Bupa Care Homes (ANS) Limited

The Harefield Nursing Centre

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 15 March 2016 and was unannounced.

The last inspection of the service was on 1 September 2015 when we found breaches in five Regulations relating to person centred care, privacy and dignity, staffing, consent and good governance.

The Harefield Nursing Centre is a care home with nursing for up to 40 older people. At the time of our inspection 33 people were living at the home. Some people living at the home were living with dementia. The home was run and managed by Bupa Care Homes (ANS) Limited. There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Although the provider had reassessed and improved the staffing levels and deployment at the service, there were times when people's needs were not being met and they were placed at risk because there were not enough staff deployed to support them.

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

The environment was well maintained and clean.

There were appropriate procedures for safeguarding people.

People received their medicines in a safe way and as prescribed.

The provider's recruitment checks were designed to ensure the staff were suitable to work at the service.

People's capacity to consent had been assessed and the staff made sure people consented to their care as it was offered. Where people lacked the capacity to make specific decisions the provider had acted in the

person's best interest and had consulted with those who were important to the person.

The staff received the training, supervision and support they needed to care for people safely and meet their needs.

People's nutritional needs were met.

The staff worked with other healthcare professionals to make sure people's healthcare needs were met.

People told us they had positive relationships with the staff. The staff were kind, caring and respected people's privacy. However, some people felt that there were long periods of time when they did not have sustained or meaningful interactions.

People's care needs were met in a way people wanted. Although some of their preferences and personal wishes were not recorded in care plans.

People had access to a range of organised activities, but some people wanted more opportunities for things to do.

There was an appropriate complaints procedure and the provider responded to complaints.

People living at the service, staff and visitors found the manager approachable and felt the service was well managed.

There had been improvements to the service and the manager had a plan for on going and continuous improvements.

Records were well maintained, accurate and up to date.

There were a number of different audits and checks which enabled the manager and staff to monitor the quality of the service.

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

Some aspects of the service were not safe.

Although the provider had reassessed and improved the staffing levels and deployment at the service, there were times when people's needs were not being met and they were placed at risk because there were not enough staff deployed to support them.

The environment was well maintained and clean.

There were appropriate procedures for safeguarding people.

People received their medicines in a safe way and as prescribed.

The provider's recruitment checks were designed to ensure the staff were suitable to work at the service.

Is the service effective?

Good

The service was effective.

People's capacity to consent had been assessed and the staff made sure people consented to their care as it was offered. Where people lacked the capacity to make specific decisions the provider had acted in the person's best interest and had consulted with those who were important to the person.

The staff received the training, supervision and support they needed to care for people safely and meet their needs.

People's nutritional needs were met.

The staff worked with other healthcare professionals to make sure people's healthcare needs were met.

Is the service caring?

Good

The service was caring.

People told us they had positive relationships with the staff. The staff were kind, caring and respected people's privacy. However, some people felt that there were long periods of time when they did not have sustained or meaningful interactions.

Is the service responsive?

Good

The service was responsive.

People's care needs were met in a way people wanted. Although some of their preferences and personal wishes were not recorded in care plans.

People had access to a range of organised activities, but some people wanted more opportunities for things to do.

There was an appropriate complaints procedure and the provider responded to complaints.

Is the service well-led?

Good

The service was well-led.

People living at the service, staff and visitors found the manager approachable and felt the service was well managed.

There had been improvements to the service and the manager had a plan for on going and continuous improvements.

Records were well maintained, accurate and up to date.

There were a number of different audits and checks which enabled the manager and staff to monitor the quality of the service.

The Harefield Nursing Centre

Detailed findings

Background to this inspection

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

This inspection took place on 15 March 2016 and was unannounced.

The inspection team consisted of two inspectors, a nurse specialist advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience on this inspection had personal and professional experience of caring for someone and using care services.

Before the inspection we looked at all the information we had about the service, including notifications of significant events and the provider's action plan following the last inspection.

During the inspection visit we spoke with seven people who lived at the service, six visitors and the staff on duty, who included the registered manager, deputy manager, nurses, care assistants, kitchen staff, domestic staff and the activities coordinator. We observed how people were being cared for and supported. We looked at the environment and records relating to this. We also looked at the care records for 10 people, the recruitment, training and support files for five members of staff, the records of complaints, accidents and incidents and the records that the provider used to monitor the quality of the service.

