Care Quality Commission

Amber ARC Limited

Kimberley Nursing Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on 3 December 2014 and was an unannounced inspection. The home had last been inspected in April 2013 and at that time was found to meet all the legal requirements we looked at. There were 48 people living at the home.

There was a registered manager in place at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The home provides residential and nursing care to older people and people living with a dementia. The home was set out over two floors and was registered to provide care for 72 people. However, the registered manager was in

Summary of findings

the process of creating smaller lounges for people to sit in and so currently the home can only accommodate 58 people. One area of the home was called The Willows and this was a secure unit for people living with dementia.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

People's safety was compromised in a number of areas. We saw care was not always planned in a way which would protect people from harm. Furthermore, we saw that where care was appropriately planned staff did not always deliver care in accordance with people's care plans. Systems to support staff to administer medicine were not embedded or kept up to date which increased the risk of a medicine error.

While staff responded quickly in an emergency the current staffing levels did not allow staff to always meet people's needs in a timely manner. Staff were very task orientated and focused on getting the task completed and did not always have the time to personalise care to meet people's individual needs. Staff training did not always cover all the area's staff needed to develop their skills in. Where training was in place staff did not consistently demonstrate appropriate skills while caring for people.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect themselves. People who were at risk of having their liberty deprived had their rights protected by a senior staff team who had received appropriate training.

However, where people were unable to make decisions for themselves the systems in place to make decisions for them did not always meet the requirements of the Mental Capacity Act 2005 (MCA).

People were not always supported to have a choice of meals and were not positive about the food. We saw people were not supported to eat their meals while they were warm and a staff did not enquire about why people had not eaten much food. People were not always supported to have continuous access to drinks.

People told us about and we saw some good examples of care. However, this level of care was inconsistent and we observed some poor levels of care. This meant that people could not be assured that the level of care they received would fully meet their needs. In addition, the records we looked at highlighted there were concerns with the quality of service provided. People said they would like more support with activities and pursuing their hobbies. We found people in the dementia wing had less opportunity to take part in activities and hobbies than people in other parts of the home.

The registered manager had identified a number of areas for improvement, they were in the process of employing a deputy manager and more care staff to improve the quality of the service provided. Staff said the registered manager was supportive and they were happy to raise concerns with the registered manager and were confident they would be dealt with. Staff said there had been lots of positive changes to the home recently. However, we found that the care was not person centred and staff did not always take account of people's wishes and needs when providing care. The systems in place to review the quality of service provided to people did not identify areas of concern. Incidents and accidents were not routinely analysed to identify if changes were needed to improve the level of care provided.

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?
The service was not safe.

People were protected by staff who received training in protecting people from harm. However, people's risk of harm was increased as care planning did not identify all the risks a person was exposed to.

Where a risk was identified staff did not always provide care in accordance with the person's care plan.

People were at an increased risk of a medicine error as the systems in place to protect them were not adequately maintained.

Inadequate

Is the service effective?
The service was not effective.

There were some gaps in the training that staff received. Staff did not always put the training they had received into practice while caring for people.

Where people were unable to make decisions, records did not clearly identify who had been involved in making decisions on their behalf.

People were not adequately supported to make choices about the food they ate. Food was cold before people were offered assistance to eat their meal.

Inadequate

Is the service caring?
The service was not always caring.

We saw inconsistencies in care which showed people could not rely on the care provided to always meet their needs.

Staff did not always take people's wishes into account when providing care.

Requires Improvement

Is the service responsive?
The service was not always responsive.

People had not been involved in planning their care. People told us that it was difficult to find an appropriate member of staff to discuss their care with.

People were not always supported with person-centred activities. People with dementia were given less support to take part in activities and hobbies.

People were not always sure how to raise a complaint.

Requires Improvement

Is the service well-led?
The service was not always well led.

Care was not person centred and staff were focussed on completing the task as opposed to providing individualised care to meet each person's need.

Requires Improvement

Summary of findings

The registered manager had made some changes to the home and staff were positive about the support they received from the registered manager.

