Care Expertise Limited

Holmwood Nursing Home

Inspection report

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Ratings

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

Overall summary

Holmwood Nursing Home provides nursing and care for up to 48 people most of whom have dementia. At the time of our visit 38 people lived here.

Care and support are provided on two floors. Each bedroom has en-suite toilet and washing facilities. Communal areas, include two large rooms, one of which leads out to the secured gardens.

The inspection took place on 30 September 2015 and was unannounced. At our previous inspection in November 2014 we had not identified any concerns at the home

Overall there was positive feedback about the home and caring nature of staff from people and their relatives. One person said, “The carers are very friendly here.” A relative said, “I can’t fault the care here. They look after my family member so well. The manager is wonderful.” Another said, “Nothing is too much bother for them (referring to the staff). I never felt a care home could be like this.” However we identified a number of concerns around the home.

The leadership and management of the home had an impact across all five of the key questions that we looked at. It impacted on the safety of people as risks to people had not been identified; It limited the effectiveness of the service to be able to provide person centred care, such as supporting people to keep healthy; It affected the caring

Summary of findings

nature of the staff as staff had little time to spend with people to talk or get to know them; It reduced the responsiveness of the service so people did not receive care that met their needs.

People were not always safe at Holmwood Nursing Home. People's medicines were not always managed in a safe way. Risks to people's health and safety had not always been identified. Plans were therefore not in place to manage these risks.

The home was not responsive to the needs of the people that live here. Visibly obvious signs that people needed care were not seen by staff. Support needs identified in assessments carried out with people before they came to the home had not been carried across to care records. Staff were unaware of the need and people did not have the support they needed. People did not have activities that met their needs. Staff did not always know the people they cared for as individuals.

People did not always receive support to remain healthy. Although some people did have referrals to external health care professionals we could not be assured that the recommendations made had been followed by staff. Other people had not been referred to healthcare professionals where they should have been, so were not receiving effective care that met their needs.

Where people did not have the capacity to understand or consent to a decision the provider had not always followed the requirements of the Mental Capacity Act (2005). Decisions had been made for people without an appropriate assessment and review being completed. People told us that staff did ask their permission before they provided care.

Where people's liberty may be restricted to keep them safe, the provider had not always followed the requirements of the Deprivation of Liberty Safeguards to ensure the person's rights were protected. People were not free to access all areas of the home. The front door and some interior doors were operated by keypad entry. Many bedrooms had gates on the doors to stop people wondering into to others rooms.

Some people had behaviour that may challenge themselves of others. These people were at risk of harm. Staff had not been given the guidance or training to respond in a safe manner and not injure the person. Staff had not received training to support the individual needs of people in a safe way in other areas, such as choking.

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 2008 and associated Regulations about how the service is run.

Modifications have been made to the home to meet the needs of people that live here. Extensive redecoration of the home was in progress at the time of our inspection. The registered manager assured us that part of the redecoration would be to make the home more suited to the needs of people that live with the experience of dementia.

People told us that they enjoyed the food and had enough to eat and drink. They were given a choice if they did not like what was on offer. People's specific dietary needs were met.

Staff had a good knowledge of their responsibilities for keeping people safe from abuse. The provider had carried out appropriate recruitment checks to ensure staff were suitable to support people in the home.

People told us that staff were kind and caring and treated them with dignity and respect. People knew how to make a complaint. Feedback from people was that the registered manager and staff would do their best to put things right if they ever needed to complain.

We identified seven breaches of the regulations. 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?

Requires improvement

The service was not always safe.

People's medicines were not always managed in a safe way. People did have their medicines when they needed them.

The provider had not always identified risks to people's health and safety nor put guidelines in place for staff to minimise the risk.

There were enough staff to meet the needs of the people. However the staff were not always present to provide support to people when they needed it.

Appropriate recruitment checks were completed to ensure staff were safe to support people at the home.

People felt safe living at the home. Staff understood their responsibilities around protecting people from abuse. People would be kept safe in an emergency.

Is the service effective?

Requires improvement

The service was not always effective

People did not always receive support to remain healthy. Guidance given by health care professionals was not always followed, and referrals were not always made to the appropriate services to meet people's needs.

People's rights under the Mental Capacity Act were not always met. Assessments of people's capacity to understand important decisions had not been recorded in line with the Act.

