Bupa Care Homes (CFHCare) Limited

Amerind Grove Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out a comprehensive inspection of Amerind Grove Nursing Home on 28, 29 July and 10 September 2015. Following this inspection, we served a Warning Notice for a breach of one regulation of the Health and Social Care Act 2008 relating to safe care and treatment. In addition to this, we also found an additional eight breaches of five other regulations of the Health and Social Care Act 2008 during that inspection.

Following the inspection the home was placed into special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements at its next comprehensive inspection and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Following the inspection the provider wrote to us to say what they would do to meet the legal requirements. We undertook a focused inspection on 3 February 2016 to check the provider was meeting the legal requirements for the regulation for which they had been served a Warning Notice; this related to safe care and treatment. At our focused inspection on 3 February 2016, we found that the provider had taken sufficient action to achieve compliance with the Warning Notice.

You can read the report for previous inspections, by selecting the 'All reports' link for ' Amerind Grove Nursing Home' on our website at www.cqc.org.uk

At this inspection the provider had made sufficient improvements to be removed from special measures.

Amerind Grove is a nursing home with a total of 171 beds. The home is split between five individual units. Kingsway provides nursing care, Picador is a residential unit for people with dementia and Embassy, Regal and Capstan units provide a mixture of residential and nursing care. Capstan unit in particular provides care for people with acute dementia. At the time of our inspection there were 96 people living in the home and Embassy unit was closed.

There was 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.

People's needs were regularly assessed and resulting care plans provided practical guidance to staff on how people were to be supported. Care plans however were not consistently person centred. Care plans were not personalised and did not contain individual information and references to people's daily lives.

Procedures for the safe covert administration of medicines were not followed appropriately.

Training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) had been provided to staff. DoLS aim to protect people living in care homes and hospitals from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely. Staff were not knowledgeable about the protection of people's rights. The service had also failed to ensure that best interest decisions were undertaken when people lacked the mental capacity to make decisions and give their consent.

Risk assessments did not always reflect necessary actions required to reduce risks to people. Some risk assessments were risk averse and placed unnecessary restrictions on people's independence. Other risk assessments did not contain enough information to enable staff to prevent risk to people.

People were not supported to undertake person centred activities.

The provider had quality monitoring systems in place which were used to bring about improvements to the service. Some improvements had yet to be embedded by the service.

There were enough staff to meet people's basic personal care needs.

There were mainly positive and caring relationships between staff and people at the service. We did see some instances of care which was uncompassionate. People praised the staff that provided their care. We received positive feedback from people's relatives and visitors to the service. Staff respected people's privacy and we saw staff working with people in a kind and compassionate way when responding to their needs.

The staff had received training regarding how to keep people safe. They were aware of the service safeguarding and whistle-blowing policy and procedures.

There was a robust staff recruitment process in operation. The recruitment process was designed to employ staff that would have or be able to develop the skills to keep people safe and support their needs.

Staff demonstrated a detailed knowledge of people's needs. They had received training to support people to be safe and respond to their care needs.

People had access to healthcare professionals when required, and records demonstrated the service had made referrals when there were concerns.

There was a complaints procedure for people, families and friends to use and compliments could also be recorded.

The provider had made appropriate notifications to the Commission; notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled.

We found three breaches of regulations at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Some risk assessments placed unnecessary restrictions on people and others did not provide staff with strategies to prevent risk.

Improvement was required in relation to processes for covert medicine administration.

People were protected from the risk of abuse. The service had provided staff with safeguarding training. They also had a policy and procedure which advised staff what to do in the event of any concerns.

The service had safe and effective recruitment systems in place.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights were not being upheld in line with the Mental Capacity Act 2005.

DoLS applications had been made for those people that required them.

People were provided with nutritious food and sufficient drinks.

Is the service caring?

Requires Improvement

The service was mostly caring.

We saw instances of uncompassionate and distant care from staff.

People told us staff were kind and caring. Relatives said they were happy with the care and support provided.

Relatives spoke positively about the support provided by staff. Staff understood people's needs and preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive

Care plans did not always provide staff with the information needed to provide person centred care.