However, systems to monitor the quality of service people received did not identify the shortcomings of the care provided to people.

Kimberley 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 was 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 3 December 2014 and was unannounced.

The inspection team consisted of two inspectors, a specialist advisor and an expert-by-experience. The specialist advisor had had experience in providing care for people living with dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the service. We also reviewed information sent to us by the local authority who commission care for some people living at the home.

During the inspection we spoke with 13 people living at the home and seven visitors to the home. Some people had problems with their memory and were unable to tell us about their experiences of living at the home. Therefore, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with ten care workers, a nurse and the registered manager.

We looked at 12 people's care records. We also looked at 14 people's daily records which recorded the care they had received to see if it was adequate. We also looked at staff training, complaints and the quality assurance records.

Inadequate

Is the service safe?

Our findings

We identified a breach of the regulations in relation to people being cared for safely. Some risk assessments were not up to date and did not accurately reflect people's abilities and the care they needed. One person's care plan identified that they could mobilise with one member of staff to support them. However, their records showed that at times they were not supported to get out of bed as they were unable to use the standing hoist which needed two staff members. Bed rail risk assessments did not sufficiently take into consideration the provision of the pressure mattress which reduced the height of the bed rail and increased the risk the bed rail would not stop a person falling out of bed.

Staff did not always use appropriate moving and handling techniques when assisting people to mobilise. We observed one person being transferred between a chair and wheelchair in the dementia lounge. We saw this was completed in a way which left the person at risk of harm. No equipment was used to make this transfer safer. We also saw staff assist a person who had fallen. Two members of staff assisted the person to stand using a combination of under arm lifts and a grasp of their upper arm. This left the person at risk of harm.

The dementia unit operated a locked door policy. Individual risk assessments had not been competed regarding the restriction of movement in and out of the unit. Bedroom doors were self-locking and people living in the unit did not have keys to their own doors. Only the team co-ordinator and the senior carers carried keys. There were times when there was no senior or team co-ordinator in the unit. Had there been an incident in any of the rooms, the staff would not have been able to open the door and respond.

This was a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 Person-centred care.

We identified a breach of the regulation in regard to their being enough staff to care for people. People living at the home said staff responded to their needs. However, it was not always in a timely manner. One person told us how they used the call bell to ring for help. They said that sometimes when they use the bell a carer will come in and say they will be back in a while. The person said that on most occasions the care staff would return. They said, "They do their best, but they are so busy."

We also saw that at the midday meal there were not enough staff to support the 16 people having their lunch in the main dining room. At one stage there was only one member of care staff in the dining room and people were sitting with their meals in front of them for 10 minutes before staff came to assist them. In the dementia unit there were insufficient staff to support all the people who needed help. One member of staff was supporting a person and on three occasions they stopped helping them with their food to assist others.

We looked at the rotas for November 2014 and could see that staffing levels for carer workers and senior carer workers were consistently below the level the registered manager told us was required. For example, on 20 November 2015 there had only been approximately half the staff on shift compared to what the manager told us was required. Staff told us that the registered manager was trying to increase staffing levels but that staff sickness had caused problems. The rotas confirmed that there had been changes in the rota due to sickness on 24 of the 28 days we reviewed.

The manager told us that they had identified a tool which would help them ensure there were enough staff available to meet people's needs. However, they had not started to use it at the time of our inspection.

This was a breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014, Staffing.

In the dementia lounge we observed a member of staff administering medicine to people who needed residential care. They wore an apron requesting that people not to disturb them. Other members of staff respected this and so interruptions which may lead to medicine errors were kept to a minimum. We saw the member of staff supported people to take their medicine and ensured they had swallowed it properly before recording that it had been taken.

Staff told us that they received regular training and updates regarding medicines. They also said that their practice was

Inadequate

Is the service safe?

observed and they received feedback which helped them to improve their practice. Audits had been completed both by staff, the home and the community pharmacist and no concerns had been identified.

