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Southdown Nursing Home

Inspection report

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Inadequate



Is the service effective?

Requires improvement



Is the service caring?

Requires improvement



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

This inspection took place on 1 and 9 April 2015 and was unannounced. At our previous inspection on 11 June 2013, the service was meeting all the regulations we inspected.

Southdown Nursing Home provides accommodation and nursing care for up to 23 people. At the time of our visit, there were 20 people using the service including some people with specialist care needs relating to dementia, strokes, diabetes and other conditions. The service is owned by an individual provider who also fulfils the manager's role. It does not therefore require a registered manager.

We found several safety concerns at the home, including a failure to address and manage risks relating to individuals and the service as a whole. Risks around bed rails, falls and building work being carried out at the home had not been adequately assessed, meaning that people were at risk of coming to harm and at least one person had sustained a serious injury as a result. The service did not have a robust accidents and incident monitoring system, so there was no clear way for the provider to identify trends and learn from these to prevent future incidents. We are taking action against the provider and will report on this when we complete our action.

Summary of findings

We also found that fire evacuation procedures were not clear and that staff did not have the information they needed to know how to keep people safe in the event of a fire. Some areas of the home were not sufficiently clean to safeguard people from the risk of infection.

Medicines were managed in ways designed to keep people safe from the risks of inappropriate administration and storage of medicines.

We recommend that the provider consult national guidance about staffing levels and develop a system to monitor the levels required in the home in relation to people's needs.

Consent to care and treatment was not always sought in a way that followed legal requirements. Sometimes, relatives were asked to make decisions on behalf of people who used the service, including medical decisions, where the law required other procedures to be followed. Assessments were not always carried out to decide whether people had the capacity to make their own decisions about their care. This meant that people were at risk of receiving care that was inappropriate for them or not in their best interests.

People felt that the food choices were adequate but did not get opportunities to suggest items for the menu. Some people may have been at risk of malnutrition because these risks were not adequately managed and their food intake was not monitored. People received appropriate support to access healthcare professionals when required.

Staff received enough training, supervision and support to carry out their roles effectively.

People gave us positive feedback about staff, saying they were kind and respectful. Staff supported people's cultural needs, for example by encouraging families to bring in food for their relatives. People were involved in reviewing their care plans, although there was no evidence that they were involved in initial assessment and care planning processes.

People and their relatives fed back that staff respected and promoted people's privacy and dignity. The service used an evidence-based framework for supporting people's end of life care needs and this helped them to

ensure people were comfortable at the end of their lives and their care was managed in a dignified way. Some of the language used in care plans did not promote people's dignity, however.

Some assessments of people's needs were not carried out regularly, which meant that people were at risk of receiving care and support that did not take their changing needs into account. Records were not sufficiently detailed to provide evidence that people were receiving appropriate care and support according to their care plans. Care plans were not sufficiently personalised, which meant that staff did not always have the information they needed to ensure that each person was receiving individual care that was appropriate for them.

Relatives felt that there were not enough planned activities at the home and people told us they would like to go out for day trips and activities in the community but the service did not support this. Sometimes people's religious needs were not met. The service did not keep records of the activities people took part in so we were unable to find sufficient evidence that people's needs were met in this area.

People and their relatives knew who to speak to if they had any concerns or complaints. They told us the provider was responsive to their concerns and we saw evidence that complaints were addressed appropriately. Staff did not always document minor concerns, which meant the provider did not have a system to monitor these and identify any trends.

We received mixed feedback about the leadership of the service. Some people said the provider was approachable and easily available, but others said communication from the provider and senior staff could be improved. Relatives told us they had opportunities to give feedback at meetings, but people who used the service said they were not aware of these.

We saw some questionnaires from a survey the provider was carrying out during our visit. They told us they were going to use the feedback to help them improve the service. The provider demonstrated some improvements they had begun to work on.

Summary of findings

The provider used audits to measure and monitor the quality of the service, but these were not always effective because some of the identified areas for improvement were not addressed and some of the problems we found were not picked up.

The provider failed to notify us of events that they are required by law to tell us about, including when people who use the service die.

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 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. Risks to people and the service were not adequately assessed or managed and at least one person had sustained a serious injury as a result. There was not an adequate system to identify any trends in accidents and incidents. Parts of the house were dirty and presented risks in respect of the spread of infection.

