Primrose (2013) Limited

Blackdown Nursing Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 15 and 18 May 2015 and was unannounced.

We last inspected the home in November 2013 and found no breaches in the regulations we looked at.

Blackdown Nursing Home is a registered home for a maximum of 33 people. The home offers short and longer term nursing care and respite care for people with a variety of physical and mental health needs including physical disabilities and people living with dementia. There were 33 people using the service at the start of the inspection.

The home 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.

Not all risks were identified or managed to promote people's safety. Some related to safety within people's

Summary of findings

rooms and one related to the safe management of hot water. Although extensive improvement had been made to the water systems, recommendations made in 2011 toward water safety had not been followed through.

Staff did not comply with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. This was not being done and had led to people making unlawful decisions on other people's behalf.

DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The staff were aware of DoLS protection but had not taken the required steps to gain the legal authority to subject people to continuous supervision and control, including preventing them from leaving.

People's care and treatment was not designed around their needs and preferences. Staff did not involve people when they completed their care plan. Activities that would be meaningful to an individual may have not been identified or planned for. We have made a recommendation about staff training on the subject of dementia.

The provider had not ensured the service was run to maximise safety. Records were not always clear or complete and information was difficult to find. There was limited overview of safety; environmental risk assessments were not completed and incidents and accidents were not audited to look for trends and minimise risk. Policies were not completed and available for staff use.

People liked the food and they were supported to maintain a healthy diet. Concerns were followed up. However, the service had identified that meals were sometimes served too close together and had not yet resolved the problem.

Medicines were managed so people received their prescribed medicines in a safe way and when needed.

People and their families liked the staff and felt they provided good care. One said, "The nurses are good, absolutely top notch. I can't grumble, can't complain at all. I'm looked after properly." People received a standard of care which protected them from some risks, such as pressure damage, infection and accidents. Staff received training, supervision and there was constant support available to help them fulfil their roles.

People were treated with kindness and respect by staff who were concerned about their welfare and well-being. Staff responded promptly to any identified need people had, such as walking safely, helping with food and providing reassurance.

End of life care was undertaken with compassion for the person and their family and with regard to the person's dignity.

Staffing numbers were sufficient and there was flexibility in the arrangements where needed. People said call bells were answered promptly and staff were satisfied with the staffing arrangements.

The service protected people from abuse and harm. Staff understood their responsibilities and had acted to protect people were necessary. Recruitment checks were completed and the recruitment procedures should ensure that staff unsuitable to work in a care home environment were not employed.

Complaints the service had received had been investigated and where it was felt necessary an apology was given. People felt confident they could take any concern to the registered or deputy managers, provider or staff members and it would be followed up.

The provider had frequent contact with the home and provided support and resources as necessary. People and their families felt the home was well-led and expressed a lot of confidence in the registered manager (Matron). A health care professional said, "Matron has always been fantastic with patients, a wonderful nurse and a real ally to people. Very loving and kind." People and staff's views about the service were sought and plans to improve the service took their views into account. This included planning improvements for people to access the gardens and have safer outdoor space.

We found five breaches of Regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

Some risks within the home environment were not being assessed or managed, such as the risk from Legionella, emergency evacuation plans and risks within people's rooms.

Medicine management protected people but further good practice measures could be taken.

People were protected from abuse. Recruitment procedures protected people from staff unsuitable to work in a care home. People said they felt safe.

Staffing numbers and arrangements were sufficient to keep people safe.

Is the service effective?

Requires improvement

The service was not always effective.

Staff did not comply with the legal requirements to make sure people's rights were protected.

People enjoyed their food and people's dietary intake was monitored but the spacing of people's food and drinks needed attention.

Staff received training, supervision and regular support in their role. People were happy with the care they received.

Is the service caring?

Good

The service was caring.

People received kindness from staff who had a caring attitude. The registered manager received particular praise.

People were treated with respect, dignity and their privacy was upheld.

Staff provided compassionate end of life care.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's care and treatment was not designed around their needs and preferences. Staff did not collaborate with people when completing their care plan. Activities that would be meaningful to people may have not been identified or planned for.

Staff responded quickly to any identified need, such as physical and emotional support.

The complaints procedure and process had been effective.

Summary of findings

Is the service well-led?

The service was not always well-led.

