The Limes Residential Care Home Limited

The Limes Residential 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 was carried out on 7 and 10 July 2015 and was unannounced. This was our first inspection since the provider was registered with CQC to provide a regulated activity.

The Limes Residential Home is registered to provide accommodation for persons requiring nursing or personal care for a maximum of 32 people. At the time of our inspection 28 people were living at The Limes Residential Home some of whom have physical disabilities or are living with dementia.

The service had a registered manager. 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.

At The Limes care is provided on three floors. A lift is available for people to access the rooms on the upper floors. A large dining room and three lounges are located on the ground floor. The garden was well maintained and people had access to the outside areas.

Care provided at The Limes was not safe. Medicines were not managed safely and safeguarding incidents were not

Summary of findings

reported and investigated appropriately. Risks to people's health were not always assessed and action taken to reduce the risks. At times there were insufficient staff available to ensure people's needs were met in a safe way.

Whilst staff treated people with kindness, they were not always respectful when addressing people or recording information about people's needs. Staff respected people's privacy but were not always careful to protect their dignity. The provider did not ensure that the appropriate process was followed to protect people's rights when people lacked mental capacity to make some decisions.

Staff practice was not monitored effectively and some staff were not up to date with training necessary to meet people's needs. People's care plans were not always up to date. Care plan reviews were not always effective which meant people's most current needs were not always documented.

Staff were aware of the signs of possible abuse. The registered manager did not always report incidents that were notifiable to CQC or to the local authority safeguarding team. Some staff were unaware they were using unlawful restraint on people whose behaviour placed themselves and others at risk.

Checks on the suitability of staff wishing to work in the home were carried out. Complaints were responded to however the policy was not detailed enough to ensure people knew how to escalate their complaint if they wanted to.

People enjoyed the food which was plentiful and presented in an appealing way. People had a choice of main meal and several choices of dessert. People's specific dietary needs were met. A pleasant and calm atmosphere was present in the home and staff chatted with people in a relaxed manner.

Some people did not have access to meaningful activities. We have made a recommendation to the provider about this. The environment had been adapted to assist people who were living with a diagnosis of dementia and outside areas were accessible and well-maintained.

Staff responded to calls bells in a timely manner and people said staff were attentive to their needs. Staff took care to promote people's independence and provided assistance only where this was required.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

Medicines were not managed safely. There were insufficient staff to care for people's needs during the evening and at night.

Some risks to people's health and wellbeing were not assessed and action was not taken to reduce the risk. Safeguarding incidents were not investigated or reported appropriately.

Inadequate

Is the service effective?
The service was not effective.

Some staff training was not up to date and regular, effective monitoring of staff practice was not in place.

Some staff were unaware they were using unlawful restraint when caring for people.

People enjoyed the food provided. The environment had been adapted to enable people to enjoy the outside spaces safely.

Inadequate

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

People felt respected although staff did not always address them in a respectful manner.

People were not always supported in a way that respected their specific communication needs, and respected their dignity.

Staff promoted a friendly and jovial atmosphere in the home.

Requires improvement

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

People's care records were not always accurate and up to date reflecting their current needs.

The provider responded to complaints in a timely manner. Activities and day trips were arranged for people which they enjoyed.

Requires improvement

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

Notifiable incidents were not always sent to CQC.

Quality assurance checks were made on the service provided, however these were not always effective in identifying where improvements were required.

Requires improvement

Summary of findings

The registered manager was supportive to staff and available for advice and guidance.	

The Limes Residential 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 service under the Care Act 2014.

This inspection took place on 7 and 10 July 2015 and was unannounced. The inspection was carried out by two inspectors and an expert by experience in the care of the elderly. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service including notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 20 of the 28 people living in the home and six relatives. We also spoke with the registered manager, deputy manager, the administrator, seven care staff, a cook, and a maintenance staff. We spoke with two health professionals. We observed staff providing care and support to people in the lounges, and during the lunchtime meal in the dining room. We looked at care plans and associated records for eight people living in the home. We checked staff duty records, two recruitment files, records of complaints and accidents and incidents, medicine administration records, staff and residents' meeting minutes, quality assurance records and some of the provider's policies, procedures.