People did not have access to meaningful daily activities.

The service had involved other professionals to support people and people were supported to access health care services.

The service had a robust complaints procedure.

Is the service well-led?

Requires Improvement

The service was mostly well led.

Although the provider and manager had put quality assurance systems in place these were not fully effective.

People told us staff were approachable. Relatives said they could speak with the registered manager or staff at any time.

The provider sought the views of people, families and staff about the standard of care provided.

Amerind Grove 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 between the 12 and 15 April 2016 and was unannounced. The inspection was undertaken by three inspectors and two experts 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.

Prior to the inspection, we viewed all information we held about the service, including information of concern and statutory notifications. Statutory notifications are information about specific important events the service is legally required to send to us. We also viewed the Provider Information Return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

We spoke with 33 people that used the service, 22 relatives and 18 members of staff. We also spoke with senior management staff including the area manager and registered manager.

We reviewed the care plans and associated records of 16 people who used the service. We also reviewed documents in relation to the quality and safety of the service, staff recruitment, training and supervision.

Requires Improvement

Is the service safe?

Our findings

Care plans contained risk assessments for areas such as moving and handling, falls, and the use of bed rails. To enable people's safety care plans and risk assessments had been reviewed monthly and amended if a person's circumstances changed. We found however there were people being cared for in bed because they were at risk of slipping out of their chairs. For example we found that this was the case for one person who repeatedly called for help all day long. A letter from the dementia partnership team dated in February 2016, gave advice that to promote this person's well-being they needed to be able to access communal areas where other people were present and there would be more stimulation. The service was not following the advice provided.

The confinement of this person to their room, in their bed, on their own did not demonstrate an approach to care that was less restrictive and in the person's best interests. The service had not sought to provide for example a mobile standard reclining chair on wheels which may have been suitable until an occupational therapist (OT) seating assessment had been carried out. We were informed that an OT seating assessment had been requested but that to negate any risk in the meantime that it was safer to care for the person in bed. We raised this as a concern with the registered manager and were informed that there were reclining chairs available for this person to use. The staff has not considered or been aware of this equipment and had chosen a risk averse approach until the OT had completed the assessment. We spoke with a visiting OT who told us that OT referrals for a seating assessment can take up to 17 weeks. The 'cared for in bed' approach had the potential to be more damaging to the person's physical and mental wellbeing through a lack of exercise and social isolation. We found this was also the case for another two people who were cared for in bed.

Risk assessments and care plans did not always give clear guidance on what steps to take to reduce the risks. For example we found that one person had recently been reassessed to be at high risk of falls due to the two recent falls sustained in March and April. We were informed that the person spent most of the time in their room. The care plan was unclear. It stated that the person 'walks independently with a zimmer frame.' But in contradiction, also stated 'staff should supervise [person's name] when walking in the unit'. The care plan also recorded that a sensor mat had been put in place following the fall in March 2016 but did not state where the mat should be positioned and nor when it should be used. On checking the persons room, the sensor mat was under their bed and therefore not effective in alerting staff to reduce the risk of falls to the person.

These failings amounted to a breach of Regulation 12 (1) and (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

During this inspection we looked at the arrangements for storing and giving medicines and spoke to staff in all four units. We looked at people's medicines administration records on all of the units. We found that suitable systems were in place for the safe handling of medicines but some improvements were needed in the covert administration of medicines. This is when staff disguise people's medicines in food or drink to make sure they will take them.

Although procedures were in place for the safe covert administration of medicines, when this was in the person's best interest, records did not confirm that staff had always followed these. Procedures included checking with a pharmacist that it was safe to give the medicines in this way. We looked at the medicines records for six people assessed to need covert administration of medicines. Staff had not recorded the advice given by the pharmacist, so they were not able to check whether they were administering medicines safely.

One person on Capstan unit was prescribed a medicine which should not normally be crushed or chewed when taken, but staff told us they regularly crushed this tablet before giving it. This could mean the medicine would not work correctly and could harm the person's health. Staff on duty did not know whether anyone had checked the safety of this with the pharmacist.