Risk management systems were not sufficiently assessed or monitored to mitigate risk and ensure people's safety. Policies and procedures were not completed and adequate for staff use.

Records were not always clear or complete which had the potential to increase risk and affect decision making.

People using the service, their families and staff were happy with the way the service was run and their views about the service were sought through surveys, meetings and the regular availability of the provider.

Requires improvement 

Blackdown Nursing Home

Detailed findings

Background to this inspection

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

The inspection visit took place on 15 and 18 May 2015. The inspection team consisted of two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Not everyone was able to verbally share with us their experiences of life at the home. This was because of their dementia/complex needs. We therefore 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.

Before our inspection, we reviewed the information we held about the home, which included incident notifications they had sent us. A notification is information about important events which the service is required to tell us about by law. We received information from two people professionally involved with Blackdown Nursing Home and reviewed information held by local authority commissioners toward the inspection.

During our visit we spoke to nine people who used the service, eight people's families, 11 staff, the registered and deputy managers and the providers. We looked at records which related to six people's individual care and some medicine records. We looked at three staffing records and policies which related to the running of the home, such as equipment and utilities servicing records and risk assessments.

Requires improvement

Is the service safe?

Our findings

Not all aspects of the home environment were safe for people. Whilst some doors had the benefit of fire safety fittings others were held open by wooden wedges or other items, thus rendering them ineffective if the fire alarms activated. These had been replaced with correct fittings prior to our second visit.

Systems which should have effectively improved people's safety were not being used adequately to that effect. For example, the registered manager said that personal evacuation plans were "not up to date." Some individual room assessments had not been completed since 2008 and those which contained information about window restrictors, dated 2015, were not actually risk assessments. One person's room contained several items which could pose a risk to the person or other people who might get hold of them. Staff knew the items existed but not detail about them. There had been no risk assessment for the person themselves or other people using the service. This meant that the risk was not being measured and not being managed.

Equipment was serviced and maintained. However, the risk from Legionella was not fully managed. A survey had been undertaken by an external agency in 2011. The report recommended an 'Appropriate risk control system'. The provider confirmed this had not been done adding, "We need to get one set up." They confirmed that most of the hot water outlets were regulated and extensive work had been done to improve the water system. Also, bath temperatures were taken to reduce the possibility of scalding. However, the measurement of outlet temperatures was not done and thermostatically controlled valves were not regularly checked.

The provider said that there were plans to completely change the hot water/heating system in the near future.

Incidents and accidents were recorded but not audited. This meant there was no overview to identify where improvement could be made.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Without exception people using the service said they felt safe at Blackdown. No one could recall hearing any shouting or seeing anything that gave them concern.

Visitors also said they had not seen or heard anything that gave them concern. People said if they were worried about anything they would tell "The nurse"; "Older staff"; "Senior staff" or "Senior carer or Matron."

Staff were aware of the types of abuse and their responsibility to protect people from abuse and harm. They confirmed they received training in the safeguarding of adults.

The safeguarding and whistle blowing policies at the home set out types of abuse, how to recognise abuse and the steps which should be followed to safeguard vulnerable adults, such as working in partnership with the local authority. However, those policies were not easy to find in the three files and did not include contact telephone numbers for the agencies, such as the local authority safeguarding team. The registered manager pointed out that this information was displayed in another place but had been covered up by other information.

The registered manager and provider understood their responsibilities and where they had received information of concern about one staff member's practice, they had taken action to protect people.

The registered manager and nursing staff said that the staffing numbers could be flexible and they were based on an assessment of people's needs. Staff felt there were enough staff to meet people's needs although they added this might be affected during summer holiday times.

The home normally operated with two nurses on duty during the day and one at night. There were usually five care workers to get people up and a minimum of two on each floor and one working between floors. Staff said they were fully staffed the day of our first visit. However, one person did not receive their breakfast until 9.35am. They said this was unusual. Staff said it was because one staff member started later due to family commitments. Most staff worked a 10 hour day. Night times, from 6pm to 8am, there was one nurse and two care workers. Non care staff were a cook/chef, kitchen assistant, administrator, maintenance worker and two staff with domestic duties. There was always one staff member in each lounge during our two visits; one said this was to make sure people were safe and cared for.