Requires Improvement

Our findings

At the inspection of 1 September 2015 we found that people's needs were not always met because there were sometimes not enough staff and the staff were not always deployed in a way which effectively met people's needs.

At the inspection of 15 March 2016 we found improvements had been made. The provider had reassessed staffing levels and at the time of the inspection the home was not fully occupied therefore there were more staff available per person. People told us that call bells were answered promptly and they did not have to wait long when they needed care or attention. We observed this to be the case. However, there were a number of situations where more staff or a more suitable deployment of staff would have resulted in people's needs being better met.

One visitor told us, ''There never seems to be enough staff but that seems to be the situation in most places.'' Another visitor said that their relative's needs were not always met because the staff did not have time to check on them. For example they said, ''(Staffing levels) have improved but there needs to be more supervision; (my relative's) coffee is still untouched this morning because she has poor eye sight and no one has been to check on her.'' Another visitor told us, "They don't always have time to attend to (my relative's) needs as much as I'd like. There are more staff here since the last Care Quality Commission report but I wouldn't feel happy unless I was coming in every day to make sure she was okay and has enough to eat and drink."

There had been a number of incidents at the service where people were put at risk of harm from other people. For example, in March 2016 there had been nine incidents where people living at the service or staff were hit or threatened by another person. In order to help keep people safe the staff told us they needed to give some people individual support to distract them from becoming agitated and threatening others. We saw that on the day of our inspection one member of staff spent a large part of the morning sitting with one person supporting them to feel calm and engaging them in an activity so they did not become agitated. The other two care assistants in this part of the service were supporting people with their morning personal care. This meant that seven people who were seated in the lounge and dining area were not getting any support from a member of staff. Although each member of staff entering the room spoke with people and there was a member of staff nearby who was keeping a visual check on them, people were not engaged in any activity or speaking with each other. Therefore during this period of time, their social and leisure needs were not being met. The manager told us that they were working with external professionals to reassess individual

staffing needs. However, whilst a decision about additional staffing was being assessed people living at the service were either not adequately protected or did not have their needs met because the staffing levels did not allow for both.

We observed that although staff were available and attentive, sometimes people's needs were not being met because the staff were attending to other activities. For example, during lunch in one of the home's units there was no assigned kitchen assistant to help with service. Therefore one care assistant spent a large amount of time serving food. One other care assistant was supporting people to eat in the dining room and two care assistants were supporting people in their rooms, As a result a number of people seated at the dining table waited for over half an hour for their food because they required support and only received support when others had finished their meal. Two people were supported by visiting relatives and people would have waited even longer to be served if this had not been the case. Two people who were eating their meals without support required encouragement but they did not have an assigned member of staff for this. Therefore they received only periodic encouragement from different members of staff when they walked past the person and were in between other tasks.

The staff told us that it was particularly challenging to support people at night times when the staffing levels were reduced. They said that some people did not sleep well at night and required additional support. We noted that some of the incidents of aggression had taken place during the night when there were less staff to offer support for people.

The staff had mixed views about whether staffing levels were adequate. Four members of staff told us that staffing levels did meet the needs of people in one part of the home. However, staff in the other part of the home told us that they could not always meet people's needs. For example, 14 out of 16 people in one unit required two members of staff to help them transfer from beds to chairs. There were three care assistants working in this unit each morning. This meant that only one care assistant was available to support people in the lounge area whilst the other two care assistants were supporting people to get washed and dressed.

Although there was a noticeable improvement since the last inspection. This is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

During our inspection people were being supported in an unhurried way and the staff spent time making sure the person they were caring for was comfortable and well before they left them to attend to another task. For example, when the staff supported people to move to the lounge and dining rooms, they allowed people time to familiarise themselves with the environment before they sat down, they provided them with drinks and made sure they were comfortable and warm before they left them.

