Four Seasons (No 7) Limited

The Riseborough Care 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?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

This was an unannounced comprehensive inspection carried out on 28 and 29 January 2015. Our previous inspection of the home on 30 April and 1 May 2014 found a breach of regulations relating to the care and welfare of people who use services, management of medicines and the maintenance of records.

We required that the provider send us an action plan by 30 August 2014 detailing the improvements they would make to keep people safe. We received the action plan and reviewed the actions the provider had undertaken as part of this comprehensive inspection. We found that although improvements had been made to meet the management of medicines, improvements were still needed relating to the care and welfare of people who use services and the maintenance of records.

People's records were not always completed consistently. Some records gave conflicting advice which would prove confusing for staff and could result in people's needs not being met correctly. We found the provider needed to make improvements in this area. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

At this inspection, we found a repeated breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

We found that quality assurance systems were not effective, as action had not been taken to assess and monitor the quality of record keeping. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of this report.

The Riseborough Care Home provides accommodation, nursing care and support for up to 74 older people, many of whom have complex nursing needs. At the time of the inspection 29 people were living at the home. The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

Although the majority of people told us they felt safe living in the home, everyone said they felt there were not enough staff and they often had to wait for support and assistance.

There were not always enough appropriately trained staff available on each shift to ensure people were cared for safely. The registered manager told us they were in the process of recruiting staff and were one staff member short on each shift. They told us where possible they were using bank staff to ensure there were enough staff on shift but sometimes due to staff sickness they were running shifts with less than the desired number of staff. Staff told us they did not have enough time or support to do their job effectively. We observed staff delivered support and assistance in a gentle and friendly manner but did not have time to spend any quality time with people.

These shortfalls in staffing levels were a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not consistently given access to social activities. The registered manager told us the activity co-ordinator had left the home and they were in the process of recruiting two further activity members of staff. People told us they had nothing to do and had not had any outings for months. We observed people were left in the lounge area for most of the day watching television or sleeping. Many people spent the majority of their day sat in their own bedrooms, relatives told us "There's really never anything for them to do".

The provider had a system in place to ensure staff received their required training courses. Staff were knowledgeable about their role and told us they received training but the training was largely on line training. They said they did not feel this was effective and felt they would benefit from more practical face to face training. Staff told us they were not well supported by the registered manager. They said they could approach the registered manager but felt they were often ignored and their views not taken seriously. Staff told us they felt very frustrated and stated that was the reason why so many staff were leaving the home. They stated the home had a demoralised atmosphere causing a culture of frustration and despondency.

People's needs were assessed and care plans were person centred and outlined the support and care people needed to ensure their individual care needs were met. Medicines were managed safely and stored securely. People received their medicines as prescribed by their GP.

The provider had a system in place to ensure staff understood their responsibilities in regard to the Deprivation of Liberty Safeguards (DoLS). The DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in nursing and care homes are looked after in a way that does not inappropriately restrict their freedom. The safeguards should ensure that a nursing or care home only deprives someone of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them.

Summary of findings

The provider had processes in place to safeguard people from different forms of abuse, however their safeguarding policy was dated 2006, and referred to an organisation that ceased to exist during 2010 and did not include current contact details for local authorities should people wish to raise concerns. Staff had completed training in safeguarding people and were knowledgeable about the provider's whistleblowing policy. Staff told us they knew the correct process for raising concerns if they should observe any form of abuse.

There was a range of systems in place to protect people from risks to their safety. These included risk assessments for health issues such as, skin integrity, manual handling and falls as well as risk assessments for premises and maintenance issues, for example for equipment such as hoists, stair lifts and all electrical equipment.

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

People were not always kept safe at the home.

People were at risk of receiving unsafe or unsuitable care, because appropriate records were not maintained.

People told us they generally felt safe and staff treated them respectfully, but that more staff were needed.

Staff were knowledgeable about reporting any suspicions of abuse, but the providers safeguarding policy required updating.