There were not sufficiently robust systems to check that staff were suitable to provide safe care to people.

Medicines were managed adequately. People felt safe from abuse and discrimination and there were procedures in place to identify and report these.

Inadequate



Is the service effective?

The service was not consistently effective. The provider did not always follow the correct legal procedures to ensure people's rights were protected when they did not have the mental capacity to consent to decisions about their care.

People told us the food provided at the home was of an acceptable standard. However, the provider did not take sufficient steps to ensure people were protected from the risks of malnutrition. Care plans did not contain enough information to ensure this. People's dietary intake was not monitored when they may have been at risk of malnutrition.

Staff received sufficient support and training to equip them with the knowledge and skills they required.

People received appropriate support to see healthcare professionals when needed.

Requires improvement



Is the service caring?

The service was not consistently caring. Some people told us they were not always kept informed about changes within the home and we did not find evidence that people were involved in their initial care planning. However, people were involved when care plans were reviewed and their views were recorded. People spoke positively about the caring nature of staff.

Staff respected people's privacy and dignity when providing personal care. However, some language used in care plans did not support people's dignity or personal views.

The service followed a care framework designed to ensure that people received good quality care around the end of their lives.

Requires improvement



Summary of findings

Is the service responsive?

The service was not consistently responsive. Care plans were not sufficiently personalised and sometimes lacked information staff needed to respond to people's individual needs. Records were not always sufficiently detailed.

Some assessments were not regularly reviewed to ensure care plans were up to date. People's care plans were regularly reviewed, however.

Relatives fed back that people did not always have enough activities to do and people told us they were not supported to do activities outside the home. People's religious or spiritual needs were not always met.

People knew how to complain and the provider responded appropriately to complaints.

Requires improvement



Is the service well-led?

The service was not consistently well-led. The provider failed to report events they are required by law to notify us about.

Some relatives felt that the provider was approachable and easily available. Others felt that communication from the provider should be improved.

The provider collected feedback about the service from people and relatives and planned to use this to improve the service. They carried out audits of the quality of the service but these were not always effective.

Requires improvement



Southdown 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.

This inspection took place on 1 and 9 April 2015 and was unannounced. It was carried out by one inspector.

Before the inspection, we discussed the service with representatives of local authority and clinical

commissioning groups and local authority safeguarding teams. We reviewed the information we held about the service, including previous inspection reports and notifications that the provider is required by law to send us about specific incidents and events.

During the inspection, we spoke with four people who used the service and three relatives of people who used the service. We spoke with four members of staff, a visiting social worker, a visiting healthcare professional and the provider. We looked at four people's care plans and six staff files and we observed staff interacting with people who used the service.

Is the service safe?

Our findings

The provider did not always adequately address risks to people to protect them from harm. Some people used beds that had rails attached to reduce the risks of them falling out of bed, but we found no assessments of the risks associated with these. One person had sustained a serious injury as a result of trapping their finger in their bed rails seven months before our visit, but there was no information in their care plan about how staff should support the person or others using bed rails to prevent this from happening again. The provider did not send a notification to CQC about this incident, as they are required to do. Staff had recorded injuries to the person's hands on three previous occasions within the last two years, but there was no evidence that this information had been used to assess and manage the risks. The provider told us they would put appropriate risk assessments in place.

Another person's care plan stated that they were at high risk of falls and required assistance to move from place to place, but there was no information about what assistance and equipment the person required. This meant there was a risk that staff did not have the information they needed to support people safely. A third care plan stated that to prevent the person from falling, staff should always "identify [the person]'s risk hazards." There was no information about what the hazards were for this person, how staff should identify them or how they should respond. This lack of information put people at risk of receiving care and support that was not safe or appropriate for them.

At the time of our visit, the home was undergoing renovation work which had been ongoing for five months in communal areas. Most people we spoke with felt the building work was well managed in a way that kept them safe, although one said the work was too noisy. However, our findings did not confirm that the work was carried out in a safe way. The provider had not carried out a risk assessment of the impact this would have on people and their quality of life. Risks such as those associated with dust and dirt, builders' equipment, noise, distress caused to those with impairments in their short term memory or orientation and people becoming isolated by spending more time alone in their bedrooms had not been considered, although temporary walls were in place to prevent people entering the building site itself. We saw building materials and wire stored in an unattended

corridor where people could trip or otherwise injure themselves on them. There was a risk of people's mental or physical health being affected or of people otherwise coming to harm because these risks had not been managed appropriately. The provider told us they were in the process of creating a risk assessment.