Where people's freedom was restricted to keep them safe the requirements of the Deprivation of Liberty Safeguards were not always met.

Staff did not always have the necessary training to provide care that met the needs of people. People were at risk from improper use of restraint because staff did not have the training or guidance to do it safely. Staff said they felt supported by the manager. However some staff had not received supervision in line with best practice for their profession.

People had enough to eat and drink and had specialist diets where a need had been identified.

Is the service caring?

Good

The service was caring.

Staff did know the people they cared for as individuals. People were supported to practice their faith, further information could be given to staff to better support people.

Summary of findings

The home's decoration and facilities in bedrooms were appropriate to meet people's needs; the registered manager assured us that the newly decorated areas of the home would be further improved to meet the needs of people with dementia.

People told us the staff were caring, friendly and respected them. People said they were involved in how their day to day care was given.

Is the service responsive?

Requires improvement

The service was not always responsive to the needs of individuals.

People did not always get the care and support they needed. Peoples care needs had not always been identified by staff.

Care plans were not person centred and did not always give detailed information about the support needs of people. People said they had not been involved in them, or the reviews.

People had access to activities; however these were not always personalised or effective at meeting the interests and needs of the people.

People knew how to make a complaint. They said the registered manager and staff would do all that they could to address any concerns they raised. There was a clear complaints procedure in place.

Is the service well-led?

Requires improvement

The service was not always well led.

The providers systems for ensuring people received a good quality of care were not effective. Systems to improve the quality of the service such as meetings and audits were not effective.

Records to show how the regulated activity was being managed, and how well people received care were not effective. Records had gaps, incorrect information, or were out of date and generic.

People were very complimentary about the friendliness of the staff and the registered manager.

Holmwood Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 30 September 2015 and was unannounced. The inspection team consisted of two inspectors and a nurse specialist. One of the inspectors had experience of dementia care, and the nurse was a specialist in care for the elderly.

Before the inspection we gathered information about the home by contacting the local authority safeguarding and quality assurance team. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the home is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. This was because we were carrying out this inspection in relation to some concerns we had received about the home.

During our inspection we spoke with nine people, two relatives, and six staff which included the registered manager and deputy. We observed how staff cared for people, and worked together. We used the Short Observational Framework (SOFI) to understand the experiences of people we were unable to verbally communicate with. We also reviewed care and other records within the home. These included nine care plans and associated records, 15 medicine administration records, four staff recruitment files, and the records of quality assurance checks carried out by the staff.

This was the first inspection of this home since a new provider took over in 2014.

Requires improvement

Is the service safe?

Our findings

People told us that they felt safe living at Holmwood Nursing Home. One person told us, "I feel very safe here; If I want anything I press my bell and they come." Another person said, "I'm not worried about anything because they look after me." However we identified concerns around the risks to people's health and safety that had not been identified or managed by staff.

People did not always have their medicines managed in a safe way. Medicines had not been disposed of when people had left the service, and management of counting the medicines and checking that only one lot of medicines was open at any one time needed to improve. Controlled medicines and sharps (such as used needles) were also not disposed of in a timely manner. These issues increased the risk of medicine errors, injury to people, or presented an opportunity for misuse.

Staff who gave the medicines were not always able to tell us what the medicines were for, or the possible side effects. They were also not able to quickly find the information in the British Medical Association 'Bluebook', which is the standard reference for all medicines available in the UK. People were a risk as staff may not identify the signs if someone had a negative reaction to their medicine. Where a person indicated they did not want to take their medicine, the nurse dropped the tablets into their meal in front of them in an attempt to give it covertly. There was no agreement that giving covert medicine to this person was in their best interest.

The medicine administration records (MAR) were also in need of improvement. These are used by staff to record that medicines have been given, and to also identify they have been given to the right person. The records we reviewed had a picture of a person at the front, but no name. The MAR was behind this on a separate piece of paper which had the person's name on it. There was no way to know if the picture was the same person on the MAR. There was a risk that people could receive the wrong medicine as the picture of the person was not clearly linked to their name and medicine records.

Medicines were not always stored in a safe way. Medicines were found in unlocked cupboards so could be accessed by staff who may have no medicine training. Medicines and supplements were found stored in hot rooms and not stock rotated in date order. The heat could affect the effectiveness of the items, and not rotating the stock could result in out of date medicines being used.