There were not always sufficient numbers of appropriately trained staff to meet people's health needs.

Is the service effective?

Inadequate

People's needs were not met effectively.

The service was not effectively meeting the needs of all of the people who used the service. This was because people's records did not always accurately reflect their individual care needs.

Staff received training to ensure they could carry out their roles effectively, but supervision processes were sporadic.

Staff demonstrated an understanding of The Mental Capacity Act 2005 and people were asked for their consent before care or treatment was given to them.

People were offered a variety of choice of food and drink. Hot and cold drinks were offered regularly throughout the day and people were assisted to eat and drink when required.

People accessed the services of healthcare professionals as appropriate.

Is the service caring?

Requires Improvement

The service was caring but some improvements were required.

Care was provided with kindness and compassion by staff who treated people with respect and dignity. However, interactions were often hurried and staff appeared rushed.

Staff understood how to provide care in a dignified manner and respected people's right to privacy. Staff were patient and kind, and were aware of people's individual needs.

Family and friends continued to play an important role and people spent time with them, however, some relatives did not always feel the service involved and included them in the care of their family member.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not always responsive to people and their needs.

People did not consistently receive a service that was responsive to their needs. People were sometimes left for lengthy periods whilst waiting for assistance.

The provider had a complaints procedure and people knew who to and how to complain. The provider learnt from concerns and complaints to ensure improvements were made.

People were not offered meaningful social activities and stimulation, or supported to take part in activities that they enjoyed. Activity co-ordinators were in the process of being employed but there was not a programme of social activities in the meantime. Many people spent lengthy periods on their own in their bedrooms.

Is the service well-led?

Requires Improvement

The service was not well led.

People and their relatives felt able to approach the management team but did not have confidence their views would be listened to. People felt the manager was too removed from the daily running of the home.

Staff did not feel well supported in their roles.

The provider had a range of audits in place to monitor the quality of the service provided. However these had not been effective in monitoring the quality of record keeping within the home.

The Riseborough Care 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 comprehensive inspection took place on 28 and 29 January 2015 and was unannounced. In the inspection team there were two inspectors, a pharmacist and a Specialist Nurse Advisor.

Before our inspection, we reviewed the information we held about the service. This included information about incidents the provider had notified us of. We also asked the local authority who commission the service for their views on the care and service given by the home.

During the two day inspection we spoke with seven people who lived at the home and five relatives. We also spoke with the area manager, the registered manager, the deputy manager, the cook and waiting staff, and four members of care staff. We observed how people were supported and looked in depth at four people's care and support records. Because some of the people in the home had complex care needs or were living with dementia and were not able to tell us about their experiences we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific method of observing care to help us understand the experience of people who could not talk with us. We observed care and support in communal areas and looked at care records for four people and medicines administration records for 17 people.

We also looked at records relating to the management of the service including; staffing rota's, incident and accident records, training records, meeting minutes, maintenance and audit records and medication administration records.

We did not ask the provider to complete a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they planned to make. This was because we brought forward this inspection to follow up on actions the provider had completed since the last inspection.

Requires Improvement

Is the service safe?

Our findings

People were not fully protected from risks to their safety. People told us although they generally felt safe living in the home, they felt there were not enough staff to meet their needs.

At our last inspection in May 2014, we found that the service was not consistently safe and improvements were required. The assessment, planning and delivery of care did not meet the individual service user's needs to ensure their welfare and safety. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At that inspection we also found the registered person had not protected all service users against the risks associated with the unsafe use and management of medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also found the registered person had not ensured that service users were protected from unsafe or inappropriate care and treatment. This was because there were not accurate records which included the appropriate information and documents in relation to the care and treatment provided to each service user. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider sent us an action plan stating they would be compliant in these regulations by 30 August 2014.

