Smartmove Homes Limited

Hazelwood Nursing Home

Inspection report

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Ratings

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

Overall summary

We inspected Hazelwood Nursing Home on 16 and 17 September 2015 and the inspection was unannounced. Hazelwood Nursing Home is located in Longfield near Gravesend and provides accommodation, personal care and nursing for up to 50 older people. The home is set over two floors and has a lift to bedrooms and communal areas between both floors. At the time of our inspection there were 47 people living at the home, with 18 people on the ground floor and 29 people on the upper floor. Everyone at the home was living with dementia, some people had mobility difficulties and sensory impairments and some people displayed behaviours that challenged others. Many people were receiving care in bed.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous registered manager had left at the end of August and interim management arrangements were in place to cover the service whilst recruitment to the post was in progress.

Summary of findings

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

Relatives said they felt people were safe living in the home, however we found that staffing levels were not based on people's support needs and there were insufficient numbers of staff to provide the support and supervision people required.

People received their prescribed medicines, however medicines were not effectively audited and guidance was not always robust enough to ensure people received their medicines when they required them and in a way that ensured their efficacy.

People who required the most care and support were not always given the support they needed to ensure they had meaningful occupation during the day and were not socially isolated.

Although there were some systems to assess quality and safety of the services provided, not all were effective in identifying concerns and ensuring improvement.

Staff were confident in how to protect people from abuse and harm. They were aware of the procedures to follow and were clear about their responsibilities.

Risk assessments were person centred and gave staff clear concise guidance regarding people's individual needs. They included both measures to reduce identified risks and guidance for staff to follow to ensure people were protected from harm.

Staff knew people well and provided effective care that was based on detailed guidelines written in people's individual care plans. Staff had completed the training they needed to supportpeople in a safe way.

We observed that staff sought people's consent before providing care and support. Staff and management understood the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and their responsibilities.

People were provided with adequate nutrition and staff were knowledgeable about people's dietary requirements.

People were referred to health care professionals when needed and there were strong links with a wide range of health professionals including the local GP surgery.

People were treated with respect and dignity by staff who demonstrated kindness and compassion.

People's individual assessments and care plans were regularly reviewed to ensure they remained appropriate in meeting their needs.

People were supported to maintain their relationships and relatives told us that they felt most welcome.

Relatives knew how to make a complaint and were given opportunities to give their views.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe

There were not sufficient staffing levels to ensure the safety and wellbeing of people.

Medicines were not effectively audited and guidance was not robust enough to ensure people received their medicines as they required them.

Staff were knowledgeable and confident about their responsibilities and the procedures they should follow to keep people safe.

Risk assessments were person-centred and gave staff clear concise guidance regarding people's individual needs

Is the service effective?

Good

The service was effective

Staff knew people well and had received training and supervision relevant to their roles.

Staff and management understood the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and their responsibilities.

People were provided with adequate nutrition and were effectively supported when assessed as at risk of malnutrition.

People received medical assistance from a wide range of healthcare professionals when they needed it.

Is the service caring?

Good

The service was caring

People were treated with kindness and compassion.

People were treated with dignity and respect, records and information about them were stored securely and confidentially.

Is the service responsive?

Requires Improvement

The service was not consistently responsive

People were at risk of social isolation and were not supported to take part in meaningful personalised activities.

People's individual assessments and care plans were regularly reviewed to ensure they remained appropriate in meeting people's needs.

Relatives were welcomed and told us they were kept well informed

Summary of findings

Relatives knew how to make a complaint and were given opportunities to give their views.

Is the service well-led?

The service was not consistently well led

There were some systems to assess quality and safety of the services provided, however not all were effective in identifying concerns and ensuring improvement.

Relatives felt the staff and provider were approachable.

Requires Improvement

Hazelwood 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 16 and 17 September 2015 and was unannounced.

The inspection team consisted of two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the visit we looked at whether we had received any notifications. A notification is information about important events which the provider is required to send us by law. We also spoke with the Local Authority to gather information about the service.