The identified issues meant that people were at risk due to poor management of medicines. **This is a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.**

There were some good aspects to how people's medicines were managed. The home had a contract with a local pharmacy that provided all routinely prescribed medicines via blister pack system that made it simpler and safer to manage and administer people's medicines. The refrigerator used to store medicine was clean and ordered. The temperature was routinely checked to ensure medicines were kept at the correct temperature.

People who had diabetes where given their insulin in a safe manner. Records and our observations showed clear checking of blood glucose levels prior to administration of insulin. Staff had a good knowledge of the parameters of blood glucose levels for safe administration of insulin.

Not all risks to people had been identified to keep them safe from harm. Some risks to people's health and safety had been identified and a plan put into place to reduce the risk of harm; however the detail was variable and not always carried over to the care plan. Staff may not then be aware of the care they needed to provide. We identified a number of obvious risks that should have been identified by staff. A person had swollen feet and their sandals were very tight. Their feet were also not raised. The persons care records identified there was a risk of this condition, however no risk assessment or care plan had been developed to support the person. This was completed before we left at the end of the day.

People were not always kept safe because although accidents and incidents were recorded and action taken to help the people involved at the time, the information was not always carried over to the care plan to inform staff of new care support requirements. For example new wounds were not consistently recorded on accident reports, and care to address them was not given. People would be at risk of not receiving appropriate treatment.

The risk to people from substances that could be hazardous to health were not always identified and managed. Items that fell under the Control of Substances

Requires improvement

Is the service safe?

Hazardous to Health regulations were found in unlocked cupboards, which were accessible to people. This meant people were at risk of accessing substances which may have been harmful to them. We showed this to the registered manager and they arranged for the door to be locked immediately.

People were at risk from infections as not all the rooms were clean. We identified an issue in one person's bedroom with a soiled carpet and mattress. No assessment of the risk to themselves of other shad been completed. The deputy manager explained this was down to the person's particular behaviour. The room and mattress where immediately cleaned. The risk to others was low as the person chose to stay in their own room.

As a number of identified risks to people's health and safety had not been identified there was **a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.**

There were enough staff at the home to meet the needs of people; The registered manager had reviewed the needs of people and calculated staffing levels to meet those needs. Staffing rotas recorded that the specified numbers of staff required to support people had been working over the last four weeks. However it **is recommended that the registered manager review how they were deployed around the home.** At times communal areas were unstaffed and people were at risk of falls, or from the behaviour of other people. The majority of people were very happy with the staffing levels, and how quickly staff responded to them when they called. Other people who stayed in their rooms said they had to wait for care, and they were not supported to get up at the time they wanted.

Appropriate checks were carried out to help ensure only suitable staff were employed to work at the home. The management checked that they were of good character, which included Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People knew they could talk to staff if they had concerns for their safety. Staff understood their responsibilities in relation to safeguarding people. Staff had undertaken adult safeguarding training within the last year. All were all able to identify the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. Referrals had been made where required and the registered manager had a good understanding of their role and responsibility.

The home's design and maintenance also reduced the risk of harm to people. Flooring was in good condition to reduce the risk of trips and falls. Equipment used to support people was regularly checked to make sure it was safe to use. Items such as hoists and fire safety equipment were regularly checked. There was good use of risk assessments to protect people during the current refurbishment of the home.

People's care and support would not be compromised in the event of an emergency. One person said they, "Had a call bell pendent around their neck and staff always responded promptly to this when she used it." Information on what to do in an emergency, such as fire, were clearly displayed around the home. People's individual support needs in the event of an emergency had been identified and recorded by staff in personal emergency evacuation plans (PEEPs). These gave clear instructions on what staff were required to do to ensure people were kept safe. Emergency exits and the corridors leading to them were all clear of obstructions so that people would be able to exit the building quickly and safely.

Requires improvement

Is the service effective?

Our findings

People said they were able to see the doctor whenever they needed to, or go to hospital if necessary. A person told us, “Staff would listen if I said I was not well, and get the GP out; they are very good at this.” However we identified a number of concerns around how effective the service was at meeting people’s health needs.