We saw that the floor covering in the centre of one person's room was coming loose and was raised above the level of the rest of the floor. There was therefore a risk that the person or others entering their room could trip on this and sustain injury. The provider told us they had a full refurbishment of the home planned, but had not taken appropriate steps to address immediate risks.

People told us fire doors throughout the home had recently been replaced and they felt this would keep them safer in the event of a fire. We saw evidence that the Fire Brigade had already visited the home and sent a report to the provider, in which they were told to make some improvements. There was evidence that the provider had made some changes by the time of our visit. However, people did not know what they should do if there were a fire in the home and told us they would have to rely on staff as they were not sure what the procedure was. Care plans did not contain personalised evacuation plans and staff we spoke with told us they would evacuate people according to general guidelines in the event of a fire. They told us they had done fire drills but that these did not involve supporting people to leave the home. Staff gave inconsistent responses or were unsure when asked how they would support a specific person who had limited mobility. There was therefore a risk that staff were not sufficiently knowledgeable about how to support people to keep them safe in the event of a fire.

The service kept records of accidents and incidents, but did not have systems to record and investigate minor injuries such as bruises. These were recorded in people's daily notes, with no systems to ensure management investigations where necessary. We also found no record of an incident where a person sustained a serious injury from their bed rails, which showed that systems used to record and monitor incidents were not effective.

There were not sufficient measures in place to protect people from the risks of the spread of infection and poor hygiene. We observed that a communal bath and a hallway carpet were both visibly dirty and there were brown stains on a commode. The clinical waste bin in the bathroom did

Is the service safe?

not contain a bag, which meant that clinical waste could not be safely contained in it. People told us they had no particular concerns about cleanliness, although one person told us bathrooms were “clean one minute, the next dirty.”

The above issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staff files and saw that the provider had carried out checks on new staff such as criminal record checks and evidence of qualifications. However, the checks were not sufficiently robust because the provider did not ask staff to specify their relationship to the referees they supplied or dates of previous employment. It is a requirement under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for providers to obtain information about employment history including explanations of any gaps, along with satisfactory evidence of employees’ conduct in previous jobs. The information they collected was not detailed enough to meet this requirement and meant people were at risk from being cared for by unsuitable staff.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe using the service and had no concerns about discrimination or abuse. One person said, “I’d be able to say [if there were concerns about abuse] but nothing is wrong.” Another said, “I’d be happy to report any concerns.” We saw evidence in staff files that staff received training in safeguarding people from abuse, although none of the six staff whose files we checked had refresher training within the last two years. There may therefore have been a risk that some staff did not have up to date knowledge in this area. However, staff we spoke with were able to describe different types of abuse and how to identify them. They were aware of the whistleblowing policy they could use if they felt the provider was implicated or did not respond appropriately, but some staff were not clear about the reporting procedures. One member of staff told us they would report concerns to their line manager, whilst another said they would talk to the alleged victim and deal with the concern as a team. This meant there was a risk that abuse would not be reported to the relevant authorities or investigated appropriately to protect the alleged victim and others from future abuse.

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

People we spoke with were happy with the way their medicines were managed and given to them. We looked at medicines administration records for five people and saw that these were completed appropriately with any gaps in the records satisfactorily explained. Medicines were appropriately stored. We checked a selection of medicines and found they were all within their expiry dates and kept in their original packaging with pharmacy labels to help prevent errors. The service had a medicines policy that included the use of controlled drugs. Controlled drugs were appropriately stored in a secure location and we found records were accurate, up to date and signed by two nurses as required to protect people from the risks associated with the mishandling of these medicines. The service had appropriate policies and procedures in place to guide staff in relation to medicines management, and we saw evidence that the service received audit visits from a pharmacist and carried out its own medicines audits regularly. No significant issues had been identified at the last pharmacy visit in August 2014.