On Kingsway unit staff had not recorded a review of one person's covert medication assessment for more than a year. The home's medicines management audit stated that the decision to administer covertly should be reviewed on a three monthly basis and recorded on the covert medication assessment. Four of the medicines listed for covert administration had changed since the record started. Staff had not recorded any advice given by a pharmacist.

These failings amounted to a breach of Regulation 12 (1) and (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw staff giving people their medicines in a safe and respectful way. We spoke to three people using the service who told us their medicines were available for them and they were happy with how staff looked after them.

Suitable arrangements were in place for obtaining medicines. People's medicines were available for them. Staff told us the pharmacy system worked well. The pharmacy provided printed medicines administration records for staff to complete when they had given people their medicines. We looked at all the current records on Picador, Capstan, and Regal units and records for 12 people on Kingsway unit. Staff recorded the medicines they had given and the reason if they had not given a regular medicine. However, we saw one example on Regal unit where staff recorded they had given a person one of their medicines once a day for the previous four days, instead of twice a day as prescribed. We brought this to the attention of the nurses on duty.

Some people were prescribed medicines, such as pain relief, to be given 'when required'. Information was available for staff to help ensure they offered and gave people these medicines correctly.

Medicines were stored safely and securely in each of the units. Staff checked and recorded the temperatures of medicines storage areas and medicines refrigerators to make sure they were safe for storing medicines. Suitable arrangements were in place for the safe keeping of controlled drugs, which need additional security.

There were sufficient numbers of staff to support people safely. People told us that care appointments were met by staff when they needed them and the care they needed was given. We found that the staff rota was planned and took into account when additional support was needed for planned appointments outside of the home. Although people and their relatives felt people were safe they gave a mixed response about the staffing level. One person said "I feel safe, always somebody on hand, press the button and they come quickly". Relatives said "The staffing situation has got worse; people nursed in their rooms get no attention just their basics", "Staff are lovely but not enough of them, they do not prompt my [relative] to go to the loo"

and "The care is better, whereas my loved one would have had to wait for attention, now there is instant response, but there is still a long way to go".

Staff on duty also confirmed they felt there were enough staff to keep people safe however some staff felt that poor organisation meant that staff did not use their time effectively. We observed an incident which demonstrated this. A staff member was asked to perform personal care for a person in bed and decided to continue writing up care notes. Over 20 minutes later we observed that the person had not been attended to and that the staff member had continued to write their notes. In the meantime the person had become incontinent in bed. As a result they were removed from their bed, the bedding removed and the bed and bedrails cleaned which took two members of staff much longer than if the personal care had been delivered when required.

Accidents and incidents were recorded, they were analysed by the registered manager or senior staff. The analysis was discussed with staff and subsequent action plans were put in place to reduce the likelihood of reoccurrence and to keep people safe. The records we viewed showed a system which recorded timescales for response to concerns, outcomes and actions taken.

The service had a policy and procedure regarding the safeguarding of people and guidance was available in the office area for staff to follow. Staff told us that they would report any issues of concern to the registered manager. Staff also knew that they could speak to the local authority safeguarding team directly if they felt this was appropriate. One staff member said "I know where to find the phone number if I had to speak to safeguarding though I'd always go to the manager first".

Staff understood the term "whistleblowing". This is a process for staff to raise concerns about potential poor practice in the workplace. The provider had a policy in place to support people who wished to raise concerns in this way.

There was a robust selection procedure in place. Staff recruitment files showed us that the service operated a safe and effective recruitment system. An enhanced Disclosure and Barring Service (DBS) check had been completed. The DBS check ensured that people barred from working with certain groups such as vulnerable adults would be identified. We saw that the recruitment process also included completion of an application form, an interview and previous employer references to assess the candidate's suitability for the role.

The service had emergency procedures in place which included the actions to be taken in the case of fire. People also had personal evacuation plans which clearly identified their needs if evacuation was required.

People were cared for in a safe, clean and hygienic environment. The bedrooms throughout the service were well-maintained. Regular equipment and maintenance checks were undertaken.