However, we identified a breach in regulation in regard to the safe administration of medicine. The nurse who completed the medicine round for people who were receiving nursing care was continually interrupted by staff, relatives and people who lived at the home which increased the risk of errors being made. The nurse was new to the service and while they ensured people were safe and medicine was administered appropriately, they were not supported by robust systems to reduce the occurrence of medicine errors. For example, medicine records detailed people's room number in order to assist staff to identify people. However, some people had moved rooms and the records had not been updated. This meant the medicine round which started at 8am was still being carried out at 11.30am and so some people did not get their medicine in a timely fashion.

Some medicines were being altered before they were administered as staff crushed them to make it easier for people to swallow. However, there was no evidence that appropriate advice had been sought from a pharmacist before the medicine was altered. This was important as altering medicine may affect how it works.

The registered manager had identified that a larger number of people than they would normally expect were on covert medicine. Covert medicine was medicine that was hidden in food so people were not aware they were taking it .Where people were given their medicines covertly, there was no evidence in their care plans of best interest meetings to explore with other professionals the administering of covert medication as required under the Mental Capacity Act 2005. The registered manager was in the processes of introducing a specific care plan and reviewing those people on covert medicine to see if it was necessary.

This was a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

Staff told us how they protected people from harm and what actions they would take if they suspected a person was at risk of being harmed. Information on how to raise concerns both within the organisation and externally to the local council were available to staff in the handover room. However, not all staff were aware of how to raise concerns externally and did not know how to access the information.

Suitable checks were completed on staff before they started work. This ensured they were of good character and safe to work with the people living at the home who may be vulnerable to harm.

Inadequate

Is the service effective?

Our findings

We identified a breach of the regulation in regard to staff training. In addition to there being a number of people living in the dementia unit, there were people in other parts of the service who had dementia related needs. Therefore, all staff needed the skills to care for people with a dementia. However, we saw only 13 out of 54 staff had completed any training in dementia care and only eight members of staff had completed training in challenging behaviour. This was important as people with dementia may respond to situations with behaviours which they need help to manage. This meant staff may not always have the skills needed to provide appropriate care for people living with a dementia.

Staff told us and records showed that staff had received training in a variety of other subjects. For example, staff told us they had received training in how to prevent the spread of infection from person to person. Staff also had the opportunity to access training for nationally recognised qualifications in care. However, in some area's we saw there were gaps in the training records. There had been no food hygiene training for over a year and only a small number of staff had completed training in the safe use of bed rails or first aid.

Training was not always effective. Records showed that nearly every member of staff had received training in moving and handling. However, during our inspection we witnessed some poor moving and handling practice. This put people at risk of harm.

When staff started they completed an induction to the home and also had a training book which contained information about how to provide safe care. However, completion of the books was not monitored and one member of staff told us they had been working at the home for over 6 months and had not completed their induction book. This meant the registered manager could not be assured they had knowledge needed to provide care to people.

Staff told us and records showed that staff received supervisions every eight to 12 weeks. However, we saw a number of instances of staff using inappropriate moving techniques, which training would have identified as putting people at harm. Issues with care practices should have been identified and discussed with staff at supervision to ensure people were safe. Therefore, supervisions did not encourage and support staff to provide safe appropriate care.

This was a breach of Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing.

During the inspection we identified a breach in the regulation regarding how people were supported to have enough to eat and drink. A relative told us, "The [cooked/ chilled meals] were ok, really good at the beginning, but some food doesn't travel. Given a choice we preferred when the food was home cooked." Another person commented that the food looked unappetising, they said it was nice but added, "I'm not eating it." This person only ate the peas on their plate. We saw when plates were collected at the end of the meal hardly anyone had eaten very much of their food. One person told us, "That's because no-one recognises what it is." They also said, "If this was a restaurant and I got this kind of food, I would walk out." When the staff took the plates away, they said, "Not feeling very hungry today?" They did not ask if the people would prefer anything else.

We found people were not always supported to have a choice of meals or to have their choice respected. For example, one person who was a vegetarian was not offered a choice of food as only one vegetarian meal had been cooked. We saw they were not keen on what was given to them but were told to give it a try. They told us they were not sure what it was supposed to be and said that they, "Didn't fancy it." A number of people chose not to eat at all as they did not like the food on offer and were not offered an alternative. One of these people was assessed as being nutritionally at risk and the record sheet did not reflect that they had not eaten their meal.