Inadequate

Is the service safe?

Our findings

People, and their relatives, told us they felt safe in the home. People who were able to communicate verbally said they had no concerns about their safety. One person said "Safe? They're wonderful. They fuss over me like I was a puppy" We observed care being provided in the lounges and dining room. The atmosphere was relaxed and people looked at ease.

Although people said they felt safe, people were not safeguarded from abuse. The home had a multi-agency policy for the safeguarding of adults in place, but this was not always followed. We identified four records where people had sustained an injury which had not been investigated or reported in line with the policy. Two of the injuries were sustained whilst staff were providing personal care, or were supporting the person to move; others were un-witnessed. There was no consistent approach to recording and investigating incidents to ensure people were safeguarded against the risk of abuse.

Allegations of abuse were not always taken seriously and dealt with appropriately. When a person made an allegation of financial abuse against a family member the registered manager and senior staff suggested the allegation was due to the person's "paranoia", or because they may have "a UTI [urinary tract infection]". This approach to abuse allegations did not safeguard people and was not in line with the service's safeguarding policy.

The failure to respond to allegations and record, report and investigate safeguarding incidents was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's health, safety and wellbeing were recorded in people's care records. These covered areas such as moving and handling, skin integrity and falls and were not always up to date.

Several people were at risk, and had a history, of falls. The registered manager said if someone fell and sustained a head injury, their policy was that the person should be monitored at regular times for 24 hours to ensure further complications were noted quickly and acted on. One person's accident report had a half hourly monitoring form attached. The person's health and wellbeing had been recorded as monitored for only one hour following the head injury. The registered manager and deputy manager were unsure whether the person had been monitored and no record had been made to indicate they had. The lack of monitoring did not safeguard people from the possible health complications following a head injury.

One person had a health condition that could increase their risk of falls, and had a history of falls when they moved into the home. Their risk assessment for falls referred to the health condition, but did not state what action staff could take to decrease the risk for the person.

The failure to assess, record and mitigate risks to people's health and safety was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person was cared for in bed and, to prevent the person from developing pressure injuries, a turn chart was in place. This was for staff to assist the person to reposition themselves regularly. Staff were aware of the person's repositioning needs and the record showed they were turned appropriately. Other people who were at risk of pressure injury had pressure relieving equipment in place to reduce this risk. We observed staff using equipment to assist people to move around the home. This was done safely and with due regard to people's individual limitations.

There were insufficient staff available to meet people's needs in the evening and at night. The registered manager said two staff were on duty from 8pm and either the registered manager, or the deputy manager were on call at all times. The deputy manager said staffing levels had not been reviewed for some time and during that time the needs of people had, "definitely increased". At the time of our inspection, there were 28 people in the home. The registered manager said 10, and sometimes 11, of the 28 required the support of two staff. One person was receiving end of life care, and another person was prone to aggression towards other people and staff which, according to staff, "increased in the evenings". Staff said staffing levels in the evenings were insufficient to ensure the person was monitored during this time. They said that if two staff were required to support someone upstairs, this left no staff downstairs to attend to the needs of people. One member of staff said some people who required two staff were assisted to bed before 8pm as there were only two staff available from that time. Records of care provided at night showed that on several occasions recently, two people had become confused in the night and had

wandered around the home. One person had successfully exited the building. Whilst one member of staff attempted to assist the person back into the building this left just one other to meet the needs of the remaining 27 people over three floors.

The failure to ensure staffing levels sufficient to meet people's needs was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the day there were enough staff to meet people's needs. Call bells were in place in people's bedrooms and en-suite facilities so people could summon staff assistance should they require it. The call bell had two options, the first to request assistance and the second for use in an emergency. Bells were not activated frequently, but when they were, these were attended to by staff within a reasonable time. When a person activated the emergency button, staff responded immediately. Staff were available to support people in the lounges and dining area throughout the day.

Medicines were not stored safely. The room where medicines were stored was warm and the temperature of the room was not monitored which could result in the effectiveness of the medicines being compromised.