At this inspection in January 2015, we found that improvements had been made in the assessment, planning and delivery of care and in the management of medicines. However, there were still shortfalls in the completion of people's records. These shortfalls were a repeated breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in May 2014, people had told us they did not feel safe at night because they perceived there were not enough staff to assist them. At this inspection people told us they felt safe at night and felt there were enough staff available at night but they felt the home was understaffed during the day. One person told us, "The staff do all they can, they are lovely but I often have to wait ages for them to see me". Another person said, "I really enjoy living here but the staff are so busy, some days are better than others". A relative told us, "So many excellent long term staff have left, those that are left are so stretched they don't have time to sit and encourage my relative to drink, they just don't have the time". Another relative told us, "It appears the underlying problem is staffing, retaining and supplementing, staff are completely demoralised".

Staff told us they were frustrated that they didn't have the time to do their job as they wished. Staff said, "I feel very frustrated because the people are not getting their needs met, we can't deliver their care adequately".

A relative told us, "I have asked for weeks for my relative's nails to be cut, everybody seems so rushed all the time".

The shortfalls of insufficient levels of appropriately trained and experienced staff being employed is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(1) of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they were currently recruiting staff and were conducting interviews for new care staff on the days of our visits. They said they were currently running with one staff member short during the day shifts. They told us they were employing bank staff that were already known to the service to fill in when required. We reviewed the staff rotas for the week of our inspection and the previous two weeks, the rotas confirmed what the registered manager had told us. The home was a large building, that ran over two floors and could accommodate up to 74 people, with 29 people living at the home during our visit. People were accommodated throughout the premises in different areas. This meant staff were walking all around the home to meet people's needs. The registered manager said they were unable to move people to a central location because people had expressed a preference to stay in their specific rooms.

Requires Improvement

Is the service safe?

We reviewed three staff recruitment files. There were effective recruitment and selection processes in place that ensured appropriate checks were undertaken before staff began working at the service. This made sure that people were protected as far as possible from individuals who were known to be unsuitable.

Staff spoke knowledgeably about spotting the signs of abuse and knew how to report possible abuse to the local social services. Staff told us they had completed training in protecting people from abuse and were aware of the provider's policy for safeguarding people. We reviewed the provider's safeguarding policy, it had been written in 2006 and contained out of date information and did not give any contact details for the local authorities or The Care Quality Commission. This would mean staff may not have the correct contact details to hand if they needed to report any suspected abuse and this is an area for improvement. The registered manager showed us the computerised system the provider used that showed staff had received safeguarding adults training courses and received refresher training when required.

The provider had a system to ensure risks in delivering people's care were assessed and plans were in place to reduce these. We looked in depth at four people's records. This was so we could evaluate how people's care needs were assessed and care planned and delivered. We found people had risk assessments in place for areas of risk such as falls, pain assessment, nutrition and pressure area care. We saw records that showed an assessment of need had been carried out to ensure risks to their health were managed. From the four people's records we reviewed, one person had inconsistent records completed. Records showed the person had lost weight and their records did not state if they had been referred to a suitable health care professional or GP. Care staff were able to talk knowledgably about this person's care needs and confirmed they had been referred to their GP but the records did not accurately reflect what action had been taken.

These shortfalls in maintaining accurate records about people's care and treatment were a repeated breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments had been undertaken to identify whether people were at risk of choking when eating. Clear guidance was displayed in people's rooms to assist staff when supporting these people with their meals and drinks. Moving and handling risk assessments were in place which gave staff guidance to move people in a safe and effective manner. Where people were at risk of pressure ulcers, relevant risk assessments had taken place and were reviewed monthly. People's weights were recorded monthly or if they were at risk of malnutrition recorded weekly, changes in people's weight were recorded and people were referred to the relevant health care professionals or their GP for advice.

The registered manager showed us the software system the provider used to monitor accidents and incidents in the home. The system ensured all accidents and incidents would be reviewed and analysed so that learning from such incidents could be achieved and people's safety maintained.