The service improvement plan created by the manager outlined ways in which people's needs could be met through improved staffing levels and deployment. The plan stated that everyone living at the home would have their needs reassessed to determine the level of staff support they needed. There was also a plan to review the staffing structure and provide more supervision and leadership so that staff would be deployed more appropriately. The manager had noted that this work was ongoing and would be completed by the end of April 2016.

There had been a reduction in the use of agency (temporary) staff as more permanent staff had been recruited. This had helped provide better continuity of care for people living at the service. The manager told us that when agency staff were employed they tried to use the same regular members of staff. The rotas for the service confirmed this.

During our inspection we noted that one bathroom did not have a call alarm bell cord available. This meant that if someone fell or needed assistance in this room they may not be able to alert the staff. We told the manager about this and they agreed to rectify this situation immediately. The manager's service improvement plan had highlighted the need for monitoring and maintaining call bells. Where people were unable to use a call bell to request staff attention, this had been noted in their care plan and they were regularly checked by the staff to make sure they were safe and had all they needed. Where people were able to use their call bells we saw that these had been positioned where they could reach them. Staff responded promptly when the call bell alarms were sounded or when people called for help.

The environment was clean and safely maintained on the day of our visit. The staff made sure furniture and other obstructions were positioned so that people could safely move around the home. The staff supporting people wore appropriate protective equipment, such as gloves and aprons and they disposed of these immediately after use. Domestic staff attended to spillages and unexpected cleaning duties as well as following a set cleaning schedule. For example, following an incident in one area of the home, we saw the domestic staff cleaning the carpet and surrounding area.

The provider had a recorded fire risk assessment and plans for evacuation in event of a fire. These included individual evacuation plans for people living at the service. There were regular recorded checks on the fire safety system and equipment. The staff had been trained in fire safety and took part in drills which had been recorded. There were procedures for the staff to follow in event of different emergency situations. Information about these was easily accessible.

There was evidence of checks on the environment, equipment, electrical safety and water temperatures. These were regular and highlighted any concerns. There was information to show that action had been taken to address any faults and repairs. There was a record to show that regular cleaning and monitoring of infection control had taken place.

The provider had a procedure for safeguarding adults and this incorporated the local authority procedure. The staff were familiar with this and were able to tell us what they would do if they had any concerns about someone's safety or wellbeing. The staff had received training in safeguarding adults and they said this was updated regularly. They told us the senior staff and manager were ''very supportive'' when they had concerns about someone's safety and they were able to speak about situations with them in order to decide whether they needed to raise a safeguarding alert.

The manager had taken appropriate action to alert the local safeguarding authority and the Care Quality Commission of safeguarding concerns. They had worked with other agencies to investigate concerns and take action to put things right when people's safety had been compromised.

The individual risks to people's safety had been assessed by the staff. For example, the care plans we looked at had assessments of risk relating to moving around the home, risks of falls, nutritional risks, risks related to skin care and risks relating to individual physical and mental health conditions. The staff had recorded detailed observations in each assessment and these had been updated monthly. There were plans to minimise the risks and information for the staff about how to keep people safe in different situations.

We saw different equipment where needed. For example, some people had rails at the sides of their beds to prevent them from falling. Other people had special mattresses on the floor and lowered beds so that the likelihood of injury if someone fell out of bed had been reduced. There was appropriate assessment and agreements from the person or their representatives for the use of this type of equipment.

People were supported to take their medicines in a safe way and as prescribed. People told us they were happy with the support they received with their medicines. We observed the nurses administering medicines. They followed procedures and administered medicines safely, ensuring people gave their consent, were comfortable and were not agitated.

Medicines were stored appropriately and securely. However, we noted that there was no cooling facilities to help regulate the temperature in the medicines storage areas. The staff recorded daily temperature checks. We saw that the staff had reported an abnormally hot temperature on one day to the provider and action had been taken to remedy this. There was additional storage for controlled drugs and the information relating to these was correct. Medicine administration records were up to date, accurate and included the required information. Controlled Drugs and Book were correct. There was evidence that medicines were being disposed of safely and in accordance with Regulations.