Requires Improvement

Is the service effective?

Our findings

There were inadequate processes in place to make best interests decisions in accordance with the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff did not have a good understanding of the Mental Capacity Act (MCA) 2005 and how it related to consent to care. Completed mental capacity assessments were in place in people's care plans. There was not however best interest decisions recorded for people who lacked capacity to give consent. Across all units we saw care plans where people who lacked capacity had bedrails in place. Bed rail assessments had taken place to ensure the use of bedrails was safe for the people concerned. There were not however always best interest decisions recorded for these people. This meant that the person's rights were not being protected because the best interest process had not been followed.

We also saw that for another person staff had not followed the best interest decision making process. The person had not been assisted since the previous night with personal care; it was approximately 20 hours since personal care had last been given. Staff told us this was because the person had refused personal care and they felt that going against their wishes, could be seen as abuse. We discussed the need to act in people's best interests. This was particularly relevant in this person's case as they had been assessed as lacking mental capacity to consent to the care plan for skin care. The person also had a moisture lesion and was at very high risk of further skin breakdown if continence and personal care was not adequately given. There was no best interest decision in place to underpin the care plan for skin care. The staff accepted the person's refusal and did not act any further. There was no evidence in the care plan of how staff should manage the person's reluctance/refusal. Strategies might have included for example: retreating and returning, trying different a staff member, choosing a good time of day for the person, ensuring effective communication methods, negotiation, or providing incentive. The staff were very concerned that the person should not be "forced" as they put it. This showed lack of understanding and confidence in relation to lawful restraint under the MCA i.e. a proportionate response (using the minimum force for the shortest time possible) to the risk of the person otherwise suffering harm (and the seriousness of that harm).

These failings amounted to a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We found that people's mental capacity to make decisions had been assessed and appropriate DoLS applications had been made.

Staff received training provided by the service when they joined as part of their induction programme. On

completion of their induction they also received regular refresher training. Training subjects included moving and handling, infection control and food hygiene. Staff we spoke with told us they had been given training relevant to support the people they cared for. Most care staff however did not have basic first aid training and felt that this would help them in their daily work with people.

Training did not include specific training to support staff to recognise and meet the needs of people. For example there were people using the service who lived with epilepsy and diabetes. Specific training for staff to meet people's needs is good practice if staff are regularly undertaking care for people living with for example diabetes and tissue viability. This would enable staff to recognise symptoms and access the appropriate healthcare or assistance before the conditions became advanced.

All staff we spoke said they had been supported with supervisions recently. Records we saw demonstrated that supervisions had been undertaken but not as often as directed by the provider's supervision policy. This position was reflected in the staff records. Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff. The staff we spoke with told us they felt well supported by the management team and that although they had not received regular supervisions they felt that this would improve under the new registered manager. The registered manager assured us that regular supervisions were being planned now that unit manager staff vacancies had been filled. Staff we spoke with said told us "I feel supported by the team and manager, it feels like everyone wants us to do well".

We made observations of people being offered choices during the inspection, for example where they wanted to sit and what they would like to eat and drink. Where a person was unable to communicate well staff utilised a number of techniques such as using simple sentences and using hand gestures to enhance their understanding of the person's requirements.

People's nutrition and hydration needs were met. People were assessed for nutritional needs, and when people required specialist support this was sought appropriately. Where necessary, people were having their food and fluid intake monitored. People's food was served at the correct consistency and in accordance with their specific needs. If people did not like the menu choice they were offered an alternative. One person told us; I am never hungry, I get plenty to eat and drink" other people said "I get fed and watered", "I like the food they give me and we have a choice" and "I like most of the dishes they cook and there is plenty of variety".

During our inspection we observed lunchtimes in the units. People were provided with their lunch in a timely way including people who needed assistance to eat. The tables were attractively set with table cloths, placements, napkins and fresh flowers. People were provided with assistance to eat at a pace that suited them by staff. We observed people were given visual options in order to support making a choice for example of sandwiches or quiche, but were not always informed of the type of quiche or of sandwich filling options. People with cognitive impairment were not always shown the different options.