We spoke to three people and seven people's relatives about their experiences of using the home. We also spoke with the provider, deputy manager, the cook, two nurses, five care staff, domestic staff, and a GP. We examined records which included people's individual care records, Activity records, four staff files, staff rotas and staff training records. We sampled policies and procedures and examined the provider's quality monitoring systems. We looked around the premises and spent time observing the support provided to people within communal areas of the home.

Requires Improvement

Is the service safe?

Our findings

People told us "I am safe here and these are my family" and "I have no complaints".

Relatives said that they were confident that their family members were kept safe. A relative told us, "I am absolutely certain that the staff know how to keep my sister safe" and another said, "My mother is prone to having falls, but at night she has a mat beside her bed which alerts staff when she gets out of bed."

One relative told us, "Whenever we come, there appears to be enough staff and if you call them there is always someone there." And another told us, "There's never enough staff, night times are a bit thin." And, "They never have spare staff but as soon as someone yells out, someone will come." We found there were times when people were without staff to supervise, provide support or ensure their wellbeing and safety. For example, we observed meal times. On the ground floor where most people received care in bed staff struggled to provide people with the support they needed. On the first day of our inspection lunch was served at 12.00 and we saw that only three people ate in the dining room and there were times when they were unsupported and left alone.

Fifteen people ate their meals in their rooms, twelve of whom required assistance from staff to eat. Meals were served by the cook from a trolley and given to staff one at a time, however as there were only four staff and a nurse on duty, this took time. As the cook and trolley needed to be upstairs to serve other people living at the home, meals were plated up, covered and left whilst staff supported individuals to eat their meal. One person told us, "It's cold, even the plate is cold." We observed that another person sitting in their bedroom had their meal placed in front of them, however as there were no staff to support and encourage them, their meal remained there untouched for 25 minutes before staff provided them with the support they needed. One person who required support to eat did not receive their first course until 12.50. Staff told us, "I think we could do with more staff, mealtimes are hard…I find it even harder in the evenings as there are more courses."

One staff member told us, "The management need to calculate staffing" and, "Sometimes we meet a person's need and sometimes we don't." We found that staffing levels were not based on an analysis of people's support needs and one staff member told us that although some people's needs had changed, staffing levels during the day had remained the same, "(X) used to walk and now she is bedbound, she used to feed herself and now she needs feeding…but staffing hasn't really changed." Staff told us they felt under pressure; "We are told to spend more time with our residents but we aren't given any time to spend with them." We observed that there were times when people were alone in their bedrooms and went unchecked for 50 minutes. Where people were unable to use a call bell their records said they should receive frequent observation with some individuals requiring 15 and 20 minutes checks. However we observed that this was not always done.

Staff told us their time was taken up with key tasks that meant they did not get the time to spend with individuals. One staff member said, "Staff put the laundry away and it takes 30-40 minutes and in that time you could be interacting with the residents." Another staff member told us, "It's just about safe, basic needs are met." On the first floor, one person was sat on their own in the quiet room and we saw that they were trying to get up from their chair but there were no staff nearby to notice they were struggling and required assistance. We observed another person disorientated wanting the toilet. They had entered another person's bedroom where the person was still lying in bed and began to undress. As no staff were in this corridor an inspector called for staff to assist the person and to ensure their dignity was maintained.

This failure to ensure that there were sufficient numbers of staff deployed to safeguard the safety and welfare of people was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff as they administered lunchtime medicines. Some of the people were prescribed medicines for pain relief. Whilst staff asked people whether they needed pain relief, we observed that some people were unable to communicate verbally and appeared unable to understand what they were being asked. For example, one person who received care in bed was unable to verbally communicate and did not respond in a way that could easily be interpreted as a response to verbal questioning. We asked staff what other means they used to determine whether or not a person might benefit from pain relief and were told they considered people's facial expression and

Is the service safe?

body language. However as there were no written instructions regarding these indicators on people's care plans or medication charts, it was not possible to ascertain whether people were given pain relief consistently when they required it.