People did not always get effective support to maintain good health. Some people received a good level of external support (such as GP, or Occupational Therapist) to keep them healthy and meet their needs; however others did not. Advice and guidance from health care professionals was not always followed, or recorded by staff in care planning documents. For example, one person had an exercise plan to help keep them mobile. There were no records that staff had supported them to do these exercises. In this instance the person’s mobility had not been affected. Another example was where someone was nearing end of life and this had not been identified nor managed by the staff. When the matter was raised with the registered manager they explained that they were waiting for another service to arrange assessment for the person. The person did not have an end of life plan in place, nor were they getting access to appropriate services (such as a hospice) or medicines. Before we completed the inspection the registered manager had made contact with the local hospice and was in the process of referring the person themselves to ensure they received care and support they needed.

Because the provider had not ensured that staff consistently worked effectively with other Health Care Professionals, peoples healthcare needs were not always met. This was a breach of **Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.**

We did see some good examples of effective health care. One person had regained the ability to walk since moving to the home due to the care of staff.

People’s human rights may not always be protected because staff had not followed the requirements of the Mental Capacity Act 2005. Staff had some understanding of issues surrounding consent, such as people’s right to take risks and the necessity to act in people’s best interests when required. However where people lacked capacity to make decisions for themselves the registered manager had not always ensured a capacity assessment had been completed, nor a record of any best interest’s decisions that had been made on behalf of the person. People had decisions made for them by others who did not have the legal authority to do this. For example relatives that had power of attorney for a person’s finances were involved in decisions around that persons care. One person routinely told staff that they did not want to be at the home, but no assessment of their mental capacity around this decision or DoLS application (if appropriate) had been made by the registered manager

Where people had behaviour that may challenge themselves or others, the registered manager had put in a DoLS application that included use of restraint. There was no record of a mental capacity assessment and best interests meeting to show that this had been discussed and was in the best interests of the person.

The failings to follow the requirements of the MCA meant there was a breach in **Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.**

People’s verbal consent was sought before staff gave care or support. One person said that, "They (staff) always ask, never tell.” Staff were heard to ask people’s permission before they provided care and support throughout our inspection. People were able to make day to day decisions for themselves and their choices and views were respected by staff.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. DoLS are part of the Mental Capacity Act 2005 (MCA). They aim to make sure people in care services are looked after in a way that does not inappropriately restrict their freedom.

Where people lacked capacity to understand why they needed to be kept safe the registered manager had made the necessary DoLS applications to the relevant authorities to ensure that their liberty was being deprived in the least restrictive way possible. The registered manager was waiting for a response from the relevant authority at the time of our inspection. The registered manager ensured that people’s care was given in line with the submitted DoLS to ensure that people’s human rights were protected.

Requires improvement

Is the service effective?

Staff did not have appropriate training to effectively care for and support people. People and relatives told us that care staff had sufficient knowledge and skills to enable them to care for people. However, there were a number of people that had behaviour that challenged themselves or others and staff had not had suitable training in how to manage this. Deprivation of Liberty Safeguard applications recorded that staff may need to physically restrain a person by holding their arm or leg to stop them hurting themselves. There was no physical intervention plan in place to give staff clear guidance on exactly what they could do to respect the person's human rights and to prevent injury. Where people may display behaviour that challenges themselves or others, care notes recorded that staff should follow the management plan. If this did not work then they should issue 'As required' (PRN) medication. There was no management plan in place for these individuals nor were there any PRN medicines prescribed for the individuals. During our visit we did not see staff attempt to restrain people, nor did staff or people tell us that they had ever been restrained. However there is a risk that people may not be protected from the improper use of restraint.

In addition although the registered manager and deputy manager had knowledge of the Surrey County Council Guidelines on managing the risk of people choking, the staff we spoke with were unaware of them. As a result, staff may not have been up to date with current best practice with regards to supporting people if they choked. People had been identified at risk of choking at the home. People who may be at end of life would be supported by staff that had not received appropriate training. One nurse said they had no training in palliative care, and they were seen to support a person who should have been on end of life care.

The process for ensuring staff received a proper induction was not effective. Staff induction consisted of being shown around the home, along with a checklist for the staff member to complete. The most recent staff to be employed had not completed this induction checklist in the timescales set out by the provider. Their knowledge of the home and the people who lived there showed that the induction had not been given, nor had their progress to complete the induction been monitored by the registered manager.