Very few people said they used their call bells to ask for staff attention and those who did quoted response times of less than five minutes, with no difference day or night.

Requires improvement

Is the service safe?

People felt that staff responded to their needs quickly. However, one person was seen to have their call bell out of their reach and the nurse on duty confirmed this should not be the case.

People received their medicines as prescribed. No people using the service were managing their own medicines at the time of the inspection. Medicines were stored in one of two locked and secure areas. Those areas did not appear to be overly warm but there was no record of the temperature of the cupboards to ensure manufacturer's storage guidelines were being followed. Specialist storage was in place for medicines requiring refrigeration and those requiring other, more secure storage.

Medicines were ordered and checked into the home on a weekly basis as part of their audit of use. A nurse confirmed that any additional medicines required would be delivered quickly to the home so they could be started. This might include antibiotic therapy.

Nursing staff administered medicines. One said they had received training for the specific administration method used at the home. They confirmed that currently no person was receiving covert medicines and that, should this be necessary, it would involve family and GP agreement.

Staff used codes to indicate why a medicine might not be taken, for example, if not required for pain relief. Some medicines were administered as patches to the skin which needed to be positioned on different areas of the body when changed. However, no system, such as body mapping, was in place for this to reduce the risk from using the same area of skin. The nurse said this could easily be implemented.

Medicine records were orderly and complete and included records of medicines which had not been used. The service contracted removal of medicines to a specialist firm.

There were recruitment and selection processes in place. Staff files for the most recently recruited staff included completed application forms and a record that interviews had been undertaken. In addition, pre-employment checks were done, which included references from previous employers, health screening and Disclosure and Barring Service (DBS) checks completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Recently recruited staff confirmed they were unable to start at the home until all the checks were completed. The registered manager said staff did not enter the home, even for induction training, until it was confirmed they were safe to work in a care home environment. There was a system in place to ensure qualified nursing staff were registered and that their registration was maintained.

Requires improvement

Is the service effective?

Our findings

Before people received any care and treatment they were asked for their consent and staff acted in accordance with their wishes. Throughout our visit we saw staff involving people in their care and allowing them time to make their wishes known through the use of individual cues, such as looking for a person's facial expressions, body language and spoken word. People's individual wishes were acted upon, such as how they wanted to spend their time and whether they wanted help with personal care.

Staff demonstrated some understanding of Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and how these applied to their practice. They had also received training on both subjects. However, both the MCA and DoLS were not being appropriately followed when complex decisions needed to be made, such as whether a person should receive care and treatment in a locked environment as the least restrictive option. For example, there were no decision-specific, time-specific capacity assessments completed for this. The MCA provides the 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 is made involving people who know the person well and other professionals, where relevant.

People had Lasting Power of Attorneys or Court of Protection deputyships for property and financial affairs. A Lasting Power of Attorney (LPA) is a way of giving someone a person trusts the legal authority to make decisions on their behalf, if they are unable to at some time in the future. This is similar for the Court of Protection, when someone becomes a 'deputy' to act on a person's behalf. However, attorneys were consenting to care and treatment on people's behalf without the legal authority to do so. For example, consent to treatment plans and consent for a person to be cared for in a locked area for their safety and wellbeing. For someone to make decision about care and treatment they need to also be a LPA for health and welfare. Then they can make decisions about, for instance, where a person should live and medical care. This meant that consent was not being sought in line with the MCA.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not assessed people who may be at risk of being deprived of their liberty. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. These safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests. The Supreme Court judgement of 19 March 2014 confirmed that if a person lacking capacity to consent to the arrangements required to give necessary care or treatment is subject to continuous or complete supervision and control and not free to leave, they are deprived of their liberty.

People had not had mental capacity assessments to consider whether they were being deprived of their liberty in any way. This meant that their freedom was restricted as they required staff to support them continuously and most areas of the home were locked with the intention of keeping people safe. The registered manager had identified that people needed mental capacity assessments and possible DoLS authorisations. They had liaised with the local authority and been told not to put all applications in at once due to a back log of applications they were dealing with. Despite being told this, they had not made any applications for any of the people living at the home at the time of our inspection. The MCA and DoLS policy was displayed in the staff room as 'policy of the month May and June 2015. The policy had been reviewed in 2013. This was not up to date to reflect the Supreme Court judgement of March 2014.