We looked at the medication administration records (MAR).The MAR charts had been pre-printed by the dispensing pharmacist. Each person had a medicines profile, a recent photograph to ensure they were identifiable and information about allergies and any special instructions. Where topical applications had been prescribed there was detail on the persons file's as to where this should be applied and when. However some people's Medication Administration Record (MAR) charts were not completed satisfactorily to show that people had received the medicines they needed. For example we found that in one person's record for the administration of lunch time medicine there was no signature to show it had been given on two days the previous week. In another person's records there were gaps on six out of the previous ten days. This was a medicine to be administered as needed to help ease signs of agitation and distress and staff said they had left it empty as had judged it was not needed. Whilst this showed that there was not an overreliance to use this medicine to manage behaviour, there was no indication that the need had been assessed and discounted in line with guidance on the MAR chart.

We saw that discussion and agreements were recorded regarding the covert administration of medicine for one person. The person's records included a mental capacity assessment and the reasons for the medicines being administered covertly. However the records did not specify how the medicine should be administered which is needed to maintain the efficacy of the medicine. We asked staff about this and were told this was decided by the person administering the medicine. However this meant that there was a potential risk that the medicine could be administered in a way that was unsafe and did not ensure its efficacy.

Although the medicine trolley was clean and organised we found two over the counter preparations which were both out of date; one expired in June 2015 and another in July 2014. We checked the medicines policy to see if these were approved homely remedies. Neither preparation was on the list. The medicines policy that was on the unit was dated 2001. We asked whether medicines procedures and stock was audited and were shown some records but these did not indicate that the medicine trolley or medication administration records were checked and audited.

The registered provider had not ensured that people safely received their medicines as needed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The home displayed guidance for reporting abuse and there was a copy of the local authority's multi-agency safeguarding vulnerable adult's policy, protocols and guidance. This policy is in place for all care providers within the Kent and Medway area and provides guidance to staff and to managers about their responsibilities for reporting abuse. All the staff members we spoke with had undertaken training in safeguarding people from abuse within the last year. All were clear and confident in their role in safeguarding people should they suspect abuse. Staff were clear about their whistleblowing responsibilities and told us, "If I see someone doing something wrong, I think whistleblowing and I would go to management and CQC directly. "Another said, "If I've seen something I don't like I've spoken to the person and I've taken it further." People were protected from the risk of abuse and harm because staff had the training and guidance they needed to respond and report any concerns appropriately.

The provider explained that each person had a lockable cupboard in which to secure small things. However some relative's said that laundry, shoes and slippers went missing. One relative told us, "They all walk into each other's bedrooms and she's missing a few bits, a cushion and she has an odd shoe and an odd slipper." When approached staff confirmed that there were a number of items including odd shoes and slippers in the laundry.

We recommend that systems for ensuring safe laundering and return of people's clothes are reviewed.

We looked at four staff recruitment files and found they included a completed application with previous work history, qualifications and experience of the person applying for the job. References and criminal record checks were also included. This meant that the Provider had taken action to ensure that staff were both suitable and safe to work with people living at Hazelwood

Requires Improvement

Is the service safe?

Risk assessments were person centred and included clear guidance for staff to reduce risk and keep people safe. For example where people required support with moving and handling risk assessments set out positional changes such as turning in bed and the number of staff required to assist, the type of equipment required and when using a hoist, the type of sling the person needed.

Where people were assessed as at risk of malnutrition, guidance was given regarding the foods they preferred, the position they should eat in and the support they required from staff. Where people were at risk of pressure sores, equipment was put in place and we saw that people were regularly repositioned.

There were personal emergency evacuation plans to ensure people could be kept safe in the event of an emergency such as fire. There were risk assessments for all areas of the home including the garden and people's bedrooms. Accident and incident reports had been reviewed by the management and comments made where risk improvement actions needed to be made. Records showed that the previous registered manager had undertaken a monthly audit to ensure appropriate actions were taken to minimise risk and safeguard people from harm.