Staff told us, and rotas confirmed, that the staffing levels set by the provider were met and there was always a qualified nurse on shift. We saw that one person was always accompanied by a member of staff during our visit. Staff told us this was because the person needed one-to-one care and this was additional to the set staffing levels. People told us staff were “pretty quick” to respond when they needed assistance, but felt the service needed more staff on duty. Relatives and visiting professionals also expressed concerns that the set staffing levels were not sufficient to provide a high standard of care, although they felt there were enough to keep people safe. The provider told us they were able to increase staffing levels if people needed higher levels of support, such as when several people were receiving end of life care. However, they did not have a formal system in place to assess the needs of the people using the service in terms of staffing.

We recommend that the provider consult national guidance about staffing levels and develop a system to monitor the levels required in the home in relation to people’s needs.

Is the service effective?

Our findings

Consent to care and treatment was not always sought in line with legislation and guidance, which meant that people were at risk of receiving care that was not in their best interests. The provider told us that some people did not have the capacity to consent to certain aspects of their care such as having rails on their beds. Whilst these reduced the risks of people falling from their bed, they also restricted their freedom. The provider said that in these cases, people's relatives had consented on their behalf. However, the Mental Capacity Act 2005 (MCA) Code of Practice states that people's capacity to consent to any such decision should be assumed unless demonstrated otherwise by an assessment of mental capacity. It also states that no adult can give consent on behalf of another unless they have legal arrangements in place to do so, and that in cases such as these a documented meeting should be held with those responsible for the person's care and welfare (such as doctors and social workers) to decide whether the proposed action is in the person's best interests.

We saw some examples of mental capacity assessments about some decisions where the person was found not to have the capacity to consent and that the decision taken involved their family. For other decisions there was no evidence that any mental capacity assessments or best interests meetings had taken place, and no evidence that the service had checked whether relatives had legal arrangements in place to consent on behalf of their relatives.

We also found that the provider had not followed relevant guidance such as the MCA Code of Practice around making decisions about whether people should be resuscitated in the event of cardiac arrest. One person had a Do Not Attempt Resuscitation (DNAR) form in place, which had only been signed by a relative. There was no evidence that this relative had legal arrangements in place to entitle them to make such decisions on behalf of their family member and there was no evidence that the person's GP or other medical professional had been involved in this decision about the person's medical care. The form stated that the person had not been involved in the decision because they were "not mentally competent" but there was no justification for this such as an assessment of their mental capacity. Furthermore, the decision had not been reviewed

since 2011, during which time the person's medical circumstances may have changed. There was therefore a risk that the person would not receive appropriate treatment in a life-or-death situation and their rights upheld because the relevant procedures had not been followed.

People were sometimes deprived of their liberty without the correct procedures being put in place. The Deprivation of Liberty Safeguards (DoLS) are designed to ensure that, when a person's freedom is restricted as part of their planned care, this is done in such a way as to protect their rights in line with legal requirements. We found several restrictions to people's liberty including locked doors, restrictive bed rails and one person who was under continuous supervision and control as part of a one-to-one care plan. The provider showed us evidence that they had recently made applications to the local authority for DoLS assessments for three people, including the person receiving one-to-one care, but the provider was not able to explain why these had been delayed and applications had not been made for all people who may have been having their liberty deprived unlawfully.

The above issues were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not actively seek people's views on menu planning. People's comments to us about the food included that it was "basic but nice" and "better lately." They said they had a choice of main meals from a menu. Staff told us that the menu was set and they did not ask people to suggest meals they liked, but there were always options for people to choose from. People told us about certain dishes they would like to have, but never saw on the menu. One person said they had mentioned they would like a specific dish a number of times to staff but had not had it.

We saw evidence that the service sought and followed advice and guidance from professionals such as dietitians and speech and language therapists about meeting people's nutritional needs. This included the use of food supplements and preparing foods to different consistencies to meet people's needs. However, we also found that people did not have personalised nutritional risk assessments and management plans in place, even when they had previously required input from relevant healthcare professionals. We did not see any personalised

Is the service effective?

information in care plans about people's likes and dislikes and weight loss prevention guidelines were generic and did not take into account individual factors. This meant that the nutritional needs of people who may have been at risk of malnutrition could have been overlooked.