Medicines were securely and safely stored, recorded and disposed of. Medicines that needed cold storage were stored in a dedicated refrigerator and temperatures were monitored to ensure they remained within safe limits. There were suitable arrangements in place for the management of controlled drugs. We reviewed the Medicine Administration Record (MAR) for 17 people and the medicines section of people's care plans for six people, these showed medicines were administered to people as prescribed. Staff told us how they administered creams to people as part of their personal care. People had a Topical Medicines Administration Record (TMAR) in their bedrooms which gave detail for care staff on how often, how much and where to apply prescribed creams.

People had their allergies recorded on their medicines records and clear information was recorded for how people liked to take their medicine, when they liked to take it and how much they required. We checked the records for two people who received their medicines via a Percutaneous Endoscopic Gastronomy (PEG) tube. A PEG tube allows people to receive liquid food and medicines through a tube to their stomach, rather than by mouth if they have swallowing difficulties. The MAR for one person stated that their medicines were administered via the PEG tube, but this information was not recorded on the MAR for the

Requires Improvement

Is the service safe?

second person who received their medicines via the PEG tube. Staff spoke knowledgeably about both people's PEG requirements but the records for one person had not been fully completed.

The shortfall in the accurate recording of how one person's medicines were administered was a repeated breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection visit the community pharmacy used by the service were undertaking an audit. The registered manager told us the community pharmacy had undertaken an audit in December 2014 and the service undertook their own monthly medication audits.

Staff demonstrated they were knowledgeable about administering medicines and we saw medicines were administered in a safe way. We talked to staff about eye drops and they explained that eye drops had been prescribed for one person; however, the directions on the label had not given a frequency. Staff told us they had contacted the GP and confirmed the correct frequency to ensure the person received their correct amount.

There was robust systems for ensuring the premises were routinely maintained. Maintenance records were methodical and accurately completed. We reviewed the records held for the maintenance checks and saw fire certificates, gas safety and water safety checks had all been conducted in accordance with the manufacturers guidelines.

Inadequate

Is the service effective?

Our findings

At our last inspection in May 2014, we found people's records were not fully completed regarding the amount and target of fluid they required. Documentation did not show whether action had been taken when the individual did not reach their target amount of fluid.

These shortfalls in record keeping were breaches of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection in January 2015, we found there was a system in place for recording the amount of food and fluid people had on a daily basis. The system showed how much people had eaten and drunk during the day and had been put in place for people who were at risk from dehydration or malnutrition. We reviewed the records for two people who were having their food and fluid monitored to ensure they had enough to eat and drink. The records showed what people had eaten but the daily total of fluid consumed had not been recorded on any day. This meant staff could not easily identify if that person had received enough fluid to prevent them becoming dehydrated. The records also did not have a target amount of fluid needed on a daily basis for each person, this meant staff would not be able to identify how much fluid people would need per day to prevent them becoming dehydrated.

One person's records showed they had lost a significant amount of weight over a two month period. Their records did not contain any evidence that staff had addressed their weight loss with healthcare professionals even though records showed they had been seen by their GP for other health care issues. This meant people were not protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them.

Records we reviewed did not show an accurate record of the care and treatment provided. One person's care plan stated they needed to be seen by the chiropodist on a regular basis. There was no record in the person's care plan to show how when the chiropodist had visited this person, or what the on-going plan of care was to meet this person's needs. We asked staff if this person had received their foot care. They confirmed that this person had been visited by the chiropodist recently but the only record that showed the care had been given was the invoice from the chiropodist. Due to incomplete records, staff were unable to monitor whether this person was receiving appropriate support to meet their foot care needs.

One person's 'Do Not Attempt Resuscitation' (DNAR) record forms were not completed and additional correspondence in their care plan relating to their resuscitation wishes was not clear and appeared contradictory. This meant there was a risk that in the event of a medical emergency, this person might be resuscitated when they would not have wanted this or it was not in their best interest or that they may not be resuscitated when this would be in their best interest.