People told us that their meals were cold and we saw that there were no systems in place to keep people's meals warm until staff were able to support them. In the main dining room we saw some people were sitting at the table with a plate of food in front of them for 15 minutes before they were offered support. Two of the people were asleep when their plate was placed in front of them. Food was sent to other areas of the home on a tea trolley and was not kept warm. We saw in the dementia unit the one person's meal had stood on the cold trolley for 30 minutes. This person refused to eat their meal. Staff told us that he was

refusing to eat at present; they did not consider whether the refusal to eat was connected with being offered cold food. Other people were not supported to eat their food in a timely fashion.

Staff were not responsive to people's needs in relation to food. We saw one person who needed the nurse to be present when eating as they were at an increased risk of choking, was still waiting when most other people had finished their meal. One person was struggling to eat and put their spoon down as if they were finished after only taking a couple of mouthfuls. Staff did not ask them if they needed any help to eat their meal or if they would like anything different. Their food was just taken away.

People were not supported to have access to hot and cold drinks. At 11.15am people in an upstairs lounge said they hadn't had a hot drink all morning. Cold drinks were available on a trolley but people were unable to access them independently and staff did not offer to support them. In addition, people eating in the main dining room were not offered a cold drink until one person requested one. Staff made people hot drinks without checking if people wanted one and one person who had a cold drink was not offered a hot drink until they requested one.

This was a breach of Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2014 Meeting nutritional and hydration needs.

The senior staff had completed training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). These are laws which ensure people's human rights are respected when they do not have the ability to make choices for themselves about where they live and the care they need. However, care staff were unable to tell us about DoLS and what it meant for people in their care. They said that they hadn't had sufficient training regarding this to fully understand it.

The registered manager was aware of the recent changes in the law in relation to DoLS. This meant they were able to review people's care needs and identify if any referrals to the DoLS team were needed.

Where people were able to make decisions for themselves they were supported by staff to receive their care they way they preferred. However where people were unable to make decisions, care plans did not always show how decisions had been reached in the person's best interest or who had been involved in making the decision. For example, approximately half of the people in the dementia unit were cared for in bed. There was no information in their care plan to indicate why this was the most appropriate way to care for people and how the decision to care for them in bed had been reached.

People were supported to access healthcare professionals when needed. A visitor told us their relative had a chest infection and as soon as they walked in the door they were told about it and that the GP was coming. Records showed the involvement of other health professionals such as GP, dietician and speech therapist in people's care. Where people had received support from other professionals we saw that their care was continued by staff at the home. When we spoke with staff they were able to tell us about other professional's involvement and advice. For example, the input of the tissue viability nurse for a person who had recently had their dressings changed.

A visiting healthcare professional told us that the staff were knowledgeable about people's healthcare needs and that they were asked to see people appropriately. They said staff were helpful and were happy to follow instructions.

In the dementia unit we saw that the decoration did not support or encourage people with dementia to be independent. There was no signage or colour schemes to help signpost residents in any direction throughout the unit. We saw all the bedroom doors were painted the same colour and there were no signs or pictures on the bedrooms doors, to indicate they were bedrooms or to enable the residents to identify which room was their bedroom. People in the dementia unit were not able to access outside space unsupported.

Requires Improvement

Is the service caring?

Our findings

Some people told us they were supported to take their meals wherever they wished in the home and spoke about how when they had been feeling poorly they had requested and received their meals in their room. However, people were not always given a choice where they would prefer to eat. A member of staff told people in the upstairs lounge they would be eating at the tables in the lounge. There was no attempt made to see where people would prefer to eat their lunch and one person told us they would have liked to go downstairs to see their friends. At the start of lunch another person said they would have their lunch on a tray where they were sitting. However, a member of staff told them that they needed to come to the table.