People were supported to use healthcare services. People had regular health reviews with their GP and other healthcare professionals. When a person required additional regular clinical support this was provided. There was also evidence of input from the community psychiatric team and GPs in people's records. We saw within everyone's care plan that regular visits or appointments with dentists, opticians and dentists had happened when required. People we spoke with told us if they were feeling unwell they would tell the nurse who would call the doctor if necessary, or would wait to be seen on the doctor's next visit.

Requires Improvement

Is the service caring?

Our findings

Most of the care we witnessed was respectful and kind. However some of the care appeared to be distant; the care staff were not warm in their approach and did not smile or make eye contact. For example we observed a staff member's response to a person who was calling out "nurse, nurse" all day long. The staff member asked the person want they wanted. The person replied they did not know. The care staff responded "Why are you calling for a nurse then?" This exchange did not demonstrate a compassionate understanding of dementia; it did not acknowledge the person's feelings or the cause of the calling out behaviour which ceased when the person had someone talking to them and providing reassurance. In contrast, another member of care staff approached the same person and behaved with compassion; spoke calmly and reassuringly, provided touch, tried to work out the person's needs and offered help.

We also observed a themed 'world food day' lunch during the inspection. The chef had introduced this as a way for people to try different foods and to create discussion and reminiscence for people. We found there were various levels of engagement by staff in the theme across the units. Some staff explained the concept of world food day and the themed menu choice which was Spanish omelette to people. In one unit however we found that although staff discussed the themed day amongst themselves they did not explain the concept to people and simply asked people if they would like omelette or sandwiches. The failure of staff to engage with the theme meant that staff missed opportunities to engage with people.

Staff were knowledgeable and supportive in assisting people to communicate with them. One member of staff said they established a rapport with people by reading about their life history and then talking about their interests. They also commented on the need to build up trust and that using humour was an important part of the process. People were confident in the presence of staff and communicated with the staff when not able to verbalise with non-verbal communication. We saw people smile and use hand gestures to explain meanings to the staff. Staff gave people ample time to respond when asking a question and listened to them and acted accordingly. Terms of endearment were used appropriately and people appeared to like this.

We observed staff treating people with dignity and respect. We saw staff ask before they carried out care and knock and wait before they entered people's rooms. One staff member explained they always knocked before entering a person's room and asked permission before giving personal care and made sure the person had privacy by shutting doors and curtains. People told us that staff were respectful when undertaking their personal care. One person said "Staff are very kind and respectful when doing personal care, I am a private person and not embarrassed"

Within all units people made favourable comments about staff, they said; "Staff are excellent, we are on friendly terms, they talk to me and are respectful, if I need something they will do their best", "Staff are as good as gold", "We are like a big family, staff are kind and caring, they look after me and "I feel safe in this atmosphere, nothing to feel unhappy about, staff are all like good friends".

Visitors and relatives also provided mostly positive feedback about the care, they said, "I don't think I'd want

my [person's name] to go anywhere else" and "Staff are very caring, they kiss my loved one, I don't mind and my loved one loves it; I am totally satisfied that they look after [person's name] so well".

Requires Improvement

Is the service responsive?

Our findings

Care plans did not always contain references to people's daily lives. This meant there was a risk of people not receiving person centred care, because staff did not have the information available in relation to all of the people they were caring for. This can be significant in an environment with people who have dementia as the information can aid staff to provide care to people who have difficulty in communicating their needs. This is of particular relevance when new staff or agency staff are employed at the service to aid these staff in knowing and understanding people.

We found that care plans did not instruct staff on how people liked their personal care to be provided. For example, one staff member told us how they responded to a person who reacted with aggression when receiving personal care. The staff member told us how they had found a method of providing personal care which enabled the person to relax and accept the personal care without any aggression. The use of this method of personal care had the potential to positively alter the person's mood for the rest of the day yet it had not been recorded in their care plan.