Additionally, we noted that daily records of care did not often contain any details of what people had eaten or how much, instead containing less specific information such as "adequate food and drinks." This meant the provider did not have sufficient information to monitor trends in people's eating patterns, which could be indicative of changes in their health status, risks or, particularly if people did not communicate verbally, their food preferences.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives and visiting professionals told us staff were knowledgeable about the people they worked with, which helped them provide effective care. Staff received a range of training, including an annual update on best practice in caring for people living with dementia, to help them deliver care effectively. We saw a copy of induction materials,

including policies and procedures and values staff were expected to adhere to, that staff were required to read at the start of their employment. Staff received regular supervision to monitor their progress against set targets.

Staff confirmed that they had an induction period, during which they worked alongside more experienced staff for some time before they were expected to care for people alone. The provider told us this should be for a week, but was sometimes shorter if staff were absent due to sickness. We saw records demonstrating that staff received annual appraisals, which covered what they did well, areas for improvement, training needs and objectives over the next year. This was designed to help staff develop in their roles and gain the knowledge and skills they needed to deliver effective care.

People said they were satisfied with the support they received to access healthcare professionals such as opticians and chiropodists. We saw documentary evidence to support what people told us about seeing healthcare professionals regularly and when needed. Some people had personalised information in their care plans about how to meet specific healthcare needs according to advice from professionals.

Is the service caring?

Our findings

Whilst people's feedback about the caring nature of staff was positive, including comments that the staff were "lovely and friendly" and "all very sweet," we found that some of the practices within the service were not caring.

One relative told us the staff were "all very caring." Staff talked about developing caring relationships with people from different cultural backgrounds by making sure that their cultural needs were known and addressed. For example, they had supported some people in getting access to a specialist television channel from their own cultural background and relatives were able to bring in food from their own cultures if people wished them to.

Some of the language used in care planning was judgemental and did not promote people's dignity. For example, one person's care plan stated that they were "pleasant most of the time" and "can be difficult." This failed to take into account the person's own perspective or the reasons why staff might find their behaviour challenging at times.

We saw evidence that people and their relatives had been informed and regularly updated about the building work being carried out at the home. The provider told us this had been discussed with people and their relatives before it started and that people had agreed that the work would be beneficial to them in the long term. We saw signs and copies of written information given to people about the building work. People we spoke with mostly agreed that they had been informed, although one person could not recall this.

There was information in people's care plans about how staff should communicate with them, for example by using short sentences if they had communication needs. Relatives confirmed that staff did this. Staff understood the importance of showing respect for people by using

communication methods that were appropriate for them. An example they gave was using picture cards that the families of people who did not speak English had helped the staff team to develop.

People we spoke with were unsure of whether they had been involved in planning their care. One person said, "Maybe we chatted and they made a note of it." We did not find evidence that people were involved in their original care planning, although some people's care plans contained evidence that they were consulted when their care was reviewed.

People said staff respected their choices around routines. One person said, "We're not told what time to go to bed." There was evidence that staff asked people as part of care planning whether they preferred male or female staff for personal care.

People and their relatives told us staff respected people's privacy, for example by making sure they were covered when providing them with personal care. One relative said, "They're very good on that front." Another said that personal care was "done very nicely, with dignity."

There was a board in the office to display information staff needed to know about people. This was coded with colours and symbols to help protect people's confidentiality in case other people or visitors saw the board.

The service provided care for people approaching the end of their lives. This was based on the Gold Standards Framework, a national programme that sets best practice standards for this area of care. There were systems in place to make staff aware of how long each person could be expected to live and any factors they needed to take into account when delivering end of life care, including likely clinical and emotional issues. Staff showed an understanding of these and told us about ways in which they supported people's privacy and dignity as they approached the end of their lives, such as allowing people and their families time to talk about their feelings in private.

Is the service responsive?

Our findings

People had assessments of their needs. However, when we looked at two of these we found that one was undated and the other had not been updated since 2009. This meant there was a risk that people were receiving care based on out of date information that did not take their changing needs into account. We saw that some more specific assessments were repeated but not as regularly as care plans dictated they should be. For example, one person had been assessed as being at high risk of falls and their care plan stated the assessment should be repeated monthly. This had been done in December 2014 and January 2015 but not in February or March 2015. The same person had a pressure sore risk assessment, which should also be done monthly for people at the person's risk level. However, this had not been done between August 2014 and January 2015. Because people's needs were not always regularly assessed, the provider was not able to demonstrate that people received personalised care that was responsive to their current needs.