The home was clean and well maintained. The Provider employed a full time maintenance worker to carry out day to day repairs and the maintenance book showed that any faults or issues were dealt with promptly. Other maintenance records showed that checks and maintenance were regularly undertaken throughout the building including fire equipment, gas and electrical equipment, hoists, portable appliances and the home's lift. This meant people were protected from harm because action was taken to maintain the home and the equipment people used.

Good

Is the service effective?

Our findings

Relatives told us they felt that staff knew people well and provided the care they needed. One relative said, "The staff are well trained and efficient in caring." And, "Every carer in here is 100%."

One health professional said, "I'm confident in the staff's competence. There are some excellent nursing staff."

Staff undertook an induction period when they started work that included shadowing other experienced staff and the provider had signed up to the care certificate (a nationally recognised standard for staff induction training) which all new staff from April were undertaking. One staff member told us, "I had an interview and an induction that covered all sorts and I am doing the care certificate and every day when I go home I read some." The provider ensured staff received essential training including dementia, moving and handling, challenging behaviour, safeguarding, medication and 1st Aid. Staff told us they valued the training, "I have had some training and it helped me a lot, especially the dementia and mental capacity act training." Another told us, "Last year I did more than 20 training courses. Every year we do courses and they have told me they will pay for training and qualifications."

Records showed that spot checks were regularly undertaken which included observation of key practices such as moving and handling, personal care and infection control. Night staff also received spot checks and we could see that the most recent one had taken place at 2.55am in February 2015. Where practice issues were identified we saw records that showed that nursing staff had undertaken "supervision" of care staff. One staff member told us, "If I do something wrong, they do a supervision." Another said, "I don't know all, but I try and learn and the nurses are very good and explain." Staff also received performance appraisal that explored knowledge, innovation, communication and development. The Provider told us that they were looking to further enhance the supervision and appraisal process when the new registered manager started.

We discussed the requirements of the Mental Capacity Act 2005 with the provider and staff, who demonstrated an understanding of the principles set out in the Act. We saw that staff sought consent from individuals and explained things to people in a number of ways. Staff told us, "You have to keep asking them and reminding them" and, "It's important to see whether the person has capacity or not and has understood. It's about language and showing people their options."

Records showed that mental capacity assessments had been undertaken. For example we saw that some assessment of day to day decisions had been made and one person had been assessed as having the capacity to make a decision around the use of bed rails.

The Care Quality Commission (CQC) monitors the Deprivation of Liberty Safeguards (DoLS) which applies to care homes to ensure people are not unlawfully deprived of their liberty.

The home had a number of authorised applications and was prioritising other applications, ensuring that every new person was assessed on admission and relevant applications submitted.

We saw some care plans that described the support needed for people who exhibited behaviour that challenged others. The care plans referred to giving people time and attention and using distraction techniques and diversion to address unsettled behaviour. Reference was made to using prescribed medicines although only as a last resort if the behaviour was presenting a risk to people living in the home. The care plans did not sanction the use of restraint and we observed that staff effectively managed behaviours that challenged using distraction, reassurance and compassion.

People's food and fluids were monitored and people were weighed regularly. One staff member told us, "We make sure they have a good intake of food and fluids and it is looked at daily." Where people had lost weight, records showed that action was taken. People who were at risk of malnutrition received their food and drink fortified and referrals to the dietician and Speech and Language Therapist were made. One relative told us, "They care for her and give her little tit bits such as cut up fruit."

Those people who had been assessed as at risk of choking and required their fluids thickened, had guidance in their rooms that ensured staff knew how they required their drinks. One relative said that their family member, "Would not eat or drink and was very weak. Since coming here, she is eating and drinking and has put on weight. She looks very well now."

Good

Is the service effective?

We spoke with kitchen staff and they showed us 4 weekly menus that included an alternative for each day. The cook was aware of people's dietary requirements and kept lists that included the names of people requiring a soft diet and those people who had diabetes. People's likes and dislikes were listed and we saw that the kitchen staff kept a record for one particular individual who had been reluctant to eat when they first arrived and only enjoyed certain foods.