These shortfalls in keeping accurate records about people's fluid intake, their foot care and DNARs were a repeated breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the shortfalls placed people at risk of unsafe and inappropriate care.

People told us they liked the staff and felt they were trained and could do their job well. A relative told us, "The staff are excellent; they are very good with my Mum". Another person said, "The staff are always kind to me, they know how I like things done". A GP provided written feedback and told us in their opinion the service was improving.

Staff told us they received training but it was mainly computer based. They told us some training was done on a practical basis such as manual handling; however they said they would prefer more practical face to face training. The registered manager told us the provider was looking to change the method of training the staff. They said more practical based training would be provided to compliment the computer based training.

Staff told us they had the skills to do their job but they felt they did not always have enough support from the manager. Staff confirmed they received induction training and worked alongside more experienced colleagues when they joined the service.

The provider had a computer system in place to monitor all staff received training at the appropriate time. Refresher training was scheduled in and on the day of our inspection

Is the service effective?

visit staff were receiving a training session on The Mental Capacity Act 2005, which they found useful. Training courses staff had attended included; equality and diversity, infection control, fire safety and safeguarding adults.

Staff said they wanted more support from their manager. They told us they had staff meetings but they were not always as frequent as they would like. We saw minutes that showed three staff meetings had been held between May 2014 and January 2015, the minutes detailed what had been discussed and included action plans of what action to take. They told us they felt able to discuss their roles but did not feel that issues they raised would be listened to or acted upon. Staff said, "We can comment but we never see any improvements, we just don't feel listened to". Staff told us they had started to receive supervision meetings. We saw records that showed some staff had received supervision meetings during November and December 2014. We also saw the deputy manager had started a programme of group supervision meetings that staff had found useful.

Staff spoke knowledgeably about the people we asked them about and were able to demonstrate they were up to date with the specific care and support these people required.

There was a system in place to ensure the manager was aware of their responsibilities in regard to the Deprivation of Liberty Safeguards (DoLS) These safeguards aim to protect people living in care homes and hospitals from being inappropriately deprived of their liberty. These safeguards can only be used when there is no other way of supporting a person safely. The responsibility for applying to authorise a deprivation of liberty rested with the registered manager and the deputy manager. The deputy manager was aware of how to obtain support and guidance from the local authority regarding applications to deprive a person of their liberty. We saw records that showed the provider had a system in place to ensure DoLS were correctly applied for and completed.

Staff demonstrated a general knowledge and understanding of the Mental Capacity Act 2005 (MCA) because they had received training in this area. People were given choices in the way they wanted to be given their care and support. People's capacity to make their own choices was considered in care assessments so staff knew the level of support people needed while making decisions for themselves. If people did not have the capacity to make specific decisions, family or other healthcare professionals were involved as required to make a decision in their 'best interest' as required by the Mental Capacity Act 2005. A best interest meeting considers both the current and future interests of the person who lacks capacity, and decides which course of action will best meet their needs and keep them safe. However, consent to care was not always sought in line with legislation. We saw one record that showed the person's 'next of kin' had given consent for them to have their influenza vaccination. This was an area for improvement because being 'next of kin' does not give a relative the legal authority to make decisions on someone's behalf.

There was a system in place to manage and document the administration of covert medicines, including a cognitive assessment, best interest meeting and specialist pharmacist advice on how to administer medicines covertly and retain the medicines effectiveness.

Staff sought consent from people before care and support was provided. We observed staff spoke to people before giving assistance and checked they were comfortable. Staff told us how people preferred to spend their day for example, one person preferred to have their curtain left shut as they didn't like bright light and another person liked to have their bedroom door left slightly ajar.