Care and treatment was not always planned and delivered in line with people's individual care plans and preferences. We found that although reviews had taken place as planned and that key information relating to people's health had been recorded, the quality of person centred information was not consistent within the care plans or followed by staff. We saw in some care plans the service had worked with people to identify and record their choices and preferences, this included foods and activities. The service had however failed to ensure that some of these personal preferences were met. For example in one person's care plan it stated that the person would like to receive weekly sensory foot massages. On checking the person's records and speaking with staff it was apparent that the person had not received any foot massages for over two months.

People and their relatives gave variable responses when they were asked if they were consulted and included in decisions about their care and involved in care review meetings. Some people and relatives said they were involved and others said not. One person said "I am consulted and included in decisions about my care". One relative said "I visit daily and am involved in all aspects of their care, I get daily updates so no formal reviews".

People told us that they were given choices in their daily routines which helped ensure that their views were listened to and that they were involved in planning their own support as far as they were able. We spoke with people about the choices they had around their care. People we spoke with said "Staff know me better than I know myself, they know what they are doing; they know what I like and the way I like it, they know I am very fussy about my appearance and they help me select my clothes and jewellery, they put my make up on and do my hair". Another person said "Staff know how to look after us, we only have to ask and it is done; I leave it all to them they know what to do". When we spoke with staff they were knowledgeable about people's preferences and routines they preferred. One member of staff said "Nobody is a text book, everybody has their own character."

People and relatives commented that communication between staff was sometimes lacking and records of requests were not always passed on. On the day of inspection we observed that a message that had been relayed that morning by a relative regarding a person's physiotherapy assessment had been written into the person's care plan. The staff however had failed to undertake the guidance relayed in the message. Staff providing care to the person told us they had not been informed of the new guidance. The senior staff member in charge of the unit that day could also not recall the message being relayed to them during the last staff shift handover meeting. Staff told us that miscommunication was common because of the use of agency staff who did not always pass on information or complete records as expected.

Activities were provided and we observed group activities taking place during the inspection. Activities were not however focused on people's individual hobbies and interests. People who were cared for in bed and those who could not partake in group activities did not have access to meaningful activities. There was an activities team on site to assist people to activities which took place across the units. During the inspection we observed members of the activities team undertake the activities specified on the activities schedule for the week. This included gardening, quizzes and a mobile shop. We observed one of the activities staff with the mobile shop doing the rounds of the units. Items for sale were toiletries, drinks, crisps, sweets, chocolate and filled rolls. The activities member of staff did not attempt to engage any people who lived in the home in visiting other units with them or assisting with the shop. We saw that it was mainly staff purchasing the filled rolls and there appeared to be little stimulation in this 'activity' for people who lived in the home.

We observed that on the units where people had more profound dementia and cognitive problems that they were less likely to be involved in meaningful activities or stimulation. For example in Capstan unit we observed several people sitting in the same position throughout the time of our inspection. One person was alone in a large conservatory and another person sat alone on a wall between two openings to other areas. They were only aware of staff when they approached them to offer drinks, medication or their lunch. There was no activity or stimulation other than a T.V. and music.

Relatives we spoke with said "My [relative] sits in total isolation, although they are a shy and private person, nobody approaches them or offers them any stimulation, not even a chat". Another relative said there was little activity for people living with dementia and this was their only criticism of the home. Whilst another relative told us that activity staff had on occasion taken their relative out for coffee and while they appreciated this, they said that as they already took their relative out three times a week they felt that the activities staff were not using their time effectively or with the right people.

Staff told us that they felt 'let down' by activities staff as they felt the activities staff tended to concentrate on people who were easier to mobilise. Staff said that people whose mobility was impaired or those whose dementia was profound were not regularly included by activities staff as they found these people 'difficult to manage'. Staff also told us that to improve activities and social interaction for people it would be beneficial to have more care staff undertaking activities. The care staff told us they knew how to meet people's daily needs for meaningful stimulating activity particularly for people who were cared for in bed, whereas activities staff undertook a lot of group activities which were not suitable for all people.

These failings amounted to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people's individual bedrooms were well furnished, and people were encouraged to personalise their rooms with photographs and memorabilia. This helped ensure that people's rooms were arranged in accordance with the person's wishes and preferences.