The provider had appropriate systems for recruiting staff to make sure they were suitable to work with people. There was an initial screening by the provider's human resources department and then staff were invited for an interview with the manager at the service. Following successful interview other checks on their suitability were made. For example, the provider requested two references from previous employers, a criminal records check and checks on the staff member's identity and on their eligibility to work in the United Kingdom. The member of staff was not able to start working at the service until all these checks had been received and verified by the provider. We looked at a sample of staff recruitment files and saw that appropriate checks had been made.

Good

Our findings

At the inspection of 1 September 2015 we found that people's capacity to consent had not always been recorded and their written consent had not always been obtained. At the inspection of 15 March 2016 we found improvements had been made however, not all care plans had been signed to say that people consented to these. The manager told us this work was on going and that they were meeting with families to discuss care plans where people were unable to consent to their care.

All records included an assessment of capacity, which considered the person's ability to understand and consent to different aspects of their care, including making choices about daily activities such as what they wanted to eat and consenting to more complex decisions such as healthcare and planning for the future.

Where people did not have the capacity to consent to some aspects of their care, there was evidence that decisions about their care had been discussed with other professionals and the person's representatives.

We saw that the staff obtained consent before providing care. For example, when they were administering medicines and when they were using a hoist to move people. We heard a member of staff approaching a person who they were caring for saying, ''I would like to introduce myself as (their name) please would you allow me to…''

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).

The deputy manager showed us evidence that application for DoLS had been made where needed with the exception of two people. In one case the social care professionals monitoring the care of the person had made specific requests for a change to the restrictions and this had meant a delay in the application because they provider wanted to make sure they had the right information. The deputy manager told us that the local authority assessing the applications had requested that the provider stagger these rather than make all the applications at the same time. The last remaining application was being processed at the time

of the inspection and had been delayed at the request of the authorising authority.

The manager told us that they were arranging additional training about the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards for staff who had not received this training. She also said that staff would be asked about their knowledge of this area following training as part of their supervision. The manager hoped this work would be completed by the end of July 2016.

The staff told us they felt supported. They said they had regular individual and group meetings with their manager and they had access to a range of training. New staff starting work at the service undertook a week of classroom based training away from the service before they started working there. They also completed on line training and assessments. New staff spent time shadowing experienced members of staff until they were assessed as competent in their role. New staff completed the Care Certificate. The Care Certificate is a set of standards for social care and health workers. It is the new minimum standard that should be covered as part of induction training of new care workers. The staff told us they had access to training updates, which included safely moving people, health and safety, infection control and safeguarding vulnerable adults. The staff told us they had additional training opportunities to help them learn more about their role. One member of staff said, ''You are encouraged to request the training you feel you need, for example, more ways to manage dementia.'' The nurses told us that the clinical lead arranged additional clinical training when requested and when there was an identified need.

The staff told us they had annual appraisals of their work, although some of them felt these were not a valuable experience. We looked at staff records and saw that over half the staff had taken part in an individual supervision meeting with their manager in 2016. However, 17 members of permanent staff had not had an individual meeting since 2015. The staff told us they had good informal support from the manager and could speak with her or senior staff when they needed.

There was a handover meeting every changeover of staff. These involved all the staff discussing changes in people's needs and any appointments or specific work which needed to be undertaken. There was recorded allocation of duties so that members of staff had clear information about their role and any extra duties they needed to perform each day.

Accommodation was provided on the ground floor in two separate units. Bedrooms had toilet and hand wash basins en-suite. There was a spacious and accessible garden with raised flower beds and seating areas. Some areas of the building were brightly decorated. Information about menus and activities was displayed and there was a photograph board to show the staff who worked at the service. There were also photographs displayed of special events and activities. There were hand rails situated along corridors and in bathrooms.

Some of the communal bathrooms had been used for storing hoists and other equipment making the rooms difficult to access.

There were some photographs and personal objects displayed outside bedroom doors in boxes and on the doors. However, this was not the case for all bedrooms and there was little else to help people identify their room.

One visitor told us, ''We chose this home because it was accessible. We go out in the garden when the weather is better and visit the village.'' Another person said, ''There has not been much resident participation in choosing the pictures and decoration around the home.''

The manager told us that they were in the process of applying for additional funding to refurbish the environment and to provide new equipment and furnishings which would specifically meet the needs of people who had dementia.