We did not observe any person actively trying to leave the home or distressed by the use of locked, coded doors. Staff said they would escort any person who wished to pass through one of the doors and one person was seen to receive that support. However, this meant that person was under complete supervision without lawful authority.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoke positively about the food. Their comments included, "The food is lovely; I eat it all. I've got a good appetite"; "The food is good. Nothing wrong with the food here"; "The food is very nice but I do miss seafood which I really like" and "The food is lovely, always hot and we get plenty of it. The chefs/cook are good." No one could recall being asked what their favourite meal was but some information about preferences was recorded in people's

Is the service effective?

care files and the chef also had some information about this. The first day of the inspection lunch was a choice of fish and chips with peas and carrots or egg and chips, with stewed apple and custard. Lunch was mainly meat and vegetables with a broader range of meals available for the supper meal. One person said how they always had a full English breakfast, which they enjoyed, because they had difficulty maintaining their weight.

Meals were well presented and people seemed to enjoy them. Assistance was given by care workers who sat alongside people engaging with them. People who required assistance received their meal before the meal was served for other people. This was so staff could be sure those people needing assistance with eating had the time they required.

Drinks were available throughout the day in the lounges and people had a jug of water available in their room.

People may not have been receiving their food and fluids over an adequate period of time. For example, one person did not receive their breakfast until 9.35am and lunch was served between 12 midday and 12.30pm. Records of a staff meeting showed that this situation was recognised in December 2014 but the registered manager said they were still not sure how it could be improved upon. Food and fluid monitoring was not detailed enough to confirm people had sufficient diet over a period of time. This was in part because the recording form the staff used only provided a space to record diet taken at: breakfast; lunch; supper and snacks/supplements but no times were included. One person on 16 May 2015 had porridge for breakfast, two cakes as 'snacks' and only 300mls of drink recorded. They had refused two meals. We questioned whether they had been offered other food and whether drinks were offered when they were repositioned two hourly during the night time. This could not be confirmed by the registered manager.

One person, on a specialist feeding regime, had their fluid levels recorded in detail. People's weight was monitored and food supplements were prescribed where the need for these was identified. We saw from two records that people's weight was being adequately maintained.

People and their families said they received the care and treatment they needed and were aware that a doctor would be called by staff if needed. Records confirmed that advice and expertise were sought from external health care professionals, such as psychiatrists and community psychiatric nurses. Health care professionals felt the home might not involve staff from the palliative care team as readily as they might. No example was provided and the registered manager felt this was not the case.

People were aware that a dentist and podiatrist visited on a regular basis. One person said they continued to attend their own dentist and optician. The current monthly newsletter advised that an optician visits the home every six months.

People said they were satisfied the staff were well trained, although they felt newcomers to the staff were less well trained. One person said, "They do vary, some are very good." Another person said, "The nurses are good, absolutely top notch. I can't grumble, can't complain at all. I'm looked after properly."

Staff described a comprehensive induction to the home and the nationally recognised induction standards were used for staff induction. Staff said they were satisfied with the training they received, which included subjects related to health and safety, such as food hygiene, moving people safely and infection control. Training relevant to health conditions was provided such as dementia care. One staff said they had requested training in the care of people with diabetes and a nurse said training they requested had been provided. People's physical care needs, such as catheter care, were taught by senior care workers or nursing staff. Peopled were encouraged to undertake qualifications in care and we met an external assessor who came to work with staff on this.

Planned mandatory training was displayed for staff, including a training matrix. A 'policy of the month' provided a focus for staff information and was also displayed. Nursing staff said they had the opportunity to meet their training needs so as to maintain their registration and competence.

Staff said they received the support they needed, which included regular supervision of their work and shadowing experienced care workers when necessary. The purpose of individual staff supervision is to provide a regular opportunity to discuss the performance of each staff member and future training and development. There was a programme of staff supervision in place which was led by the deputy manager. Staff said the supervision

Requires improvement

Is the service effective?

arrangements were useful and they could influence the agenda to include what mattered to them. One staff member said the training they had requested at their supervision was now being arranged.

Good

Is the service caring?

Our findings

People said the staff were kind and caring. Their comments included, “Staff are very mannerly. I get on fine with everybody”; “The staff are very good” and “The staff are very caring and kind. They are fun and jolly with you.”