There were systems in place to respond to people's complaints, and we saw that the procedure for making a complaint was on display in the home. We viewed examples of formal complaints that had been addressed by the provider and registered manager, and saw that the concerns had been responded to. People and relatives confirmed they knew how and where to access the complaints procedure

Requires Improvement

Is the service well-led?

Our findings

At the last comprehensive inspection of this home there were nine breaches of regulations. The appointment of a new registered manager since the last comprehensive inspection had focused the service on rectifying the issues related to the previous breaches of regulations. While we recognised that improvements were being made to the home's systems and processes for maintaining standards and improving the service, many of the changes were still a work in progress and were not yet fully embedded in practice.

To ensure continuous improvement the registered manager, area and quality managers conducted regular audits to monitor and check the quality and safety of the service. They reviewed issues such as; care plans, training and records. The observations identified good practice and areas where improvements were required. We saw that personalised care plans, activities for people and staff mental capacity act knowledge had already been recognised as requiring improvement through the provider's own quality checks. The senior staff were working towards improving these areas.

There were areas which had not been picked up by the audit reviews for example; Staff audited medicines management in each of the units every three months. We saw an example of a recent audit for each unit. Staff completed an action plan to address any issued identified. The unit manager reviewed these plans. Although the audit included a section for covert administration of medicines, none of the audits had identified that the covert medication assessments were not fully completed. This meant the quality monitoring systems in place were not always effective.

There also were systems in place to ensure regular maintenance was completed and audits to ensure that the premises and safety related areas such as fire risk were monitored and that equipment tests were also completed. We saw that where actions were required to improve these areas there were action plans in place.

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. Customer satisfaction surveys were sent out to the people living in the home and their family and representatives. This survey received a good response and people living in the home raised a number of issues they wished to be addressed. The registered manager told us they had initiated actions as a result of the surveys. These actions were recorded as part of an auditable action plan which had timescales for completion. This meant that the provider was able to ensure that the progress of actions were reviewed and met in a timely way. We saw that where actions had not been completed on time the registered manager ensured that people were updated with an explanation. We also saw that there were 'you said', 'we did' posters displayed in each unit explaining how the provider was meeting the requests of people and their relatives and that regular relatives meetings were planned for each unit.

People told us the registered manager and staff were approachable and they could talk with them at any time. The senior staff also told us they operated an open door policy and welcomed feedback on any aspect of the service. Senior staff said they felt confident relatives and staff would talk with them if they had any

concerns. We also saw records that demonstrated that relatives and other people important to people living in the home were communicated with through planned meetings and also on the phone if there was anything urgent that they needed to know.

Relatives said they had a good relationship with the registered manager who they found to be accessible, approachable and supportive. One visitor told us they had encountered a problem with another visitor. They told us they reported this to the manager who dealt with it efficiently. Relatives also said "The manager is a very nice man, I can talk to him and he listens. The family requested a meeting with him to discuss financial affairs and were impressed with the way he listened and is now investigating".

Staff told us they were involved in making plans to improve the service. All of the staff we spoke with said they felt well supported by the registered manager. One member of staff said. "It feels as if the manager supports me and I feel like he wants the home to do well". Another member of staff said they felt listened to and heard and commented "now there's a different energy". They said they had attended regular staff meetings and that there was an open culture. Staff said that staff meetings were supportive in discussing and resolving staff issues.

Staff felt well supported by their senior managers and felt confident to approach the registered manager with any concerns. All staff we spoke with told us they knew how to report any concerns about the delivery of care and would not hesitate to do so. One member of staff said "things have improved so much since your last visit, there is a good team now and the place is buzzing".

All services registered with the Commission must notify the Commission about certain changes, events and incidents affecting their service or the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. We found that the registered manager had made appropriate notifications.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 Care plans were not person centred. Care was not always planned and delivered in line with people's individual needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's rights were not being upheld in line with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments placed unnecessary restrictions on people and others did not provide staff with strategies to prevent risk Improvement was required in relation to processes for covert medicine administration.