People did not always receive their medicines when required. One person was given 'as required' (PRN) pain relief as part of the regular medicines round and was not asked if they required this. This could result in them receiving too much pain relief. No pain assessments were in use although there were several people, according to staff, who were not able to verbally communicate if they were in pain. Staff said some people used hand gestures to show they were in pain. There were no pain care plans to show how each person would indicate this.

One person's eye drops which were prescribed twice a day had only been provided once a day for five weeks. Staff said they had missed this. Another person was prescribed a cream twice daily but was recorded as receiving it once a day. Two people had been prescribed creams which were not being used, and in one case the cream could not be found in the home. One person was being given a medicine which was not detailed on their medicines administration record (MAR).

Staff said they had been trained in the administration of medicines. The registered manager said they checked staff competence following training through observations. We found records of observation were not in place for two of the four staff we checked. For staff whose competency had been checked this covered the administration of medicines only, and not the recording, stock taking, storage or use of 'as required' medicines. The lack of checks meant that staff skills and training needs between training sessions were not monitored to ensure safe medicines management in the home.

Medicines stocks were not accurate. The stocks of three medicines were found to be incorrect when compared to the records. In two cases there was an excess of the medicine and in the other some tablets were not accounted for.

The home had a medicines policy in place which staff said was based on guidance from the National Institute for Clinical Excellence (NICE). However, the policy was not comprehensive and, for example, did not cover the storage, administration and recording of creams, or guidance on the use of PRN medicines and how to respond if a person regularly refused their medicines. The policy therefore was not comprehensive enough to ensure that people received their medicines safely from staff who had been trained and assessed as competent to do so.

The failure to manage medicines safely was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People said they were satisfied with staff managing their medicines. We observed part of a medicines administration round at lunch time. Medicines were transported safely in a locked trolley and this was kept locked when staff were administering medicines to individual people. Staff followed safe procedures with a respectful, gentle and discreet approach when supporting people to take their medicines.

The registered manager carried out checks on prospective staff to check their suitability to work with older people. These included employment history, a criminal record check with the Disclosure and Barring Service (DBS) and references from previous employers. Checks were completed before staff commenced employment.

Inadequate

Is the service effective?

Our findings

People were complimentary about the staff and said their needs were met. They said, "I'm well looked-after" and, "everything is lovely". Relatives said, "[my relative] gets absolutely brilliant care", and, "they are really cared for".

Staff induction, training and supervision was not always effective. Induction for new staff was not thorough. It did not include an assessment of their work or a clear plan of training. The registered manager said new staff completed a two to three day induction if they were new to the provision of care and a 'shadowing' period in which they worked alongside other staff to get to know people living in the home. For one member of staff who started work in the home in January 2015, their induction consisted of a checklist of information such as the home's policies and procedures. They had received one supervision meeting at the beginning of their employment and none since. There was no review of their probationary period, assessment of their work, formal induction or training plan. This meant the system in place did not follow a clear process of training and assessment of competence.

Staff supervision was not frequent and some training was not up to date. The provider's policy stated staff should receive supervision six times each year and that three of these would be observations of staff practice. Records of supervision showed staff had had three supervision meetings in the past year. Specific training needs had not been identified. The member of staff who arranged training said staff, "were a bit behind" on training and records confirmed this. For example, some staff had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards in 2011. The registered manager said this training should be repeated after three years. Staff were therefore overdue for this training.

At times staff said they felt ill-prepared to support people with increasing needs. They said they were working with people who had more complex needs than ever before and sometimes they found this challenging. The people they referred to were those who had shown signs of aggression although our observations showed staff were also challenged by people who had increased communication needs due to living with dementia. Staff said they had not been trained to care for people whose behaviour put themselves or others at risk. The member of staff responsible for monitoring training told us they knew staff needed training in this area of care but there were no specific plans in place to provide it. Whilst the majority of staff had received training in the care of people living with dementia it was evident that some staff were not skilled in how to care for and communicate with people living with a diagnosis of dementia. Although all staff had completed training in the safeguarding of adults, staff supervision had failed to ensure staff were implementing this in practice.