At times staff spoke with people in a kind and respectful manner and we saw staff explained to people what care they were going to provide. For example, we heard a member of staff say, "Hello [name] just going to give you your medicine," to one person. Another person told us, "The staff are always very caring." They said when they first moved in they had physical difficulties with personal care and dressing and that staff always asked permission to help with anything, and never made them feel embarrassed.

However, this level of care was not given consistently and we observed examples of poor care. On numerous occasions staff were heard calling people, 'darling, love or sweetheart' instead of their preferred name. We observed a member of staff supporting a person to have a drink in the downstairs lounge. The staff member stood over the person and was very directive to the person, they said, "Can you drink it all please." This showed that staff did not relate to the person as an individual but as a task to be completed.

People told us staff were always kind and polite but felt staff concentrated on getting the job done and did not have time to relate to them. One person described the staff as, "Perfectly nice" and said staff were always polite and asked for their permission to give care. However, the person felt the staff didn't talk to them or know much about them as a person. We also identified this and when observing interactions did not see any impoliteness but did not see a great deal of warmth in the interactions.

We also saw that staff did not pay attention to people when they expressed a preference about their care. We saw staff went to support one person who was cared for in bed. Staff asked them permission to re-position them in the bed. They refused, but staff moved them anyway.

In the dementia unit, we saw a person express a wish to return to their room. However, staff did not support them to achieve this outcome. This meant that this person's needs and choices were not respected and they were denied access to their own personal space.

This was a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014 Dignity and respect.

Staff did not always treat people with respect. We saw one member of staff rush a person who was eating by giving them another mouthful, while they still had food in their mouth. At no time did the member of staff explain what they were giving them, encourage them to assist with the process or offer them a choice of what they wanted to eat. This was done with the member of staff standing over the person, instead of sitting next to them as is best practice.

Staff did not always show concern for people's wellbeing. We saw one person was left in the dining room after lunch. They had fallen asleep in the chair. We saw several members of staff walk through this area before the person was noticed and then supported to sit in a more comfortable seat.

Staff did not always take the time to provide comfort and reassurance. During the morning we saw one person was sitting in the lounge with only one slipper on, they kept telling us they wanted their other slipper but no one found it for them, until their relative visited in the afternoon when it was found under their bed. When we checked with their relatives this person had three pairs of slippers. Staff told us this person would often refuse to put both slippers on when getting dressed. Therefore they did not take appropriate notice when the person was commenting that they wanted their other slipper.

We saw people with impaired senses were not always supported appropriately. One person had lost their glasses. This increased their level of risk as they may not see obstacles clearly or what food was in front of them. We saw one person who was deaf was not able to understand the

Requires Improvement

Is the service caring?

care worker when they were asking him what he wanted to eat so they wrote it down on a serviette. This showed no thought had been given to how to communicate with this person on an ongoing basis.

We saw staff did not always treat people with respect or support people appropriately when giving out medicine. We saw a member of staff initially ask for a yoghurt to covertly give a person their medicine. However, they then dropped the tablets into the person's dinner. Other people who were given their tablets were not offered a drink to take their tablets with and there were no drinks available on the table.

This was a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 Person-centred care.

Requires Improvement

Is the service responsive?

Our findings

We identified a breach in the regulation about respecting and involving people in their care. People's involvement with developing a care plan to meet their needs was not consistent. Three people said they did not know what a care plan was while another person told us, "I am pretty sure I have one, I leave all that to my daughter." A relative said they were concerned and frustrated about the lack of communication from the home and that they were not kept up to date with the daily routine of their relative. They told us they had not been involved in the care planning and said, "No one tells us anything." They were hoping to hear the results of some recent hospital tests but could not find a member of staff who could help them.

This was a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014 Dignity and respect.

We identified a breach in the relation in relation to the care and welfare of people who used the service. Assessments had been completed prior to people's admission to the home. However, they were not fully completed and did not give a complete picture of people's needs. Some care plans had been reviewed and updated when people's needs changed. However, we found some care plans which did not reflect people's current needs. For example, one person was no longer able to sit out in a chair due to their physical health and this was recorded. However, the person was now cared for in bed throughout the 24 hour period in order to meet their needs. This meant that staff would not be fully aware of people's needs and may provide inappropriate or unsafe care.