People's nutritional needs had been assessed. These assessments were regularly reviewed and the staff took appropriate action when there were changes in people's needs.

The manager's service improvement plan highlighted areas where improvements around food and nutrition were needed. There were systems to ensure that where people gained or lost weight this was noted, managers were told about this and action was taken. For example, a member of staff explained the action they had taken when they found that one person's weight had decreased over a number of months. They said they had made a referral to relevant healthcare professionals and also reviewed the person's diet, offering them supplements and higher calorie meals. The manager told us that additional training and coaching was being organised for the nurses to have a better understanding about assessing and monitoring nutritional needs.

The staff recorded people's food and fluid intake where there had been an identified need. However some of these records were inaccurate. One visitor told us that they provided food and drink to their relative but that the staff did not record this. There were gaps on this person's record of food and fluid intake and the record for some days indicated they had been given a lower than expected volume of liquid because the staff were not recording everything the person drank. Therefore the records had little benefit in monitoring that the person received the food and drinks they needed. We discussed this with the manager who agreed to speak with the staff responsible for this and ensure that food and fluid provided by the person's family was recorded.

People told us they liked the food. They said that they had enough to eat and were given a choice of meals. We saw that the food served at lunch time on the day of the inspection was freshly prepared, looked and smelt appetising. People said that there were enough snacks and drinks available throughout the day and night. We observed that people were offered hot drinks and snacks throughout our visit. Some people were offered hot drinks and sweet biscuits throughout the morning and after 12pm which was shortly before lunch was served. One person who had been given a number of biscuits and hot drinks told staff they did not want their lunch. The staff initially encouraged the person to eat their lunch, however when they made it clear they did not want this, the staff offered them a dessert instead. Whilst it is positive that people were given a choice and this was respected and that they were offered regular drinks and snacks, there was a risk that they may not have access to a balanced diet if they just ate sweet snacks and desserts.

Menus were on display and the staff told people what meal choices were and offered alternatives when they did not want one of the choices. The menus were sited so that they could easily be read by people who were in wheelchairs. Alternative menus, 'night bites' and mid-afternoon snacks were also advertised. People identified as requiring special diets were referred to the dietitian. Additional dietary supplements and high calorie diets were offered to people who were assessed at risk associated with low weight.

People told us they received care from external healthcare professionals whenever they needed this. For example one person said, ''My husband had a chest infection and the staff called the GP who came quickly.'' Another person told us, 'Yes, there's access to the dentist, opticians, chiropodists, doctors and nurses.''

People's healthcare needs had been assessed and recorded. There was evidence that the staff worked closely with other healthcare professionals to meet these assessed needs. We saw records of consultations with other professionals and the content of these consultations. We saw that the staff had followed their

guidance and advice. The home employed nursing staff throughout the day and night to meet general nursing needs.

Good

Our findings

At our inspection of 1 September 2015 we found that the staff did not always treat people respectfully. For example they did not always respect their privacy, offer them choices or use their names when referring to them. At the inspection of 15 March 2016 we found that improvements had been made. The manager told us that they had given the staff additional training, support and supervision to understand the importance of treating people with respect and providing good customer care.

People living at the service and their visitors told us that the staff were kind and caring. Some of the things people told us were, ''They are beautiful people. I can't fault them'', ''Staff are kind on the whole'' and ''The staff are all very friendly we know each other well.'' However one person said, ''It depends on which staff are on duty, some are kind but others not so.''

People who chose or needed to stay in their bedrooms had long periods of time when they were not engaging with people and, although staff visiting their rooms were polite and kind, interactions were short and generally task based. Other people in communal rooms also had substantial periods of time with little or no engagement. One visitor told us, "Nobody ever spends any time chatting to (my relative) – if I'm not here she's just on her own most of the time although the staff are very kind and friendly when they're in giving her a wash or helping her in and out of bed." In rooms where regular visitors were present, the visitors spoke with others and there was a more lively and inclusive atmosphere.