People were encouraged to eat and four people chose to have a cooked breakfast each day. One staff member explained, "When (X) first came she wasn't eating but now she is, we give her finger food or assist her." We saw one person having tea and toast mid-morning and they told us, "I have been to hospital for an appointment and when I got back I was hungry. We can always ask for something to eat or drink" In the afternoon people enjoyed cake with their tea and one relative told us, "They even made a cake for mum and dad's anniversary."

People received medical assistance from healthcare professionals when they needed it. One relative told us, "A few months ago mum's breathing went and she went right down, but the matron was on it straight away- she put her life in her hands, got the GP straight away." Records showed that people were supported to see a wide range of health professionals including physiotherapists, opticians, chiropodists and dieticians. One visiting health professional told us, "It's a well-oiled machine. I have worked with six or seven nursing homes and this is probably the best."

Care plans gave the staff information on general health, allergies and areas requiring on-going monitoring and people were reviewed regularly by the GP. The home had a strong relationship with the local GP surgery and robust systems were in place to ensure people's health was monitored. For example, a GP was assigned to each floor of the home and visited each week as well as when required, to ensure people received the healthcare they needed. The GP told us that they trusted staff and described how staff shared accurate observations about the health and welfare of people. They told us, "They know their patients which makes my life much easier."

Good

Is the service caring?

Our findings

One relative told us "The staff are cheerful, caring and kind-I cannot fault the care here"

Another said, "I was recommended this home by a friend who had a family member here. I have not been disappointed, the care is really good here"

Staff described how they had developed strong relationships with people and the staff we spoke with knew people well. One staff member said, "I try to talk with them, share with them some things about my life and then they talk about theirs." Another said, "I just love my patients, that's what holds me here…I like to see when they improve and when they are happy." One relative told us, "People here love their job, it's not a job to them, they treat people like their own parents."

We observed that although staff were busy and their time with people was often limited to delivering care tasks, staff were kind and compassionate in their approach. We heard staff speaking gently and courteously to people. Staff treated people with respect, and knew how to interact with people in a way that they preferred. Some approaches were respectfully formal addressing the person as Mr or Mrs (X) and others were informal with warm terms of endearment. Staff displayed good humour and enjoyment as they went about their work and told us how much they enjoyed supporting and caring for people; "Every now and then you get a smile and it makes me smile that I've made them happy." "(X) is a sweetheart even though he doesn't talk he shows that he appreciates what I've done." Another staff member commented, "I get happiness from them achieving."

Relatives confirmed they were involved in their loved ones care and told us they had confidence in the home and its staff. One relative said, "Every little thing they call us, if mum has had anything done or seen the GP they let us know. I trust them here I really do, I have no worries at all."

The Provider told us they were introducing some new accessible care planning tools. They showed us a chart called "Remember I'm me" which is an easy read document designed to capture and record people's needs, interests and preferences. We saw staff acknowledging and speaking to people as they were passing and talking to people as they were providing care and support. One relative said, "Residents and visitors are treated with the utmost respect and residents are always asked permission before any care is carried out."

We observed that staff demonstrated patience and compassion. For example, one person repeatedly performed the same actions and asked the same questions and each time staff responded to them in a way that was caring and warm.

Relatives told us people were treated with dignity and respect and one explained, "They always put mum's earrings in and they match her clothes up. They care about them." Another said, "When (X) came here she was not very clean and her appearance was unkempt because she wouldn't let us wash her and she wouldn't go to bed. Within 24 hours of being here, she was like a different person, I hardly recognised her. They have done a wonderful job."

One staff member told us, "Respecting their dignity is a big thing, not leaving them uncovered and making sure they are warm and clean." We saw staff quickly taking action to support people when they needed it. For example one staff member noticed a lady at the far end of the corridor walking with her skirt held up exposing her undergarments. They immediately walked slowly towards her and gently put their arms around her shoulders. As she looked up and smiled she let go of her skirt and thus her dignity was restored. The staff member did not leave her immediately but walked hand in hand with her up the corridor to the lounge where they helped her to sit down and relax.