Additionally, daily records kept of people's care did not always indicate that care was delivered in accordance with individual care plans. Although staff occasionally noted specifics such as how often a person was repositioned during the shift, this information was missing in most cases. This meant we did not see sufficient evidence to demonstrate that care plans were being followed and that people were receiving the care planned for them.

However, we did find that care plans were reviewed monthly and took into account people's own views. The information in review notes corresponded with what people told us about their care needs, but did not always contain specific instructions for staff. Some general instructions, such as "ask [person] what they want" were given. Although some plans of care addressing people's specific needs did contain this information, others did not and this meant there was a risk that some needs would be overlooked particularly for people who did not communicate verbally.

We also saw that much of the information in people's care plans was created using standardised templates and contained little or no personal information. For example, risk management plans and care plans consisted of a set list of possible risk factors or care tasks and these were ticked if they applied to the person. Because there was no

information entered about people's personal circumstances that might affect the risks or how care was to be delivered, there was a risk that staff did not have the information they needed to respond to people's individual needs.

People told us that staff did not routinely support them to take part in activities outside the home and that they would like to have the opportunity to do this. One person said, "I have spoken about going out, but they don't really give you a proper answer." Some people mentioned that they were able to go out with family members but felt that the service relied on their relatives to facilitate this and that people without family often missed out. Staff told us it was difficult to support people to take part in external activities because they would have to arrange outings in advance and deploy extra staff. However, this showed that the provider was not taking all the steps they could have taken to improve and maintain people's quality of life.

People said they usually had enough activities to occupy them in the home, although some relatives were concerned that there was not enough for people to do while the building work meant they could not use communal areas. Staff told us there had been plans for a musician to visit the home on the day we visited, but they had to cancel this because of the building and we did not see activities taking place. One relative said they felt that more activities could be provided and they did not know why there were not more activities. We looked at some results of a survey taken in 2014 and found that most relatives felt that the quality and availability of activities was poor or average and some had included suggestions about improving this. The provider told us they planned to train a dedicated member of staff to be responsible for ensuring appropriate activities were provided.

We looked at people's records and found that activities people participated in were not recorded. This meant the provider did not have a system to monitor whether the activities provided were meeting people's needs.

We found that the service did not always support people with their religious needs. At the time of our visit, the Easter weekend was approaching. Some people told us they would like to celebrate Easter but did not think there were any plans to do so at the home. When we returned after Easter, staff confirmed there had not been an Easter

Is the service responsive?

celebration although some people and their relatives had requested a service. Staff told us they had tried in the past to arrange for religious leaders to visit the home as people requested, but they had been unsuccessful.

The above issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were able to speak to the home's lead nurse if they had any concerns or complaints. One person said, "They act quick. They're pretty good." Another person said, "I am pretty confident raising issues with staff." One relative said, "Everything gets dealt with."

Staff told us they had a complaints book but did not document minor concerns that could be resolved straight

away. The provider was therefore not able to identify and monitor any trends in minor concerns people had and they may not have been able to learn from these. We fed this back to the provider, who took note and said they would improve the system.

We looked at the complaints book and saw that, where formal complaints were made or concerns raised directly with the provider, the provider recorded the action they had taken. We were able to see evidence of this action and staff we spoke with gave examples of changes that they were required to make as a result of complaints. There was evidence that, where people who used the service had complained, the provider had later spoken with them to check they were satisfied with the outcome.

Is the service well-led?

Our findings

People and their relatives felt that, in general, they were confident in the senior staff and management. One person told us the provider was “very nice and quite easy to get on with” but also said they were confused about who the manager was. Another person named a senior member of staff that they were comfortable speaking to. Relatives told us they were confident speaking to the provider about the care of their family members. One relative said, “They ask my opinions very much [about the care of my relative].” Two relatives felt that staff were not always good at communicating information about their relatives’ care and that this could be improved. We saw that this had been discussed at a staff meeting so staff were aware of the areas for improvements.

We found that the provider was failing to submit notifications that the law requires them to send to us. This included notifying us of the death of any person who was using the service. At the time of our visit, the service had not submitted any notifications to us since March 2014. However, when we asked staff to check records during our visit, they confirmed a number of people had died at the home since March 2014.

