M D Homes

Frithwood 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

The inspection took place on 1 March 2016 and was unannounced.

The last inspection of the service was on 23 October 2014 when we found one breach of Regulation because the provider had not always obtained people's consent to their care and treatment or acted in accordance with the Mental Capacity Act 2005. At this inspection we found the provider had made the necessary improvements with regards to this. However, we found breaches of other Regulations.

Frithwood Nursing Home is a nursing home for up to 26 older people. Some people were living with the experience of dementia. There were 26 people living at the service at the time of our inspection. There were three rooms which were shared by two people each. The service was managed by MD Homes, a private organisation who managed five nursing homes in North West London.

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 and associated Regulations about how the service is run.

People were at risk because cleaning products, containing dangerous chemicals, were not always stored securely and had not been correctly labelled.

The electrical cables in the sluice room had been damaged and presented a risk for people accessing this room.

People received their medicines as prescribed. However some of the practices for the storage and administration of medicines meant that people were at risk.

The environment was not always designed and used in a way which reflected people's preferences and took account of their needs.

People's privacy and dignity was not always respected. Some staff were rude towards the people who they were supposed to be caring for. The staff did not always show people respect, offer them choices or think about the care they were providing from the person's perspective.

People's individual needs and preferences were not always being met.

The provider had a registered manager in post, however, there was no contingency plan for when the manager was absent and therefore people living at the service had been placed at risk of poor practice.

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

There were procedures designed to safeguarding people and the staff knew what to do if they thought someone was at risk of abuse.

The risks to people's safety and wellbeing had been assessed and were recorded.

There were enough staff on duty to meet people's needs.

People's capacity to consent to their care and treatment had been assessed and the provider had acted in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

The staff received the training and support they needed to care for people.

People's nutritional needs were assessed and they had a variety of freshly prepared food.

The staff worked with other healthcare professional to assess and meet healthcare needs.

People told us they liked the staff and found them caring.

People's needs were assessed and care was planned to meet these needs.

There was an appropriate complaints procedure and people knew how to make a complaint.

There were systems to monitor and audit the service and plans for improvement.

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.

People were at risk because cleaning products, containing dangerous chemicals, were not always stored securely and had not been correctly labelled.

The electrical cables in the sluice room had been damaged and presented a risk for people accessing this room.

People received their medicines as prescribed. However some of the practices for the storage and administration of medicines meant that people were at risk.

There were procedures designed to safeguarding people and the staff knew what to do if they thought someone was at risk of abuse.

The risks to people's safety and wellbeing had been assessed and were recorded.

There were enough staff on duty to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

The environment was not always designed and used in a way which reflected people's preferences and took account of their needs.

People's capacity to consent to their care and treatment had been assessed and the provider had acted in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

The staff received the training and support they needed to care for people.

People's nutritional needs were assessed and they had a variety of freshly prepared food.

The staff worked with other healthcare professional to assess and meet healthcare needs.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not always respected. Some staff were rude towards the people who they were supposed to be caring for. The staff did not always show people respect, offer them choices or think about the care they were providing from the person's perspective.

People told us they liked the staff and found them caring. We observed a small number of interactions which were kind, considerate or polite.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's individual needs and preferences were not always being met.

People's needs were assessed and care was planned to meet these needs.

There was an appropriate complaints procedure and people knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had a registered manager in post, however, there was no contingency plan for when the manager was absent and therefore people living at the service had been placed at risk of poor practice.

There were systems to monitor and audit the service and plans for improvement.

Frithwood 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 1 March 2016 and was unannounced.

The inspection team consisted of two inspectors and a nurse specialist advisor.

Before the inspection we looked at all the information we held about the provider, including the last inspection report and notifications of significant events and changes.

During the inspection visit we spoke with eight people who lived at the service, two visitors and the staff on duty, who included a nurse, six care assistants, a student on placement, the chef and housekeeper. We also spoke with the provider's operations director who was at the service during the inspection. We observed how people were being supported and cared for, looked at the provider's records, which included five care plans, the records of care provided for ten people, staff training and supervision records, the recruitment records for five members of staff and the provider's audits and checks. We also looked at records of accidents, incidents and complaints, how medicines were stored, administered and recorded and the environment.

Requires Improvement

Is the service safe?

Our findings

Cleaning products were not always stored safely or securely. In addition some of these were not correctly labelled. Some of the people who lived in the home had dementia and could have been placed at risk because they had unrestricted access to these products. For example, a bottle of clear liquid, labelled, ''Urine Protector'' was left unattended on a trolley on the first floor landing throughout the morning of our inspection. The container did not have a suitable label on with details about what chemical the product was, therefore the correct first aid may not be administered if someone ingested or sprayed this product on themselves. In the unlocked laundry room we found a jug, of the same style and design used by the service to provide drinks in people's rooms, contained an unknown yellow cleaning product looking similar to a milkshake drink which we had seen offered to people at the service. There was no indication that this was not a drink and this presented a risk as people may have mistaken this. Another cleaning product, which was in the correctly labelled container, was left on an unattended trolley in the ground floor corridor for the morning of our inspection. Therefore people were placed at risk of harm because they had access to these products and the staff would not necessarily be aware if they used these products inappropriately.