The Provider described how people were supported to feel they matter. For example everyone was supported to celebrate special events including wedding anniversaries and birthdays. One person had recently celebrated their 50th wedding anniversary and the home had decorated the lounge and provided tea and cake for visiting family members. Another person had celebrated their 100th Birthday with a party including an entertainer and twenty family members.

People were encouraged to maintain their independence. For example, the home had small snack kitchens on each floor and we saw that one person's care plan included risk assessment for using these to make their own drink. Another person had moved to the home the previous year not speaking or eating. They were now speaking some

Good

Is the service caring?

words and accessing the dining room and eating independently. One relative told us, "When mum first came she was walking and staff tried very hard to keep her walking."

People's information was treated confidentially. Personal records were stored securely and people's individual care records were stored in a lockable filing cabinet in the staff office on each floor.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us they thought the home provided a responsive service that was based on good care and staff knowing people well. One relative told us, "They know about mum's past as they are always asking questions." Another told us, "I cannot fault the care here" and, "They always phone me if (X) is unwell or had a fall."

We looked at people's care plans and saw that although there was detailed information regarding people's physical needs, there was little information regarding their social and spiritual needs. Although care records included a section for likes and dislikes this was found to be incomplete and in some cases empty. Some pre-admission assessments included detailed information regarding physical needs but no information regarding people's social needs.

Every person had a "Working and Playing Care Plan" but these consisted of generalised aims common to all plans and very little person centred information.

People also had "Religious, Spiritual and Cultural Care Plans however these did not always set out how people's needs would be met. For example, one person's care record noted that family and religion was important to them. However their Religious, Spiritual and Cultural Care Plan was made up of tick boxes that said they required help to practice their religion but did not give guidance as to what this should be.

During our two day inspection we observed that people with the most complex needs spent most of their time alone and in their bedrooms. One staff member told us, "Where people are not mobile they spend their time in bed but if she was my grandmother I would like her to have more time, more activities." Another staff member said, "I think people are safe here but it's not enough."

We looked at care and activity records which showed that many people required one to one support and could not take part in group activities. However as there was mostly only one activity co-ordinator a day, their time was split over two floors and concentrated on group activities. As a result, many people were without meaningful occupation, stimulation or interaction for long periods of time. One staff member said, "I never see them (the activity co-ordinators) go in their rooms. People who don't go in the lounge don't do much." Another said, "Personally I think the residents that are able to, should be supported to go out and the activity ladies should go to people who are bed bound."

One person's care plan said "(X) is unable to participate in activities as she is blind in both eyes (due to glaucoma) and advanced dementia." During our inspection we observed that this person was left alone in their room for long periods of time. Their activity records showed that there were periods when they received no person centred activity for up to a week. One staff member told us, "When you help people eat, that is the most time you get to sit with them and see how they are feeling and how their day has been."

Another person receiving care in bed had a care plan that stated, "Ensure social contact at regular intervals during the day." However their activity records showed that they had last received person centred activity on the 28 June 2015. This involved an activity coordinator visiting their room and recording, "Popped in to see (X), played some sand sea and winds on IPAD." Records showed that they had received four visits by the activity co-ordinator in five months with nothing recorded for July, August or September.

Another person receiving care in bed had two recorded visits since February 2015. Another person had three activities since February and another person, three visits to their room since May 2015. Staff told us, "It just doesn't work out, the number of staff and number of residents." and another said, "If we had more staff it would be easier to spend time with the residents"

We observed group activities that took place on each of the days of our inspection and found that they did not always engage people. On the first day, the activities co-ordinator was in the lounge with people, music was playing very loudly and some people were asleep in chairs. A large soft ball was being thrown in a game of catch and there were an assortment of mostly unused objects and activity equipment placed on tables in front of people. One relative said, "Why can't they have visiting entertainers which would appeal to more people with dementia, rather than games that they don't understand?" On the second day we observed that sixteen people were in the upstairs dining room, again with music playing loudly and at times only one staff member facilitating. No organised activity was taking place and the co-ordinator went from table to table asking how people were. Two people were painting and

Is the service responsive?

some people touched objects. However other people were slumped forward with their heads on the table, one person was asleep and others sat at the side of the room with no activity. Although people were sat at tables with objects positioned in front of them, there was not always sufficient staff to facilitate interaction and activity.