People were cared for by staff who said they felt supported in their work. They had opportunities to meet with their managers to discuss their performance. However some staff had not had an appraisal with their line manager, and nurses did not have any clinical supervision. This is where their professional skills are checked to ensure they are up to date with current best practice.

The gaps in staffs knowledge and training on important care subjects meant there was a breach in **Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.**

The home was generally clean and was in the process of being refurbished. This had nearly been completed upstairs. Within the refurbished areas there was no enhancing of the new environment for those with dementia or sensory impairments e.g. no door demarcation / identification by having different colour door frames, no visual aids within the bathrooms for people living with dementia. The registered manager assured us that this would be put into place once the decoration work had been completed.

People were positive about the quality, amount and choice of meals and drinks. One person said, "The food is not bad. The cook comes to tell myself and others about choices. They cook an alternative if wanted." Another person told us, "I see staff offering choices with meals". Some people had to wait a long time before they had their meals, watching while others were supported to eat. People were offered fluids throughout the day and staff supported people at meal times. Staff were heard to explain the choice available to people and then provide the food that people had chosen.

People's dietary needs were met and they received support with any specialist diets; how these were managed could be improved. During tea time sweet treats were given out to people with their hot drinks, but those with specific dietary needs could not eat the same as everyone else. An alternative was offered, however the fact that they were not offered a similar option as others then brought on a change in people's mood and behaviour.

People who had particular dietary requirements either due to medical or religious of cultural needs had their needs met. Care staff, including the chef, were able to tell us about individual people and their dietary requirements. example people that were on soft diets as they had a risk of choking, enriched diets if they were losing weight or their dietary choice due to their belief system.

Good

Is the service caring?

Our findings

We had positive feedback from people about the caring nature of the staff. Some told us that they had good relationships with staff and that staff were kind and caring. One person said, "I can speak with any one of the carers, they are really nice." A relative said, "I can't fault the care here, they look after my family member so well."

Staff did not always know the people they cared for. A staff member was overheard to ask someone if they would like someone who spoke their own language to help. The persons care records clearly showed the person was fully fluent in English. We asked the nurse who had supported the person if they knew this. They said she did not. The person had been at the home for two weeks, which was enough time for staff to get to know the person as an individual.

People's needs with respect to their religion or cultural beliefs were met. Basic information was recorded in care plans; however detailed guides for staff on how to support people to practice their faith were not always in place. One person had a clear sign in their room to alert staff to their specific faith, for example the food items they could not eat; However further information could be given so that staff would fully understand the support the person needed with regards to their other religious needs.

The atmosphere in the home was calm, relaxed and throughout the day we observed respectful and caring interactions with staff to people. There were several good natured exchanges/banter between certain people which they enjoyed. One person said, "I can have a laugh and a joke with them (staff)." People in the communal areas did have their needs met although the staff were busy all the time, and spent little time sitting or talking with people during our inspection.

People's privacy and dignity were respected and promoted by staff. When people had to use a hoist to help them get into and out of chairs a curtain was placed around them so that others in the room could not see this taking place. People we spoke with told us that staff treated them as individuals and respected their privacy and dignity.

However people's privacy could be comprised as some doors did not have locks on, and others had locks on the outside, which could not be opened from the inside. The registered manager told us these were not used and would be removed when the current refurbishment works were completed.

People were supported by kind and caring staff. A relative told us about when they had come to look around the home and the positive interaction she saw from the registered manager. A person came into the office while he was talking with them. Rather than asking the person to leave, the registered manager invited them in and asked if they wanted to be involved in the conversation. When the relative was given a tour of the home, the registered manager asked the person if they would like to come along as well, which they did. The relative said, "To me that is caring, it really struck me on that first day."

Information was given to people about their care and support in a manner they could understand. One person said, "Staff do explain what's needed, and it is easy to understand." Staff spoke with people at a pace and in a manner which was appropriate to their levels of understanding.

Relatives were happy that the registered manager and his team were approachable, and that they were called if anything happened or decisions needed to be made around the care of their family member. One person told us how they had been told about the home refurbishment and that it would mean they would have to move rooms while this took place. The explained how the staff had shown her the new room and asked if she was happy to move. A relative explained how their family member's room redecoration had been put on hold as they were not feeling well. These examples showed that aspects of the home were caring, and people's well-being had been considered.

