively about the registered manager. We saw people had welcome packs in their room which provided information about what the service provided. There was also information in reception, such as the statement of purpose, service user guide, staff pictures and roles, and general information about the service that visitors could refer to.

Staff told us they enjoyed their jobs and said the registered manager was approachable and supportive. They felt that the staff group worked well as a team with one staff member saying, "We work as a team and as a family." We saw that staff communicated well with each other and offered assistance to each other where required.

We saw that records of people's needs and the support they had received were not always completed to provide an accurate account of their care and treatment. The majority of the care records we looked at did not contain care plans for how people were to be supported in all areas of their care. Although staff did express knowledge about people's individual needs, this information was not always recorded. Each person had a 24 hours care log in their room where staff recorded the care given, diet taken and fluid intake. We saw these were not always completed fully which meant in some cases it was not possible to establish what support the person had received. For example, we were told by staff some people required regular repositioning but the frequency of this was not recorded in care records and the logs did not always show how often this took place. Daily progress notes we looked at for one person contained regular entries which read 'all cares given as per care plans' however the person only had one care plan in place for privacy and dignity. We saw a number of documents in care records for assessments in a range of areas such as environment, behaviour, cognition and bathing records which were not completed.

We also found that some written entries in records were difficult, and in some cases, illegible to read. This was an issue that had also been identified by the registered manager at an earlier staff meeting. This meant there was a risk of mistakes being made in care provision as the information could get misread. We also saw that some medication administration records (MAR) charts were loose and detached from the folder they were in. The folders were quite full and bulky and these was a risk of important information going missing from them.

We found the provider had failed to insure that an accurate, complete and contemporaneous record in respect for each person living at the service was in place. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We saw that regular staff meetings took place and staff confirmed they had these were regularly held. Minutes of the meetings covered a number of areas which included discussions around training, documentation, medicines and complaints. We also saw that staff were acknowledged and recognised for good practice and when staff had completing training. The registered manager operated an 'employee of the month' system which was also displayed in reception.

We saw there were monthly audits completed by the provider which included speaking with staff, people at the service, inspection of premises and records. The provider worked from an office at the service. They were on holiday at the time of our inspection. The registered manager said she could go to the provider and could request support if she needed to make improvements at the home. At the time of our inspection, the service had recently had new flooring in corridors, lounges and communal areas and a plan was in place to decorate and improve the remainder of the home.

Requires improvement

Is the service well-led?

We saw the manager completed a variety of audits in areas of medication, infection control, equipment and care plan audits. Where shortfalls had been identified, we saw actions in place to address these. The manager had identified areas for improvements and told us of new systems which included more robust audits which she was implementing. The registered manager also completed 'home inspections' which were evidence of regular checks of various areas of the service. For example, there were records of call bell response time checks, checks of the menu, checks of documentation and that rooms were tidy. Where actions were needed, these were documented with the responsibility of who was to follow this up.

Accidents and incidents were logged each month. The registered manager said she checked these individually first however the system she used was not designed in a way to capture themes and trends as it only contained basic information. She informed us she would expand on this to minimise the risk that patterns may be missed.

We saw the findings of the latest quality assurance surveys from July and December 2015. The majority of responses were positive. We could see actions were taken where people had commented on areas for improvement, for example increased menu choices. Quality assurance surveys were not provided to staff or other stakeholders which meant not all areas of feedback were being captured.

The manager submitted notifications in accordance with the statutory notifications required to be made in line with the Health and Social Care Act 2008. She was aware of the circumstance of when these should be submitted.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: Care and treatment was not always provided with consent of people or in accordance with relevant legislation where people lacked capacity to consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Risks to people's health and safety were not assessed to ensure care provided was safe and risks were mitigated. Medicines were not managed in a proper and safe way to make sure care and treatment was provided safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Accurate and complete records were not maintained in respect of people who used the service including the care and treatment they received.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

This section is primarily information for the provider

Action we have told the provider to take

How the regulation was not being met:

Recruitment procedures were not operated to ensure people involved with carrying out the regulated activities were of good character and had the skills and competence for the role. Recruitment was not in accordance with information specified in Schedule 3 of the regulations.