People did not always receive personalised responsive care that met their needs. Some people were at risk of becoming socially isolated with little activity to stimulate or interest them. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We spoke to the Provider about this who acknowledged this was a significant concern and said that they would be looking at ways in which they could improve opportunities for people. They told us, "It's not just about providing care with dignity but I want to focus on wellbeing and I want to look at things we can do to bring them alive." And, "There is more we can do; I agree that it is all about wellbeing." We will assess whether improvements have been made regarding the personalised support people receive and their quality of life when we next inspect.

Care records showed that a pre-admission assessment was undertaken that included information regarding people's medicines, mobility and care needs and some files included comprehensive information supplied by hospitals. People's individual assessments and care plans were regularly reviewed to ensure they remained appropriate in meeting people's needs. Where people's needs had changed the home took a proactive approach to contacting other agencies for professional support. During our inspection the Provider was liaising with relatives and a range of professionals regarding one person who had been admitted the month before but was refusing treatment and intervention. The provider was keen to ensure that the person's best interests were represented and as such had sought timely advice in order to ascertain whether the placement should continue in their best interests.

People's rooms were personalised with photographs and mementos important to them. One person kept alcohol in their room and other people had cuddly toys and model planes. Preferences such as food and meal times were respected and where people requested female only carers this was adhered to. However where one person's care plan stated "Respect his dignity and send male carers to assist him"; we found that this had not been respected and that even when male staff were on duty the person had been attended by females.

We recommend deployment of staff is reviewed to ensure people's preferences are respected.

People were supported to maintain their relationships and relatives told us that they felt most welcome. The provider said, "I want relatives to be a part of the home and to trust that everything is safe and that they should have no fear." One relative said, "They make us feel welcome, you can go and make a cup of tea whenever you want and you can have a meal here for free." One staff member told us, "Visitors are welcome, children and grandchildren. Most of us know the relatives and I get really upset when we lose people." Another said, "I try to talk to families, try and support them, ask if they are ok." And another said, "We talk to them (families) - it's about keeping them in the circle."

Relatives were encouraged to take part in events such as BBQs and celebrations and some relatives regularly had Sunday lunch at the home. During our inspection we saw that people received frequent visitors at all times of the day and one family arrived with their dog and made their way upstairs where they were seated in a small private lounge with their loved one. One relative told us how much they had appreciated the staff's support and communication; "I will always be grateful for the initiative she (staff member) showed. We have been extremely well supported in our bereavement, they couldn't have been kinder"

Relatives told us they felt comfortable raising issues. One relative said, "If something happened to mum that I didn't like I would go straight and complain." Guidance for making a complaint was displayed in the area where visitors signed in as well as in the home's Statement of Purpose. The guidance included timescales for responding to complaints and contact details for the local government ombudsman, as well as CQC. One relative explained "At the beginning of her stay, I had to raise some issues but these were dealt with swiftly to my satisfaction." Another told us, "I know and understand the process if I need to raise any issues or complaints."

Requires Improvement

Is the service well-led?

Our findings

Relatives told us they were confident that the home was well managed and that there was an open door policy. On relative said, "The owner is a very nice man, he doesn't act as a manager he acts as a friend." Another said, "He (the Provider) is approachable, I would go and see him if I needed to raise something."