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

The provider told us that there had been a flood in part of the building shortly before the inspection. As a result part of the sluice room had been damaged. The electrical cables and casing these were in had been disconnected from the wall and hung midway between the floor and the ceiling across the sluice room. This room was primarily used by staff, but was not locked so could also be accessed by people living at the service or visitors. The provider told us that repairs were being planned to the room, however at the time of the inspection the positioning of the electrical cables presented a risk for anyone using this room.

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

In general the environment was clean and we saw staff attending to cleaning throughout the inspection. However, some bathroom floors were sticky or had limescale stains and some high up areas, such as the tops of switches and door frames, were dusty.

The provider carried out checks on the safety of the environment and equipment used. For example, we saw up to date checks on fire safety equipment, water temperatures and electrical safety. There was a clear and up to date fire risk assessment which included information about individual people's needs. All first floor windows were restricted from opening wide by approved devices which were regularly checked.

People received their medicines in a safe way and as prescribed. The majority of medicines were stored correctly. However, one person who managed their own medicines did not have a secure place to store these and the staff had not checked that the medicines were stored safely. We observed that this person's

medicines had been left on the top of a chest of drawers in their room. Some people who lived at the service had dementia and there was a risk that they could remove these from the room or consume these medicines. We alerted the staff to this and they agreed to move the medicines to a safer place. The trolleys used to store other medicines were kept secured but were stored in a room where the temperature sometimes exceeded 25◦C meaning that some medicines might be altered or damaged because the manufacturer had recommended storage below this temperature. The provider told us they were reviewing where medicines would be stored. There was an air conditioned room which some medicines were stored in.

The majority of medicines were administered safely and as prescribed. However, the staff crushed one person's medicines in order to administer these. The person's GP had agreed to this method of administration but there was no evidence the dispensing pharmacist had been consulted to make sure the properties of the medicine were not altered by crushing. The provider contacted the pharmacist about this directly after our inspection visit. We observed one member of staff using a prescribed thickener to thicken a person's drink. The person was prescribed this particular thickener however the container used by the member of staff had been prescribed to another person. The staff member told us, ''We always just mix and match.'' This practice was not in line with the provider's medicines procedure and presented a risk for people because the staff could wrongly administer a medicine or dose if they did not use the correct supply for each person. The provider told us they would ensure the staff followed the correct procedure following our observations.

People's individual medicines needs were appropriately recorded including allergies, variable doses of medicines and any specific needs. The staff administering medicines had received training in this area and had their competency assessed by the manager. Records of medicines which had been administered were accurate and up to date. One person was administered their medicines covertly (without their knowledge). The provider had consulted the person's next of kin, GP and others to make sure this decision had been made in the person's best interest. One person administered their own medicines. There was an appropriate assessment of their capacity to do this.

The provider had a procedure for safeguarding people, which included reference to the local authority safeguarding procedure. The staff demonstrated they were aware of this and knew what to do if they had any concerns about someone's safety. They told us they would report concerns to the manager, provider or the local safeguarding authority. There was evidence the provider had taken appropriate action following safeguarding concerns and had worked with the local authority to investigate these.

The staff had assessed risks to individuals and had put in place measures to help keep people safe. Each person had a summary of risks which outlined areas where they were vulnerable and the action the staff needed to take to keep them safe. These included risks to their physical health, mental health, risks involved with falls, moving safely, equipment and developing pressure sores. The risk assessments were regularly reviewed and dated. Changes in people's needs had been recorded. There was equipment to help keep people safe, such as pressure relieving mattresses and bed rails.

There were enough staff on duty to keep people safe and meet their needs. People told us they did not have to wait long if they required support. Call bells were situated in all bedrooms, bathrooms and toilets. We saw that these were left within easy reach for people who remained in their rooms. The cords for call bells reached the floor in bathrooms and toilets so could be accessed if someone fell when in these rooms. We witnessed the staff responding promptly to people who used the call bells to request help.

The provider had appropriate procedures for the recruitment and selection of staff. These included inviting

people for formal interviews and making checks on their suitability. The staff we spoke with confirmed they had taken part in an interview with senior managers and had given the names of referees to be followed up. We looked at a sample of staff recruitment files. These contained evidence of reference checks, criminal record checks, checks on people's identity, eligibility to work in the United Kingdom and nursing pin numbers. However, some of the application forms completed by the staff were incomplete and the provider had not evidenced what action they had taken to follow this up. For example, one person had not signed their application form or reference to the Rehabilitation of Offenders Act. Another person had not completed any details of past employment. We discussed this with the provider who agreed that they would ensure the missing information was obtained and future recruitment of staff would include checks to make sure application forms had been completed.