The failure to ensure staff received appropriate induction, supervision and training was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had two policies which referred to the use of restraint and these were contradictory. One policy stated restraint would not be used in the home. The other addressed 'managing violence' and stated, 'if physical restraint is necessary it must be to the degree appropriate to the actual danger or resistance shown by the resident'. Two staff described actions they had taken when a person who lacked capacity was resistant to the delivery of personal care and had the tendency to "thrash about". Both actions amounted to restraint. The person's care plan contained no information about the use of restraint. Their risk assessment for 'aggression towards staff' stated that when the person was anxious and frustrated staff were to speak calmly and quietly and walk away from the situation as long as the person was safe and return in 10-15 minutes. The registered manager and other senior staff were not aware staff were using restraint with the person.

The failure to ensure people were not unlawfully restrained was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A lack of understanding and application of the Mental Capacity Act (MCA) 2005 code of practice amongst staff meant it could not be ascertained whether decisions were made in people's best interests. The MCA provides a legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant. Care records indicated that three people lacked capacity. However, the support the person required to enable them to make a decision, or information on how a decision was

Is the service effective?

made in their best interests, was not documented. A form was in place for staff to indicate when the person's capacity to make decisions had been reviewed. These had been signed but the deputy manager said this was to indicate the care plan had been reviewed and not the person's mental capacity.

Three people had bed rails in place as they were at risk of falling from their bed. The decision to use bed rails had been recorded which showed this had been discussed with appropriate people who knew the person and their GP, or hospital staff where appropriate. The use of bed rails was adopted as in the person's best interests as the safest way to protect them from harm. However, the person's capacity to consent to restrictive measures for their own safety had not been recorded.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Applications for a DoLS had been made for three people with the support of a local GP. Whilst the registered manager understood the process to follow with regard to DoLS, there was no record that the mental capacity of the person's concerned had been assessed.

The failure to ensure the MCA 2005 code of practice was implemented was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to maintain good health, and care records showed they had access to health care services as needed. District nurses, GPs and mental health professionals were all involved in people's care as required. People had access to chiropody and optician services and were supported to attend hospital appointments when required. A health professional said, "as soon as they see a problem they contact us".

People were provided with a variety of nutritious food and drink with choices of main meal and several choices of pudding. The lunchtime meal was provided in two sessions. People who required a specialist diet, such as pureed food, or additional support to eat and drink were served first. Staff provided support to people in a discreet and respectful manner and varied the support people received, according to their needs. For example, some people required a word of encouragement to eat whilst others needed staff to assist them to eat. People ate a good proportion of their meals and the atmosphere was calm and unhurried. Later the room was reset and people who were more independent when eating were assisted to the dining room. People chose where to sit and with whom and clothes protectors were available when people requested them.

The chef was aware of people's needs, including two people with diabetes, and provided choices so that people could still eat puddings. One person required their fluids to be thickened due to difficulties swallowing. The chef and staff knew this and made sure the person was provided with appropriately thickened drinks. Some people's care plans showed they were of low weight and staff should encourage the person to eat snacks. Their daily records of care showed they ate a sandwich before bed and staff said this was offered to everyone in the home around 9pm.

The home had been adapted to support people with needs associated with living with a diagnosis of dementia. Handrails throughout the building were painted in a bright colour to stand out from the walls and lounge chairs were brightly coloured to help people orientate themselves when sitting. Toilet doors were similarly brightly coloured so people could locate them more easily and extra lighting had been installed in the hallways.

People said they enjoyed being in the garden which was wheelchair accessible and had been adapted to support people to enjoy the outside space safely. Pathways had handrails of a bright colour, and a sensory water feature provided texture and sound. There were a variety of places for people to sit, both in the sun and shaded, and the garden was well maintained. A picnic area was provided and we saw people enjoying the outside space.

Requires improvement

Is the service caring?

Our findings

People said they were treated with kindness and that staff respected them. They said, "they're wonderful girls", "they're lovely", and "everyone's so attentive". Other comments we heard were, "I'm very happy", and "I've settled in really well. I'm very comfortable. I've made friends", "It's very good here; if it wasn't for the staff I wouldn't know what to do; they are pleasant, kind, respectful". A relative said, "I have no doubts about anyone here. They do seem to genuinely care. It's as nice an arrangement as it can be".