We also saw inaccuracies in two people's care plans which could affect their care. In one care plan we saw a body map which indicated that a person had a pressure ulcer which required treatment. However, the care plan for skin care stated that areas were intact.

People's care needs were inconsistently met by staff. One person's relatives said they were happy with the care received at Kimberley Nursing Home and staff could describe people's care needs and how they liked care to be given. However, people told us and we saw that the care was not always provided when people needed it. We saw that when people asked for help they were sometimes ignored by staff. For example, staff did not always respond positively to requests when people asked to be taken to the toilet and people were left waiting and uncomfortable.

This was a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 Person-centred Care.

We identified a breach in relation to the regulation about respecting and involving people. There was an activities co-ordinator for the home. However, it was unclear how much time they were able to spend engaging people in social activities. This was due to a discrepancy between the hours they told us they worked and what the registered manager said. The more able people were pleased with the activities at the home. They said they had been out on outings to the garden centre and for Christmas shopping. People also said that they had outside entertainers who came to the home. People said they had been encouraged to pursue their hobbies they had prior to moving into the home such as knitting and crocheting.

However, this was not the view of everyone in the home. One person said, "They don't have much activities it would be nice if they did." Activities which did happen were not well planned. Half way through the morning, the activities co-ordinator told people they were going to make Christmas cards. A little later, they came in and said, "Change of plan ladies, I can't get to my cupboard, and it's all a mess in there anyway, we'll play board games in the lounge later." One person said, "We are often told we will do certain activities tomorrow, but tomorrow never comes, if you know what I mean."

Activities for people in the dementia unit happened with less frequency than in other areas of the home and they were not invited to join in with visiting entertainers. The activities coordinator was unable to tell us about any activities they had completed on the dementia unit in the two weeks prior to our visit. On the afternoon of our inspection, there were some carol singers in the home. People were encouraged to go to the main lounge to watch them. However, no one from the dementia unit was asked if they wanted to go and listen to the singing.

The registered manager had also not taken activities into account when looking at how to manage a person who

Requires Improvement

Is the service responsive?

frequently spent time walking around the dementia unit. There was no record in their care plan to identify why the person walked so much or to see if their needs could be met by an activity.

This was a breach of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2014 Dignity and respect.

People told us they did not have information on how to make a complaint and some said they would not know how to go about it. One person said "You just have to put up with it." We asked another person if they knew how to complain and they said, "No."

Relatives said they did not consistently know how to raise concerns and some said they had received no guidance on how to make a complaint. However, they did say they would talk to a member of staff if they had concerns. One relative said, "I would talk to staff I know. The staff are really helpful and if there was something I was not happy with I would raise it." However, they said, "I've not got any complaints here at all. The staff are always helpful." Another relative said they knew how to make a complaint. They said they saw the registered manager every time they visited and they would talk to the registered manager or team co-ordinator if they had any concerns.

The provider had received four complaints since April 2014. We saw that in each case the complaint had been investigated and appropriate action taken.

Requires Improvement

Is the service well-led?

Our findings

The manager had been registered as the home's manager since August 2014.

We identified a breach of the regulation in relation to how the registered manager assessed and monitored the quality of service they provided to people. Accidents and incidents were recorded in an accident book. There were no currently no procedures for investigating accidents/ incidents. If it was felt the accident needed further investigation, then this was done. However, there was no documented evidence supporting this practice. This lack of investigation and analysis meant that there was a risk that opportunities to prevent further accidents and incidents were being missed.

Some of the changes in the home had happened quickly and there seemed to be little time to embed new policies or discuss them, prior to placing them into circulation. The registered manager showed us a new policy which had been written on the day of the inspection concerning covert medication. In the process of one day this seemed to have been produced and released. Therefore no training, instruction or information had been given before the procedure was put into circulation. Therefore, there was a risk staff would still not follow the correct procedures to ensure people's rights were protected when medicine was administered without their consent.