The home was without a registered manager as the previous manager had left several weeks before and although a new manager had been recruited they were not due to start until October. As a result the Provider was managing the home. Relatives told us, "I was upset that the manager went, but they (the staff) carry on as normal, there's no change." One health professional also told us that the previous registered manager had "Left a good legacy" and that there had been "No down turn since X (former registered manager) left." Staff however had mixed views. One staff member said, If I have something on my mind, I go straight away to the office and they support me." Whilst others told us, "Management are good in some ways and in some way not. Issues get raised and they just seem to keep being raised and not sorted" We looked at the management's quality assurance systems and found that there were times when action had not been taken.

Although we found some comprehensive quality assurance had taken place we also found shortfalls that the management had failed to identify or act upon. The home's Service User Guide and Statement of Purpose both described how people could expect to be supported with interests and hobbies. The Service User Guide described how there was "An on-going programme to provide varied entertainment and activities for residents. In order to meet the personal, social and religious needs of each individual, resident appropriate indoor pastimes are regularly organised." However our observations indicated that this was not the case and that staffing levels were not effective in ensuring people always received the support and interaction they required.

We saw that the home undertook questionnaires and that these were completed by staff and relatives. However feedback had been received that had not been acted upon. For example, two relatives and nine staff all noted that more staff were required in order to ensure people received time and attention. One relative's feedback said, "Is there any way more stimulation can be given to bed bound residents as well as TV? I realise this would be very difficult because of the one to one contact." Another noted; "With more staff the residents would get more quality time with them, especially meal times etc." When asked, "In what ways do you feel the care service could be improved?" nine out of eleven staff replies responded with a request for more staff. One said, "More staff to improve quality of care to residents" and another said, "By providing adequate staff in each shift the quality of care could be improved."

We looked at policies and found that these were not always reviewed or up to date. For example, the medicines policy staff referred to was dated 2001, although the provider supplied a 2014 version to us on the second day. The home's Statement of Purpose had not been reviewed since 2013 and the Service User Guide referenced the Commission for Social Care Inspectorate which had ceased to be in 2009. This meant people and relatives did not have up to date information to describe the service they could expect and whether the staff were providing the service they were paying for.

The registered provider had not ensured that there were effective quality monitoring systems in place. This is a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

There were some systems that assessed and monitored aspects of the quality of the service that people received. For example, we looked at records and found that the care records had been periodically audited by the former registered manager. The manager had made comments and set actions required to update the records and address some gaps in the information. We saw that these actions had been revisited and signed off when completed.

We looked a quality assurance audits that had been undertaken. There were a range of audits in place including audits on call bells, accident and incidents, pressure sores, infection control, wound management and weight loss. When the registered manager had undertaken these they had identified issues and taken action accordingly. For example, one person had been identified as having three falls in a month and we saw that appropriate medical attention was sought, a meeting with staff and the person's family was held, risk assessments updated and a pressure mat and increased observations put in place. Where pressure sores were monitored the manager had looked at

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treatment plans, equipment and multi-agency working. Where a loss of 2kg in weight had been noted, comprehensive action was taken that included GP, Dietician and Speech and Language Therapist input.

We looked at surveys that had been completed by staff and relatives. On one questionnaire a relative had suggested that staff wear name tags and the provider explained that they were instead going to be displaying staff photographs with their names. Another relative suggested that the garden have some new plants. As a result, during the summer the home had secured voluntary help from a young people's project and the garden had been replanted.

The home had links with local community groups including the local church, a children's nursery that came at Christmas, Easter and Thanksgiving to sing to residents and the local Grammar School who placed Students on work placement.

The Provider was linked to national and local best practice groups including a local dementia group. They told us that they were aware of what the home did well and areas that they needed to improve upon; "We are not perfect but we are aiming to be."

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 9 HSCA (RA) Regulations 2014 Person-centred care People were at risk of becoming socially isolated with little person centred activity to stimulate or interest them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered provider had not ensured that medicines were effectively audited and that guidance was robust enough to ensure people received their medicines as they required them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered provider did not have effective systems in place for monitoring the quality and safety of the service, identifying when there were issues and acting upon these in a timely way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered provider had not ensured that staffing levels were based on people's support needs and that there were sufficient numbers of staff deployed to ensure people's safety and wellbeing.