A health care professional said of the registered manager (Matron), “Matron has always been fantastic with patients, a wonderful nurse and a real ally to people. Very loving and kind.”

Staff described a concern for people’s wellbeing and this was supported by observing them engaging with people in a caring manner, for example, sitting chatting with people. Staff talked about the positive experience of caring for people, one saying, “(People) have had such fantastic lives and you have to make them feel they are really precious.” Staff were quick to engage with people to relieve any anxiety. One person, frequently walking but unsteady on their feet, was accompanied by a care worker in a friendly manner.

Staff readily provided information for people, telling them what was happening and why. Where people were more able to be involved in decision making that involvement was promoted. For example, two people chose to play the piano during the inspection and both were assisted to do so when they wanted to.

People received their personal care in private and staff were polite and respectful as they supported people. It was unclear whether people actually influenced which gender of staff provided their personal care. The home benefitted from a mixed gender staff group but male staff were providing intimate care to female clients, and vice versa. The registered manager and staff explained that, if any information indicated people had a preference this would be recorded.

People felt they were listened to and staff took the necessary actions to meet any requests. All interactions seen between staff and people using the service were calm, with normal levels of speech and good use of diversion tactics when necessary. Staff showed an understanding of people and how their health condition affected them.

There were many visitors to the home and visitors said they could visit without restriction and were welcomed. Family were supported to be involved with people’s care if they wanted this. One person said, “I am very involved in my husband’s care. I can come up any time.”

People received end of life care with dignity and compassion. A health care professional said of a recently deceased person, “The family couldn’t fault the care – well cared for”. They felt the staff provided “basic end of life care; kindness, respect and empathy with the family”.

During the inspection staff were very attentive to one person whose wellbeing was a concern. The nurse in charge said, “They need a more regular eye on them.” The nurse ensured the person received effective pain relief and fluids; they regularly monitored the person’s needs. The nurse explained how, in anticipation of end of life care, medicines were in place for pain and anxiety relief for that person. The nurse was prioritising that person’s care and providing support and information to their family.

Requires improvement

Is the service responsive?

Our findings

People's care records did not ensure they received person centred care. Care plans are a tool used to inform and direct staff about people's health and social care needs and each person at Backdown Nursing Home had a care plan. However, they were not person centred in that there was very little information about each person as an individual and how to meet their individual needs. The Alzheimer's Society says: 'Everyone affected by dementia has a unique story to tell'. Those stories were not evident at Blackdown, which meant that staff would be less informed and able to engage with people in a way which was meaningful to the person. For example, with an understanding of their past life and what mattered to them. We recommend that the service finds out more about training for staff, based on current best practice, in relation to the specialist needs of people living with dementia.

Care plans did not always provide the information needed for staff to deliver the care in a safe and consistent way. For example, staff were unaware exactly which medicaments one person had in their drawer and there was no plan how to manage the situation. One care plan was confusing in that the section which should have been the care plan, which was referred to as the plan for staff to follow, was actually the evaluation and not directions for staff to follow. The nurse on duty said, "The plan is not there."

Most people using the service would be unable to communicate their views verbally and one person's family said they were unaware of any care plan. Of the six care plans we saw there was no evidence that people had been involved in their care or their views sought about their current care needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were responsive to people's day to day needs. People's families said, "Staff react quickly to requests and people are not kept waiting to go to the toilet" and "I know (my family member) can be very difficult and the care here is excellent. The staff here react to his needs straight away." One staff member was able to respond in the person's native language, Spanish.

Some people said there was not much to do at Blackdown so they preferred to remain in their room, reading books, newspapers or watching the television. Others said that when the weather was suitable they enjoyed walking around the gardens surrounding the home. Two people using the service were accomplished musicians and made regular use of the home's electric piano. A hairdresser attended one day a week. One person said, "The staff will get shopping for me and take me to Tavistock." There were some photographs and some previous craft work displayed. However, there was no evidence of activities planned to meet people's social, physical and emotional needs, based on an assessment of those needs, on a regular basis.

The current monthly newsletter announced the appointment of a new activities coordinator who would be at the home two days a week. No activities took place for the majority of people during the inspection visits although some entertainment and summer events were advertised.