We observed the staff being kind, caring and gentle with the people who they were supporting. We saw that they allowed people to take time to make decisions and offered them choices. They cared for people in a respectful way, explaining what they were doing and gaining the person's consent. The staff approached people who were asleep when lunch was served in a quiet and calm way, gently informing them that it was lunch time and allowing them to wake up slowly. The staff supporting people with lunch allowed people to eat at their own pace. They told them what the meal was and spoke in a positive and encouraging way.

We observed some thoughtful interactions, where the staff smiled at people, bent down to speak with them and held their hands. The staff complimented people on how they looked and what they were doing. They supported people to feel at ease. For example, one person was holding a toy doll. A staff member approached them complimenting them on their ''beautiful baby'' and asking permission to cuddle the toy.

The staff offered people choices and respected the choices people made. For example, we saw people being

offered a range of different drinks and snacks, a choice of where to sit and choices about whether they wanted to wear protective aprons at mealtimes. The staff listened to the decisions people made and if they did not understand the choice they explained this in a different way.

People told us their privacy and dignity was respected. Since the last inspection the provider had taken action to secure records about people who lived at the service so that they could only be accessed with staff permission. The nursing station in one part of the home was situated in a position where everyone visiting the home walked past. One of the members of staff said that they felt a privacy screen or raised edge to the station was needed so that they could look at records without fear of others seeing confidential information as they passed the area.

People told us the staff offered care behind closed doors, knocked when entering bedrooms and called them by their preferred names. One person said, ''(My relative) has chosen to keep her bedroom door open when she is in there, the staff close the door when they need to care for her.''

People were given the care and support they wanted at the end of their lives. Care plans included information about people's preferences for receiving care and there was evidence the staff had worked with people's GP and the palliative care nursing team to provide the care people needed.

Good

Our findings

At our inspection of 1 September 2015 we found that people did not always receive care and treatment which reflected their individual needs and preferences. At this inspection we found improvements had been made.

Some people and their relatives told us they could remember being involved with planning their care and agreeing to care plans. One person said, ''Yes I do remember signing a care plan.'' A relative told us, ''I brought a list of do's and don'ts, likes and dislikes for the staff when (my relative) moved here.'' Some visitors told us their relatives received the care they needed and they did not want to worry about what the care plans said. One visitor told us, ''Don't talk to me about care plans, we had two documents, one was 43 pages and the other 22, far too much paperwork.''

People and their visitors told us that care needs were generally being met. For example, one relative said, ''The staff are very good. They got my husband an extra-long bed because he slips when sitting up.'' Another person told us, ''My husband has a wash down. He always looks clean.'' Visitors told us they were able to visit the home at any time and were involved in planning and caring for their relatives if they wanted. One visitor said, ''What I like about this place is that we can visit any time of day or evening. Nobody minds.'' Another visitor told us, ''I come at lunchtime as I think it helps the staff.''

We saw that staff were attentive to people and responded when they had a need. For example, when people requested support with moving to a different part of the home, needed help with eating their meals or asked to take part in a particular activity, the staff listened to what the person wanted and provided care which reflected their preferences. However, records to show how often people had been offered and taken showers or baths indicated that people had not always had regular access to these. For example, we looked at records for seven people over the period of one month. Three people had no records of baths of showers, one person had had one bath and one person had two showers during this time. We spoke with the manager about this. They told us people were offered regular baths and showers but sometimes refused these. The manager told us that staff had been reminded to record refusals but sometimes did not. The records for one person showed they had been given regular showers. People at the service looked clean and well kept, their hair and nails were clean and they were dressed appropriately.

Each person had a care plan which outlined their needs. Care plans were updated each month and information was clearly recorded in different sections. There was clear information for the staff on how to

meet individual needs. However, care plans did not always indicate people's preferences or give much detail about how they would like their care delivered. The registered manager told us that the provider had introduced new paper work for care plans and they were in the process of transferring information to these. The registered manager said that the new templates made better provision for recording personal preferences.

Some people told us they enjoyed the organised activities at the service. Others told us they would like more things to do and one person told us they were lonely living there. There was a member of staff responsible for coordinating and facilitating activities. On the day of our inspection some people were involved in a game of bingo. They told us they enjoyed this. Other organised events included quizzes and music. People told us they sometimes visited the local village but did not go out of the home as much as they would like and there were no transport facilities to go out on trips. One person told us, ''When the (activities coordinator) is not here, nothing much happens.'' There was a list of planned activities and events but this information was not clearly recorded or easy to read and therefore people did not always know what events were planned.