People told us the food was good and there was always a choice of meals and snacks. The dining room was attractively laid out during meal times. We saw a varied menu was prepared each week and was available for all people to see outside the dining room. People's dietary needs were assessed and the provider employed two dining staff to specifically assist and help people during meal times. This meant the care staff were available to assist those people at meal times who stayed in their bedrooms. People were weighed monthly or weekly depending on the risks identified and any concerns regarding weight gain or loss were recorded and referred to the appropriate healthcare professionals as required. Clear guidance was on display in people's bedrooms if they had been referred to the speech and language therapists (SALT). This informed their nutrition plans and set out how staff should manage identified risks such as swallowing difficulties.

There were systems in place to monitor people's health. Records showed referrals were made to health professionals including tissue viability specialists,

Inadequate

Is the service effective?

dieticians and doctors. People were supported to maintain their health and have on-going healthcare support. Care plans showed people had access to a range of health care professional and specialist health teams including, speech and language therapy and district nurses.

Where people were at risk from pressure damage to their skin, we saw skin integrity assessments had been completed and they had pressure relieving mattresses in place. Generally, air mattresses were set at the correct setting although records showed one person's weight had reduced which meant they required a lower mattress setting. The mattress had been set at the correct rate but the person's records had not been amended to reflect the changes. Generally, records showed people were re-positioned as detailed in their care plans to meet their skin care needs.

Requires Improvement

Is the service caring?

Our findings

People told us they enjoyed living in the home. People told us, "Staff provide an excellent service, everyone on the team is kind and caring" and "The staff are very kind and gentle, I'm always treated with respect". Another person told us, "I very much like being here; it's a lovely place, very friendly and very happy". Relatives told us, "The staff are wonderful; they always do that little bit extra to help". Staff told us, "People who use the service always come first". People praised specific staff members for the care and attention they gave them and told us they had their "Favourites" who they liked to see.

Some of the people living in the home had complex needs or were living with dementia; this meant they could not always tell us how they were feeling. We conducted observations in the main lounge in the morning period to observe how the staff assisted and supported people. We used the Short Observational Framework for Inspection (SOFI) and observed four people. During our observations people were largely left unattended, sat in armchairs watching the television or sleeping. Each person had a call bell alarm on a pendant around their neck so they could summon assistance if they needed it. We observed staff checked on people to make sure they were comfortable but they were often in a hurry and appeared rushed.

We observed staff were kind to people, using their preferred names and explaining to them what they wanted them to do. Staff guided people to where they wanted to sit and checked they were comfortable before leaving them.

People and relatives said that staff treated them with dignity and respect and as individuals. We observed that people were supported to dress appropriately and their clothing and bed clothes were arranged to promote their dignity.

People were able to maintain relationships with their friends and family. Relatives told us they visited when they wished and were made to feel welcome. During our two day inspection visit we observed visitors called at the home throughout the day. People told us they often had relatives calling in to see them.

Relatives told us that although they were pleased with how the staff responded to them they were not so positive about the approach of the registered manager. Relatives commented the registered manager was, "Not very approachable…. seems to spend all the time in their office… never seems to be available". Another relative stated, "The staff are very caring, but so many have left recently, it's such a shame".

Relatives said they used to be involved and attend meetings at the home, but they hadn't been invited to any recently. We saw minutes from relatives meeting and the registered manager told us the last relatives meeting had been cancelled but another one had been scheduled. One relative told us how they had been invited for Christmas lunch, which they said was "Fabulous" and enabled them to spend Christmas with their family member.

We received mixed feedback from people regarding their involvement with their relative's on-going care. Some people told us they were generally very happy with the service their relative received and were normally kept up to date with changes. However, other people told us, they had to constantly ask staff for updates on their relative. People told us "It's difficult to see the same member of staff twice, as they are always changing".

Our observations indicated that staff were primarily engaged in completing routine care tasks. Staff were friendly and caring towards people but their interactions were often brief. Staff told us, "I would love to spend more time with people, but we just don't have the time, I'm always rushing around trying to help everyone at once".