Complaints and concerns were listened and responded to. Most people said they knew how to make a complaint and would speak to "Matron" or a senior member of staff. Only one person said they had made a complaint and confirmed they were happy with the outcome. One person's family said, "Anything I'm not pleased with Matron will look into it." An example showed that one person's complaint, having been substantiated, led to an apology by the provider and an assurance there would be no repeat.

Requires improvement

Is the service well-led?

Our findings

Systems and processes were not sufficient to enable the provider to identify where safety was being compromised. For example, risk assessments relating to people's rooms were not undertaken. A recommendation from an external company relating to risks from water storage had not led to a system for regular checks of the water system. There was no formal system in place to make an overview of incidents and accidents at the home although accident records were in themselves checked by the registered manager. The registered manager said the quality monitoring arrangements for the home consisted of an audit of all care plans "approximately monthly" and a weekly medicine records audited at the time medicines were checked into the home.

There was insufficient overview of how the service was delivered and action had not been taken to meet legal requirements where this was required. Examples included, people being unlawfully deprived of their liberty and staff not complying with the Mental Capacity Act 2005. Whilst the registered manager was aware of her responsibilities those responsibilities were not being met and the provider had not checked the service was complying with the legislation.

Policies and procedures, which should support staff knowledge and understanding, were not complete. Those we were shown were a standardised format which had not been made service specific and therefore lacked some information. For example, where there were gaps for inclusion of local addresses and telephone numbers these were not included. Neither were individual policies easy to find within the three folders. The provider said he had not yet completed the policies because of the many hours work to do this properly. Also, other professionals needed to have their input and this took time. Following the inspection we were told there was an "old file" at the home which was being replaced.

Inspectors found it was not possible to confirm the actual care people were meant to receive based on the care plan information, some of which was historic, for example, going back to 2011. We observed both the registered manager and a nurse looking for information in care plans which we asked about; neither seemed to be sure about finding it. This had the potential to affect the care people received. One health care professional described the record keeping at Blackdown Nursing Home as a "chronic weakness" and records of a professional visit during 2014 also described inadequate record keeping. The registered manager said the information which was available was up to date.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Positive comments about the home included, "I am delighted to be here in good company. This is a lovely place and I am very happy"; "I enjoy it here. Everybody here seems to get on with one another. ; "I don't know what they could do to improve it" and "This is the best home I know of and I am very content for my (family member) to be here." We received one negative comment relating to a person's hygiene needs.

The registered manager, known as Matron, was in post for 10 years. One person said, "I'm quite fond of her." A person's family said, "The Matron is one of the old school. It's a pleasure to see her around." People said they were satisfied with the way the home was led by her. Matron was supported by a deputy manager and the registered providers make regular visits to the home and were known to many of the people using the service.

Staff felt the home was well-led. Their comments included, "Anything we need to know or ask is given"; "We can go straight to management and they listen" and "We all work together really well." One said, "I love every minute of it." They said they were able to contribute to staff meetings and they felt valued.

People's opinion was sought toward continuing improvement of the service. No people using the service could recall being invited to complete a survey or attend a resident's meeting but three people's families said they had completed a survey at some point. A notice thanked people who had completed recent surveys and announced that an 'annual residents' meeting would be held on 17 June. The registered manager said the previous survey was conducted at the end of 2014 and they were conducted yearly. Most of the feedback was very positive but there was mention about the grounds and more use being made of them. The residents meeting in June was to discuss the plans for the grounds, and possibly summerhouse, which included having direct access from one of the two lounge areas in frequent use.

Requires improvement

Is the service well-led?

Surveys received in January 2015 included health care professionals who knew the home and received positive responses.

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 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **People did not always give consent for care and treatment and the provider did not act in accordance with the Mental Capacity Act 2005.** Regulation 11, (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People were not adequately protected through assessment and mitigation of risks to their health and safety.** Regulation 12, (1) (2) (a) (b) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People did not received person-centred care designed around them as individuals.** Regulation 9, (1) (b) (c) (3) (a) (b) (c) (d) (e) (f) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **People must not be deprived of their liberty without lawful authority.** Regulation 13 (5)

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 operate effective systems to ensure risk was managed and was not ensuring records were clear and complete. Regulation 17, (1) (2)(c)

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.