We saw that in some areas of the service, the staff supported people with individual and small group activities. However, some people told us they would like more support with this but the staff were, ''often too busy to help.''

People told us that they knew how to make a complaint and felt confident that these would be listened to and acted upon. One person told us about a complaint they had made and that changes had been implemented as a result of this complaint.

There was a complaints procedure and this had been shared with people living at the service, their visitors and staff. The provider kept a record of all complaints and the action taken to address these. Information about concerns and complaints was included within the manager's monthly audits of the service.

Good

Our findings

At our inspection of 1 September 2015 we found that records were not always accurately maintained or up to date. In addition, the service was being managed by an acting deputy manager. The registered manager was not working at the home at the time of the inspection and this had an impact on how well the service was being led.

At the inspection of 15 March 2016 we found that improvements had been made. The registered manager had returned to the service and there was a clear senior staff structure supporting the other staff. There had been improvements to record keeping and care records were generally well maintained, accurate and up to date.

The registered manager returned from their extended leave at the beginning of December. They had worked at the service for over five years and had a good knowledge of the service, the needs of the people who lived there and the staff. They spent time working alongside staff caring for people as well as managing the service. There was a deputy manager who was also the clinical lead, supporting the nurses and making sure people's nursing needs were being met.

The registered manager told us that she was organising for the nurses and senior carers to have leadership training to empower them in their roles and to ensure the staff had better supervision and support at all times.

The staff told us they found the registered manager supportive. Some of the comments they said were, ''(The manager) is very supportive and very good'', "There's a much better atmosphere since (the manager) came back. Things have improved hugely and she's sorted out all the previous problems", ''She has covered other staff absences when we need her and works well with all of us'' and ''(The manager) is always available if I need to speak with her, she is fair and knows the service well.'' The staff told us the registered manager had a ''hand's on'' approach and was always very ''visible.'' They said that the registered manager spent time walking around the service every day speaking with people who lived there and visitors.

The registered manager had created a service improvement plan where they had recorded concerns identified at the last inspection and other concerns highlighted by the local authority monitoring team and the provider's own audits. They had a plan to make improvements and they had demonstrated progress in these areas.

There were meetings for people who lived at the service and their representatives. There had been a meeting the day before our inspection.

The provider had contacted people living at the service and their representatives in December 2015 asking them to complete a satisfaction survey about their experiences. The provider had created a report which outlined the feedback and results from these surveys. The report indicated that most people were satisfied with their care, liked the staff and were happy with the service. One area where people felt improvements were needed was that staff were not always available when they wanted them.

The registered manager and staff carried out audits and checks on the service which included checks on the environment, medicines, records and people's care needs. The provider's senior managers and quality monitoring team visited the service to conduct audits. They reported on their findings and requested an action plan from the registered manager to address any improvements. The most recent visit had been by the provider's quality team on 7 January 2016. We saw the registered manager's action plan from these and evidence that they had taken the actions required.

The registered manager recorded a monthly evaluation of the service. This included information on wound care, changes in people's weight, medicines, complaints, infections, accidents and incidents and nutritional needs. There was evidence of any areas of concern relating to the service and the action that had been taken to address these.

We looked at a sample of other audits which included checks on care planning, medicines and risk assessments. There was evidence that the provider had taken action to improve the service where problems had been identified. For example, there was a detailed report on each care plan which had been audited and information about what needed to improve and who was responsible for this.

There was system of ''resident of the day'' where each person had a specific day where their needs were reviewed by the nurse on duty, the activities coordinator, chef and other relevant persons. The staff spoke with the person and their family to make sure they were happy with their care and asked if they required any changes.

The provider kept a record of all accidents, incidents and significant events. Records of these included action which had been taken to minimise the risk of reoccurrence. They had been viewed and signed by the manager, or another senior member of staff. The staff had notified the Care Quality Commission of serious injuries and other significant events.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not always deploy suitably qualified, competent, skilled and experienced staff to meet the needs of service users. Regulation 18(1)