People's rooms were personalised with family photographs, ornaments and furniture. This made the room individual to the person that lived there. Relatives were able to visit whenever they wanted and told us that they were always made to feel welcome.

Requires improvement

Is the service responsive?

Our findings

People were generally positive about how the service responded to and met their needs. One person told us, "I have come on so well since I came here, (staff) really helped me." However we found a number of areas where the staff had not responded to, or identified people's needs. People had not received the care they needed.

People's needs were not always identified by staff, and people did not always receive the care and support they needed. People told us that they were generally happy with the level of care provided by the staff. One person said, "I need staff support to move and they do help me when I need it, but sometimes I have to wait for them." However other people had clearly not had their needs met. Changes in people's needs had not been identified and managed by staff. Where a person had developed a wound there was nothing in their care plan about how staff needed to care for the person. One person had two dirty dressings that were coming off their arm. There was no care plan or incident form / skin map recording these wounds. The two nurses were not aware of these injuries/ wounds when we asked them. The nurses did redress the wounds and develop a care plan when we raised this with them. Care had not been given in an appropriate manner to care for the wound. Staff had also not responded where a person was seen to have very swollen feet. The person said they were in discomfort and indicated a loss of sensation in their feet. This had not been identified by the nurse or care staff. Immediate care was given by the staff. The persons need to have this condition supported had been clearly identified in the person's assessment of needs, but no plan of care had been put into place for staff to follow. Staff had not provided care in a way to address these people's needs.

Before we left the home, we ensured that the people we had identified above had their needs met by the nursing staff, and care plans and risk assessments had been developed to record the support these people needed. Additionally the people were added to the GP list so they would be seen the next day. This ensured that people had not been left with their care needs not being met.

People were not always involved in the planning and review of their care. People gave a mixed response when asked about their involvement in care and support planning. A person said, "Staff are very good at explaining things to me." Another person told us they had not been involved in their care plan. A third person told us that they had not seen their care plan, but staff had put a document up in their room. They had limited mobility so could not see what it was. With their permission we talked them through the document. It was a summary of the persons care needs for staff to follow. The person agreed that the care given by staff matched with what had been recorded; however they had not been involved, nor had staff explained what the document was when they put it up. Care plans were written in task focussed rather than personalised, person centred approach. Care records did not record how or if people had been involved.

People had access to activities; however these needed to be more focused on individual's interests and needs. Arrangements were not in place to provide scheduled activities when the activities person was not present, for example due to illness. One person said, "I do my jigsaws, and when I am out of bed I go into the lounge. The activities person used to come and give me some one to one activities, but this has slowed down." We observed people were sitting in chairs in communal areas for long periods of time without contact or interaction with staff members or other people. Contact with people is important for people living with dementia. Giving people time to have conversations sparks memories and stimulates the mind. People's religious and cultural requirements were not always clearly documented in care plans. Nor were their structured activities to enable them to practice their faith.

The failure for staff to identify and provide care to meet the needs of people meant there was a breach in **Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

People that were more independent were supported to continue with activities that they enjoyed. A relative told us about how their family member was "Well supported by staff to carry on with their hobby." Another person said, "When the activity lady is here – she is fantastic. We also have a music lady, one hour every couple of weeks". A second person said, "I would like to stay up (in the evenings) but nothing is going on. In the summer it's different, we have more going on."

People's independence was not always promoted by the provider. During our observations we did not observe the use of any eating aids during lunchtime, for example plate guards for those that could assist themselves at some level.

Requires improvement

Is the service responsive?

People were supported by staff that listened to and responded to complaints. People and relatives knew how to raise a concern or make a complaint. People told us they would feel comfortable making a complaint if they needed to and were confident that any concerns they raised would be addressed. One person told us, "I have only ever needed to raise minor things, and they put them right straight away. The registered manager kept a record of complaints. These had been resolved using the home's complaints procedure to the satisfaction of the people that raised them.

Requires improvement

Is the service well-led?