We identified that the hoists and stand aids in the dementia unit were out of date for their services. The lifting cycles were not recorded on the hoists. This was not being picked up on audits which meant the registered manager did not have appropriate systems in place to ensure the equipment was safe to be used.

We identified a number of issues with people's care plans and medicine administration records. We did not see that these concerns had been identified by the registered manager through audits or other quality assurance processes. This meant that the registered manager did not have robust systems in place to monitor the quality of service provided.

The provider did not gather the views of people who using the home. People said they did not feel engaged to able to input into how the home was run. People told us there were no meetings or other opportunities where they could voice opinions and suggestions, nor was there a newsletter or any flow of information. The registered manager told us they had plans in place to complete a quality survey and would send it to people living at the home and health care professionals who visit the home. One person said sometimes the activities co-ordinator would ask if there was anything in particular they would like to do, although they couldn't think of anything that had actually been introduced as a result. Another person told us they had made a couple of suggestions about what they would like to see on the menu but none of the items had ever appeared.

This was a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance.

Systems and culture in the home did not promote a person centred attitude to care. For example, the registered manager referred to staff who came in to support people to eat their meal as "The Feeders." This did not promote compassion, dignity or respect for people. As the registered manager used this language they were not leading by example and staff would think it was appropriate to use such terms to describe people. The care plans did not have the names of the people on the outside of the file They were referred to as room numbers rather than the person's names. This encouraged staff to ask for a room number rather than a person, when referring to the files. Some staff was not always helpful. We observed a relative went to the office and asked a staff member for assistance with a catheter. The member of staff indicated that it was not their role; the relative was unclear who else to ask and asked for further clarity as to what colour uniform to ask. The relative was not supported to identify an appropriate person to help the person who needed attention.

Staff told us the registered manager was supportive and they were happy to raise any concerns they had with the registered manager. They were confident that the registered manager would deal with any issues raised appropriately. Staff told us that since the registered manager had been in post there had been lots of changes and improvements to the home provided. This improvement in the home was also commented on by a visiting healthcare professional we spoke with.

The provider had a whistle blowing policy in place. This ensured staff were able to raise concerns without fearing reprisals. The registered manager was supported by two

Requires Improvement

Is the service well-led?

team co-ordinators. Staff told us that when the registered manager was unavailable the team co-ordinators supported them and they took forwards any concerns staff had.

Staff attended regular staff meetings and felt able to raise issues. They said that they felt listened to and gave examples of when things had been changed as a consequence of their input. For example, the purchase of an additional piece of equipment.

Since working at the home the registered manager had identified a number of areas for improvement and we could see that they had taken action. The registered manager had identified that the layout of the home and providing care to people over such a large area impacted on the care people received. The registered manager planned to split the home into four separate units with staff allocated to each unit. They had reorganised rooms and created extra lounges and offices. Other areas of the home had also been re-decorated and people commented that the home now felt more welcoming.

The registered manager had reviewed the management and staffing arrangements in the home. They had identified the need for a deputy manager to support them and for more nursing and care staff. They were in the process of recruiting to these posts.

The registered manager took account of concerns and complaints raised. Prior to our inspection concerns had been raised with us regarding the standard of the English language of some of the care staff. We discussed this with the registered manager who said they had arranged for these staff to access English lessons to improve their language skills. People, relatives and staff told us they were able to communicate with nurses whose first language was not English and had no difficulty with being understood.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment in relation to the proper and safe management of medicines was not provided to people in a safe way. Regulation 12 (1)(2)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met: The nutritional and hydration needs of people were not met. Regulation 14.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed. Staff had not received appropriate training to enable them to carry out their duties. Regulation 18 (1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Action we have told the provider to take

How the regulation was not being met:

Care and treatment provided to people was not designed with a view to their preferences and meeting their needs.

Regulation 9 (3) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met. People were not treated with dignity and respect and did not have their autonomy and independence supported. Regulation 10 (1) (2) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision How the regulation was not being met: The provider did not have an effective system to assess, monitor and improve the quality and safety of services provided or to identify, assess and manage risks to the health, welfare and safety of people using the service. Regulation 17 (1) (2)(a)(b)