However, people were not always addressed, referred to or cared for with respect. Some records made by staff referred to people as, "feeds" and as being "toileted" or "commoded" which did not show respect for people's eating or continence needs. Although staff spoke to people kindly they frequently referred to people using terms such as, "love", "sweetheart", "mate" and "darling" rather than by their preferred name. For people with dementia being called by their preferred name helps them to understand they are being addressed. One staff member was observed calling out to another member of staff in an adjoining room, "can you come and sort [person's name] out". The member of staff who came to help the person did so in a discreet manner, talking calmly without drawing attention to them. However, the staff member had drawn people's attention to the person who had removed some clothing, and did not take care to protect their dignity.

Staff did not always communicate with people in a way that showed regard for their limitations. One person was very hard of hearing. Some staff said they would write things down in large letters for the person to make sure they understood what was going on, Although their care plan stated staff should assist the person this way, it did not happen during our inspection and the registered manager said the practice, "did not always work". A staff member suggested that picture cards could be used effectively with the person but these were not available in the home.

One member of staff addressed the room in which six people were sitting, four females and two males. The staff member said, "right then ladies, would you like to watch a film?" Two people responded, one said yes and the other said no as they were reading their newspaper. This did not show regard to the two males, or the other females who were in the room, and did not take into account people's hearing and communication needs. The member of staff did not offer anyone to move to a quieter area, and instead chose the film without asking people what they preferred. When the film was put on in the main lounge, people sitting elsewhere were not asked if they would like to move to watch the film. One person in an adjoining room was heard to say, "what's that film they've got on, I can't see it from here".

The failure to treat people with respect and dignity at all times was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One member of staff did effectively communicate with people with communication difficulties. One person came and asked where the toilet was. The staff member spoke clearly, using gestures to indicate that the person should follow them to the toilet. The person understood and was supported to get there. Staff appeared to be busy throughout the day, but did have time to talk to people after lunch. We saw staff chatted to one person about their upcoming holiday, and to a couple of other people about their knitting. A relative said that their father joined their mother in the home for Sunday lunch and, "[the staff] take care of him too; it's lovely".

Staff did not ensure people were always invited to join activities if they wanted to. A birthday celebration was going on, which delighted the person, and six people in the lounge were offered snacks and glass of sherry. The celebration changed the atmosphere in the lounge where it took place and people visibly brightened and became more animated, chatting to each other and sharing the snacks. Two people were in another lounge from which the singing and chat could be heard. A member of staff came into the lounge and offered one person a glass of sherry. They did not offer the other person either a drink or the snacks, nor invite them both to move to the main lounge for the celebration if they wanted to. The care plan for one of the people stated they needed encouragement to join in activities as they were at risk of social isolation. Staff failed to follow the care plan and ensure people were invited to share in social activity. We brought this to the registered manager's attention and they said they would inquire with staff why this occurred.

People's needs when they were receiving end of life care were not recorded and kept under review. One person was receiving end of life care. The registered manager said they

Requires improvement

Is the service caring?

had a 'just in case' box in the home for when it may be needed. A 'just in case' box contains all the items readily available to ensure a person's symptoms can be managed effectively and without delay., There was no care plan in place for the person's end of life needs and wishes or arrangements to ensure that the person's preferences were kept under review and acted on. Staff were unaware of the person's end of life wishes, although the care they currently provided the person was described as, "wonderful", and "couldn't be better" by the person and their relatives.

A pleasant and jovial atmosphere was promoted during the lunchtime meal. People sat in a variety of chairs and two people were supported to move to the dining room in wheeled lounge chairs which meant they could join in the social aspect of the meal. Background music played and people appeared to enjoy the meal as they chatted to one another and to staff. Staff assisted people in an unobtrusive manner and talked with people about the meal and other topics such as the weather or visitors to the home.

Staff promoted people's independence. One member of staff discreetly observed a person eating their meal, and only stepped in to provide assistance when they faltered, saying "shall I just cut that up for you, [person's name]?" The person accepted the help and the staff member then left the person to manage for as long as they could. People had adapted cutlery and crockery, such as plate-guards where they were required. As a result people's independence to eat and drink was encouraged. People told us they were able to do things alone if they wanted to, such as bathing using their en-suite facility. This was reflected in their care plan which referred to their ability to make choices and decisions, such as when to call a doctor or nurse.