Our findings

Audits were carried out to monitor the quality of the service people received but were not always effective. Where improvements were needed these had not always been followed up or completed. The provider, registered manager and other senior staff completed a number of checks around the home; however these did not always help to improve the quality of care in the home. Areas checked by the management included medicines practice, completion of care documentation, pressure care management and cleanliness and infection control. No clear action plans had been developed and progress on identified actions had not been recorded. In some cases continued failures had been identified, but no further action had been taken to correct the issue. For example during a medicine audit it had been identified that there were gaps in staff signing medicine records. On the following month the audit identified more gaps, but no further action or escalation action was recorded to address the issue.

Provider visits to the home were ineffective at identifying if a good quality of care was given to people. The results of these visits were not fedback to staff before the senior manager left, so they had to wait for the report to be sent before they would know if any improvements were needed. This could take some weeks, during which poor practice could be continuing. No action plan was generated as a result of concerns identified during these visits, nor was there a review of the previous visit report at the next visit to see if issues highlighted had been completed. The registered manager had already brought this to the attention of the provider. The provider's visits had not identified the concerns we found during our inspection which meant they did not have a clear view of what was happening at the home and the improvements that were needed.

Management meetings were not always effective at improving the service people received. A nurse's team meeting held in August 2015 had identified concerns with inconsistencies in changing people's wound dressings, and care staff not adequately recording care given to people. These and other issues had been identified as still taking place during our inspection.

Records of care and management of the home were not completed fully to show that people received a good service. Policies that could give guidance to staff were found to be out of date, or generic documents not individualised to the home. Care records did not always reflect the needs of people, for example information was missing, such as records of fluid intake or output over a 24 hour period for a person at risk of poor hydration; or out of date information was still in the current file. Daily records of support given to people were minimal and did not show that care given was in accordance with the needs of the people. This could result in people not receiving their care, or being given care that did not meet their current needs.

The registered manager and their deputy were visible around the home on the day of our inspection; however neither had identified the concerns with peoples care and support we found. They took swift action when the concerns were identified to improve people's care. Because of the issues we found and that neither the registered manager of the home, nor the senior management from the provider had identified them, the home was not well led.

Due to the provider's failure to assess, monitor and improve the quality and safety of the service there was a **breach in Regulation 17of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

People and relatives were not always included in how the service was managed. One person said, "I am not aware of any residents or relatives meetings taking place, they just talk to us if they need anything." Another person told us there were "no residents meetings", but staff had updated them regarding the recent refurbishment of the home. The registered manager said that the provider had informed him that relatives had said they did not feel the need to have them. We asked to see a copy of this feedback, but none was supplied.

People and staff said there was a positive culture within the home between the people that lived there, the staff and the registered manager. A relative told, "The registered manager is wonderful. He has such a calming effect as do the rest of the staff. I can't fault them." People who lived there, their relatives and staff confirmed to us the manager operated an 'open door' policy and that they felt able to share any concerns they may have in confidence. When asked to describe the atmosphere at the home, one person said, "Happy." The registered manager had a good rapport with the people that lived there and knew them as individuals. However during our observations during the

Requires improvement

Is the service well-led?

day we saw that there was very little interaction between the nursing and health care assistant staff. This could result in information about people's needs not being passed on, and does not promote a sense of teamwork, and improving the service.

The registered manager was aware of their responsibilities with regards to reporting significant events to the Care Quality Commission and other outside agencies. We had received notifications from the registered manager in line with the regulations. This meant we could check that appropriate action had been taken. Information for staff and others on whistle blowing was on display in the home. Staff understood what whistle blowing was and that this needed to be reported.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Safe Care and Treatment.** People were at risk because the provider had not ensured that medicines were managed in a proper and safe manner.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Safe Care and Treatment.** The provider had not sufficiently assessed and managed the risks to people's health and safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12(2)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Safe Care and Treatment.** When working with other appropriate persons for the care of people, the provider had not ensured that timely care planning had taken place to ensure the health, safety and welfare of the service users.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Need for Consent.** The provider had not ensured that care and treatment was provided with the consent of the relevant person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Safe Care and Treatment.** The provider had not ensured that persons providing care had the skills and experience to do so safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** The provider had not ensured that people received care and support that met their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.** Systems and processes were not operated effectively to ensure compliance with the regulations, and to ensure people received a good quality of care and support.