This was a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

We saw some audits carried out by the provider, including a general audit of the quality of care at the home completed in September 2014. Some areas identified for improvement had been addressed by the time of our visit. However, others had not. For example, we identified similar concerns that the audit had picked up about food and menu choices and about the level of detail in care plans. Other concerns that we found during our inspection, such as the effectiveness of risk management plans and procedures around seeking consent, were not identified by the audit. This showed that the audit tools used by the home were not always effective.

Staff said they asked people and their relatives for their opinions about the quality of the service at meetings. However, although relatives told us they were invited to an annual meeting and their feedback was taken into consideration, we could find no evidence that such meetings took place for people using the service. People

we spoke with said they were not aware of any such meetings they could attend. One person told us they knew the staff had meetings but did not feel they had an opportunity to attend any themselves. This showed that the provider did not always ensure that people were made aware of their opportunities to have their say and contribute to the running of the service.

However, the provider had taken some steps to promote a positive culture within the service. Staff told us they were able to voice their views about the service at staff meetings and that they felt free to do this because the provider listened to them. They also told us there was a suggestion box they could use if they were not confident for any reason to express their views in person. Staff felt that the management was “strict but fair” and there were clear expectations about how they should behave. Staff felt it was important to maintain a person-centred culture and avoid institutional models of care. They gave some examples of how they did this, such as by enabling people to get up and go to bed when they wished.

We saw 12 questionnaires that people’s relatives had been asked to complete between the two days of our visit. Most feedback was positive, particularly around the availability and attitude of staff and management. Some of the feedback suggested that improvements could be made. The provider told us how they planned to use this feedback to improve the service. We asked to see last year’s survey results but the provider was unable to locate them, which meant we could not verify to what extent they used people’s feedback to help them improve the service.

The provider told us about ongoing plans to improve the service, including the physical environment and the quality of care plans. Staff said that the provider was willing to make changes if they suggested improvements to the service, although sometimes they felt the provider took too long to put their suggestions into practice. The provider and senior staff acknowledged that there were some areas in which they needed to improve the service and showed that they were willing to do this because on the second day of our visit, they had begun to make changes to care plans and other documentation.

Staff told us they were able to use team meetings and handovers to discuss their work, including best practice guidance and how to apply it.

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 9 HSCA (RA) Regulations 2014 Person-centred care The provider did not take sufficient steps to ensure that the care and treatment of service users was appropriate, met their needs, and reflected their preferences. This included designing care or treatment with a view to achieving service users' preferences and enabling relevant persons to understand the care or treatment choices available. Regulation 9 (1)(a)(b)(c)(2)(b)(c)
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 Where the service user was unable to give consent because they lacked capacity to do so, the registered person did not act in accordance with the 2005 [Mental Capacity] Act. Regulation 11 (3)
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 The provider did not take sufficient steps to protect service users from abuse and improper treatment. Systems and processes were not operated effectively to prevent abuse of service users or to investigate, immediately on becoming aware of, any allegation or evidence of such abuse.

This section is primarily information for the provider

Action we have told the provider to take

Regulation 13 (1)(2)(3)

Regulated activity

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation

Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

The provider did not take sufficient steps to ensure that the nutritional and hydration needs of service users were met. This includes receipt by a service user of suitable and nutritious food and hydration which is adequate to sustain life and good health, and the meeting of any reasonable requirements of a service user for food and hydration arising from the service user's preferences or their religious or cultural background.

Regulation 14 (1) (4)(a)(c)

Regulated activity

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

The provider did not take sufficient steps to ensure that persons employed for the purposes of carrying on a regulated activity were of good character and appropriately skilled and experienced. Recruitment procedures did not ensure that this was the case because the following required information was not available: information about employment history including explanations of any gaps, along with satisfactory evidence of employees' conduct in previous jobs.

Regulation 19 (1)(a)(2)(a)(3)(a)

Regulated activity

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation

Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services

This section is primarily information for the provider

Action we have told the provider to take

The registered person did not notify the Commission without delay of the death of a service user whilst services were being provided in the carrying on of a regulated activity.

Regulation 16 (1)(a)

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 12 HSCA (RA) Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	<p>The provider did not adequately assess the risks to the health and safety of service users of receiving the care or treatment; do all that was reasonably practicable to mitigate any such risks; ensure that the premises are safe to use for their intended purpose and are used in a safe way or assess the risk of, and prevent, detect and control the spread of, infections, including those that are health care associated.</p> <p>Regulation 12 (1)(2)(a)(b)(d)(h)</p>