We observed some good interactions with people, staff reassured people if they seemed a little anxious and having a quick joke and chat as they were passing. Staff appeared to know the people well and people were relaxed and comfortable with staff. We spoke with seven people and all of them praised the staff and told us they had no complaints with the care staff. People told us, "They all treat me well, I've no complaints".

Requires Improvement

Is the service responsive?

Our findings

People did not always receive a service that was responsive to their needs.

People told us often they had to wait lengthy periods to get up because the staff were so busy. We spoke to one person at 9.30am who told us they were just waiting for staff to arrive to support them to get up. We re-visited the same person at 11.00am; staff had just arrived to get them up out of bed.

People who needed two staff to support them told us they often had to wait for staff to assist them. People told us, "Staff do their best, sometimes I have to wait quite a while, other times they're quite quick, they do their best".

The registered manager told us they were in the process of recruiting additional staff. During our two day inspection we observed the registered manager conducting interviews with prospective care staff. Staff told us they were aware recruitment was on-going and more staff were needed. Many people living in the home had complex health needs and required two staff to assist them with their care needs, this in addition to the home not being fully occupied meant staff were constantly dividing their time between floors and different living units, which presented difficulties and meant staff were not always able to respond as quickly to people's needs as they would have liked.

Call bells and alarms were available for all people to reach. When people were in the communal areas of the home, pendant alarm call bells were placed around their neck so they could summon assistance when needed.

Records showed people received pre-admission assessments to ensure their individual health and personal care needs were met. Assessments were detailed and incorporated within people's care plans and covered areas such as, skin integrity, falls, moving and handling and nutrition. Care plans were generally reviewed on a monthly basis and updated as required. The care plan system comprised of separate, individual booklets. Staff told us they found the care plans very lengthy and quite cumbersome. We found people's records were duplicated which would take staff additional time to complete. Care plans were completed in a person centred way and described how people liked their care to be given. For example, how much assistance they needed when getting dressed, as well as information about the daily tasks such as washing their face and cleaning their teeth they were able to undertake themselves. The area manager told us, the provider was looking at ways to streamline and improve the current care plan system.

People were not always engaged in meaningful activities. Some people told us they were happy to spend time alone in their bed room and they preferred it. Other people told us they had little to do and they spent long periods in their bedrooms, when they would prefer to be entertained downstairs. One person said, "I've not been anywhere for months… we used to go out all over the place but we don't get taken anywhere now". One person told us," We had a band in for Christmas, but nothing since". During our two day visit, we observed there were little activities for people to participate in. The majority of people were sat watching television in the lounge or in their own bedrooms listening to their radio or watching television. One relative told us, "Mum simply doesn't want to come out of her bed room any more, there is very little for her to do". This meant that people who were reliant on support from staff were at risk from not having any social stimulation. The registered manager told us the activities co-ordinator had left the home and they were in the process of recruiting specific activity staff and were just waiting for the pre-employment checks to be completed. They told us they had identified two activities co-ordinators who would be employed in a job share role and who would implement a varied and full itinerary of activities for all people who lived at the home.

We reviewed the provider's complaints process which was clear and explained how people could complain. The provider's complaints policy ensured complaints would be acknowledged, responded to in a timely manner and the outcome communicated to all parties. The provider had received one complaint in the period since our last inspection in May 2014. The complaint was on-going and records showed the provider had responded in accordance with their complaint procedure. Information giving guidance on how to complain was clearly displayed at the entrance to the home. People told us they would contact either the deputy manager or the registered manager if they wanted to complain. Staff knew how to respond to a complaint and who to raise it with.

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Is the service well-led?

Our findings

During our two day inspection visit, observations and feedback received from people, relatives and staff was that the home had a failing culture, with staff becoming increasingly frustrated and despondent.

People told us, "The manager's not popular and we see very little of them, it's a shame really". Staff told us they did not have confidence in the manager and felt they were often ignored. They said they needed to be listened to and their views and comments acted upon rather than dismissed, which they felt was currently the case.