People said they were involved in their care planning and that staff respected their wishes. People were able to stay in their rooms if they preferred privacy and we observed people were able to go to their rooms at any point during the day.

Requires improvement

Is the service responsive?

Our findings

People who were able to tell us said their needs were met and one relative said they were satisfied with the care their family member received. Another relative said that aspects of the care could be improved, in particular treating people as individuals with specific needs.

Staff were aware of people's needs however care plans were not always up to date and did not always address all of people's needs. One person's care records identified they could be emotional at times. There was no care plan in place for their emotional needs and when asked, two staff related different ways they tried to support the person when they became upset or distressed. Another person had had three falls between the last two dates their care plan was reviewed. There was no information for staff on how to assist the person to try and prevent further falls. Their care records stated they could "become very frustrated and cross" however, no triggers for the frustration were recorded and no care plan was in place to help staff care for the person when they were feeling frustrated. On at least one occasion the person had had a fall on a day when they had been documented as, "very aggressive".

Some people's support plans contained information on their past history and interests. Where the person was previously known to the registered manager the information was extensive. It painted a picture of the person's life before they required care and support and it was clear the person had been involved in their care planning. For other people information on their personal and social history was blank and no information had been recorded about what interests or activities the person may wish to engage in whilst in the home.

The failure to ensure that people's care records reflected their current needs and preferences and were reviewed effectively was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulation Activities) Regulations 2014.

Some activities were planned inside the home and weekly day trips were arranged for people who wished to take part. Day trips were popular and people said they enjoyed them and looked forward to them. People said they'd had cream tea in the garden recently and a summer barbeque was arranged. A large board showed external entertainers and craft sessions were booked about once a month. Some people's records showed a lack of social activity opportunities. One person's activity record showed 11 activities during a 19 week period and seven of these were recorded as "nails cleaned" or "manicure". Others were a cream tea in the garden and two outings. No other activities were recorded as offered to, or refused by the person. When we asked staff whether group activities were arranged they said they had "offered [people] all sorts of things, but it's very difficult to get them interested". Some people had their own interests, such as jigsaw puzzles or knitting. A computer was available with a large print keyboard.

We recommend the provider researches and considers adopting best practice in relation to providing meaningful activities for older people.

People said they would talk to staff or the registered manager if they had any complaints. People said, "I would complain if I wanted to; I'd speak to [the manager]. But I have no complaints", and, "I came in for six weeks, and decide to stay, so I have no complaints; if I had, I would speak to the manager or any of the girls." The provider had a complaints policy in place and information about how to complain was included in the guide in each person's room. The policy was not specific about when a person could expect a response to their complaint. The policy stated if people were not satisfied with the registered manager's response they could escalate their complaint to the provider, but the provider's contact details were not shown. The policy stated people could also contact the local authority and / or CQC but there were no telephone numbers for these. A complaint received had been responded to in a timely manner however, the response did not inform the person how to escalate their complaint if they wished to.

Requires improvement

Is the service well-led?

Our findings

People said they were asked for their opinion of the service; this was both informally and formally with the use of surveys. One person said, "they come and ask me what I want and if I am happy". The registered manager said, "we try to get the views of residents as much as possible". A relative told us they had been sent a survey to complete.

The registered manager said they monitored the quality of the service people received through audits. The medicines audit was carried out monthly and was not thorough. The most recent was recorded on 01 July 2015 and no actions were found to be necessary. The audit was limited in scope and involved checking that all medicines were in date. It did not cover the storage of medicines and staff said they thought the maintenance staff monitored the temperature of the medicines room. However, the maintenance staff said they did not do this and therefore no record was available to show medicines were kept at the appropriate temperature. The audit also did not cover the recording, handling or disposal of medicines.

The registered manager said "I don't ask my staff to do anything I wouldn't do myself". Their vision for the home was to make it, "homely, with high standards of cleanliness, respect and dignity". They said they monitored this through training and support given to staff. However, the registered manager was not aware that staff did not always reflect their vision as they provided daily care to people. Staff practice was not monitored effectively. Formal supervisions and observation of staff practice was infrequent and did not enable the registered manager or provider to be informed of areas requiring improvement. Staffing levels during the evening and night had not been monitored in the light of people's increased needs for support. Reviews of the care people required were not thorough and care records were not audited to ensure the care people received was appropriate.

The failure to effectively assess, monitor and improve the quality and safety of services was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager carried out an annual health and safety review of all areas of the home. This was supported by a weekly environmental audit where a selection of rooms and communal areas were looked at and actions were noted and completed. Staff used a maintenance record book to record repairs that were needed, and a maintenance member of staff was employed.

People's care records were not always complete and up to date. The deputy manager said they reviewed each person's care plan monthly or more often if necessary. However we found that although the review was recorded, people's current needs were not reflected in their care plans. One care plan had not been updated following the person's admission to hospital a month previously. Their needs had changed, and for example, they were no longer able to use the hoist to be supported to transfer and were cared for entirely in bed now. Another person's care plan for eating showed they were able to eat independently however, the deputy manager said the person now had their food pureed and they needed assistance from staff to eat. Their care records did not show this change to their support needs. In a further example, the deputy manager confirmed a person's moving and handling risk assessment was out of date. The person required the use of a wheelchair to mobilise whereas their risk assessment showed they could weight bear.

The failure to maintain an accurate and complete record of the care provided to each person was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers are required to inform CQC of notifiable incidents that occur in the home. The registered manager had not notified CQC, appropriately when notifiable events had taken place in the home. These included incidents of suspected abuse, and injuries sustained by people living in the home including the development of a grade four pressure injury.

The failure to notify CQC of notifiable incidents was a breach of regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

People's feedback was sought and this was acted on. Results from the residents' and relatives' survey were positive, with most areas scored as "good" or "excellent". Two people had made comments which the registered manager had acted on. These were in relation to the meals offered and the time a person was offered a cup of tea. Several relatives had written to express their thanks for the care provided to their family member whilst at the home.

Requires improvement

Is the service well-led?

Residents meetings were held twice a year, the most recent in January 2015. The recent upgrading of the garden was discussed and staff proposed to support people to use the garden more often. The garden was used by one person who was independently mobile and people said they were occasionally asked if they would like to go in to the garden, "if it was sunny".

Staff felt supported and they had access to advice when they needed it. Staff said the registered manager and deputy manager were available to assist them with guidance when they needed it. Staff could gain further qualifications if they wanted to and one member of staff said they were, "really grateful for the opportunity" to do so. Staff meetings were held regularly, the most recent in May 2015. Minutes from staff meetings showed staff were thanked for their continued hard work which was acknowledged as demanding and stressful. The registered manager reminded staff that support was available at any time from them.

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 18 HSCA (RA) Regulations 2014 Staffing **The provider did not ensure that sufficient numbers of staff were available to meet people's needs in the evening and at night; staff practice was not effectively monitored and staff training was not up to date** **Regulation 18 (1), (2) (a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider did not ensure that the MCA 2005 code of practice was implemented to protect the rights of people who lacked mental capacity** **Regulation 11 (1), (2), (3)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People were not always treated with dignity and respect** **Regulation 10 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People did not always receive appropriate care and treatment which met their needs and reflected their preferences** **Regulation 9 (1), (a),(b),(c), (3) (a),(b)**

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not effectively assess, monitor and improve the quality and safety of services** Regulation 17 (1), (2) (a), (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The provider failed to inform CQC of notifiable incidents** Regulation 18 (1), (2) (a), (e)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People who use services were not protected from abuse because safeguarding incidents were not reported and investigated; people who use services were subject to unlawful restraint Regulation 13 (1), (2), (3), (4)(b)

The enforcement action we took:
We issued a warning notice to be met by 30 September 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services did not receive safe care and treatment because risks to their health and wellbeing were not always assessed and managed; medicines were not managed safely Regulation 12 (1), (2) (a), (b) and (g)

The enforcement action we took:
We issued a warning notice to be met by 30 September 2015.