Relatives said, "When we first came here we were so please Mum got a place in here, it's lovely surroundings but there's not enough staff, they get good staff then they leave. The manager never comes out of their room; they never seem to be about". Another relative told us, " There's not enough staff, we used to have meetings and the old manager always kept us informed and it was such a happy atmosphere, now I have to ask if I need to know anything and there doesn't seem to be the meetings there used to be. The staff are really good but they aren't supported enough".

At this inspection we found an on-going breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(2)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider told us they would meet this regulation by 30 August 2014. The registered person had not ensured that service users were protected from unsafe or inappropriate care and treatment. This was because there were not accurate records which included the appropriate information and documents in relation to the care and treatment provided to each service user.

At this inspection we found the providers systems to assess the quality of service provided to people were not effective. The provider had not identified the shortfalls we found during this inspection or taken account of the shortfalls we identified at our last inspection visit completed during May 2014.

For example, the registered manager showed us the system the provider used for monitoring and reviewing accidents and incidents. Although the system appeared detailed, the registered manager was not able to show us how the information had been used to ensure learning from accidents and incidents had happened. They explained how the system worked but they were not able to give us any examples of when learning had been put into place.

These shortfalls in the providers systems to assess the quality of service provided to people is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed staff had started to receive one to one support and group support and development meetings with the deputy manager during November 2014. Records showed these meetings were scheduled for a monthly basis. Staff told us they found the meetings useful.

There was a whistleblowing procedure in place and staff spoke knowledgeably about the process and knew how to report any areas of concern. Staff we spoke with said they would raise concerns with the management team if they had any concerns about safety or malpractice.

The service met the Care Quality Commission's registration requirements, including submitting notifications of incidents, such as deaths as required by the Regulations. There was a registered manager in post who was supported by a deputy manager who had been recently appointed.

The registered manager told us the home completed an annual survey that was sent out to people and their representatives. The survey asked people for their views on how the service cared for people. Results from the survey were analysed and evaluated and an action plan drawn up to address any weaknesses. There was a comment box available in the main entrance area for people to leave any comments or ideas they may have.

The deputy manager explained the system of 'Resident of the Day'. This was where each day a person who lived in the home was selected and a thorough check of that person, their health, their bed room and their wellbeing was reviewed. For example, these checks included, a review of their care plan, their weight, room checks including clothing and furniture, availability of toiletries, finger nail care, hair appointments, chiropody and a list of any shopping the person may need. These were signed off by the care staff and team leader. This meant that everyone

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Is the service well-led?

living in the home received an in depth personalised check on a regular basis. We saw completed records that showed this check had been completed for the 'resident of the day' during our inspection visit.

There was a detailed system in place to monitor the safety and quality of the service. We saw there was a wide range of audits that were completed on either a weekly, monthly or annual basis. Examples of monthly audits included, bedrails, slings and hoists, medication, nutrition and staff supervision. Audits that were completed quarterly included; health & safety, clinical governance and environment.

The area manager told us the service was due to have extensive refurbishment and building works which were due to start in February 2015. They told us resident and relative meetings had been booked to ensure everyone was kept informed about the building works. It was due to these proposed building works, that the service had made the decision to only keep up to 30 people living at the service when they were registered for up to 74 people.

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 17 HSCA (RA) Regulations 2014 Good governance Service users and others who may be at risk were not protected against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the services provided, and identify, assess and manage risks relating to people's health, welfare and safety.

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not sufficient numbers of staff employed with the right knowledge, experience, qualifications and skills to support people.

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 17 HSCA (RA) Regulations 2014 Good governance The registered person had not ensured that service users were protected from unsafe or inappropriate care and treatment. This was because there were not accurate records which included the appropriate information and documents in relation to the care and treatment provided to each service user.

The enforcement action we took:
We have served a warning notice.