Requires Improvement

Is the service effective?

Our findings

At our inspection on 23 October 2014 we found that procedures were not in place in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) to ensure the service only deprived a person of their liberty in a safe and correct way. The provider sent us an action plan telling us they would make the necessary improvements.

At the inspection of 1 March 2016 we found the provider had made improvements. They had implemented a procedure regarding the Mental Capacity Act 2015 and the staff had received training and information about this.

The Mental Capacity Act 2005 (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. 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The provider had carried out a capacity assessment for each person relating to different aspects of their care. Where they were considered as unable to make specific decisions this had been recorded and there was evidence the provider had discussed their care with the person's next of kind and other representatives. The provider had made applications to the local authority regarding DoLS for each person who was restricted because they were not able to leave the home unescorted and/or were restricted by equipment such as bed rails. We saw evidence of meetings to discuss the person's needs, applications and authorisations for DoLS. The information had been included in care plans to show how the person should be supported. One of the members of staff told us, ''it takes time to get to know everyone, we ask the nurse if the service user is mentally able. If they say yes, we ask the person, if not we ask the nurse or family.''

People's nutritional needs were assessed when they moved to the home and each month. These assessments were recorded and people had been referred for specialist support when needed, for example support from a dietitian. There was clear information about people's individual needs and any additional support they needed.

People told us they liked the food at the service. The chef was responsible for creating the menu which was displayed in the dining room. The chef was aware of people's individual needs. All the meat at the service was Halal and some people told us they were happy with this. People were made aware of this during the initial assessment of their needs and when they moved to the service. Some people required soft or pureed diets. On the day of our inspection one person requiring a soft diet was given a dessert which had small pieces of apple in. They were unable to chew and swallow these and they had been given this meal without the staff noticing or correcting this. The temperature of food served to people on the day of the inspection

was, in some cases, cold. This was because food was left after it had been plated up for long periods of time before it was given to people. The food and drinks people consumed were recorded. People were given hot and cold drinks throughout the day.

The environment was not always designed and used in a way which reflected people's preferences and took account of their needs. For example, the corridors and communal rooms were used for storing hoists and some furniture. We observed two occupied bedrooms had been used to store three wheelchairs each. On the day of the inspection only one bathroom and one shower room were in use. One room was locked and there was a notice to this affect whilst it was being repaired. Another bathroom had been locked and was not accessible but there was no sign to indicate this. There was insufficient signage and way finding clues for people who had dementia. For example, the lighting, colour schemes and textures of the environment did not reflect good practice guidance for environments for people who are living with dementia. Bedrooms doors were distinguished by numbers and small name plates. Information on notice boards was not always clear, and was sometimes located high on the wall. The shower rooms had signs stating they were ''bathrooms.'' There was a Christmas decoration in the lounge despite the fact the inspection was in March.

The National Institute of Care Excellence (NICE) guidance about environments for people with dementia states, '' Good practice regarding the design of environments for people with dementia includes incorporating features that support special orientation and minimise confusion, frustration and anxiety.'' The guidance also refers to the use of ''tactile way finding cues.'' The government guidance on creating ''Dementia friendly health and social care environments'' recommends providers ''enhance positive stimulation to enable people living with dementia to see, touch, hear and smell things (such as sensory and tactile surfaces and walls, attractive artwork, soothing music, and planting) that give them cues about where they are and what they can do.''

People told us they thought the staff had the skills they needed to support them. The staff were given an induction into the home. We saw evidence of this, including checks on their competency. The staff told us they had shadowed experienced members of staff and had read the provider's policies and procedures when they started work at the service. They told us they had the information they needed and we saw a range of guidance and information for the staff.

There was evidence the staff had undertaken a range of training. This included sessions with the manager to discuss specific policies and procedures. The staff told us they had taken part in classroom and computer based training. They said that they had regular updates. They told us that training had included safe manual handling, infection control, health and safety, food hygiene, safeguarding adults, person centred care and dementia. They told us the training had been useful and helped them learn about their role.

All staff took part in regular individual and group meetings with the manager. They told us they felt supported. They said that they had the information they needed and were able to raise any concerns they had about their work. One member of staff told us, ''I find meeting with the manager useful, I feel listened to and supported.''

People's healthcare needs had been assessed and recorded as part of their care plans. Nursing staff were employed at the service throughout the day and night. We saw evidence that they consulted regularly with people's GPs and other healthcare professionals. There was a record of healthcare appointments and any actions from these. There was evidence of the involvement of different healthcare professional in assessing people's needs and planning care.

During our inspection there was a medical emergency at the service. The nurse in charge managed the

situation appropriately making sure the person was safe, well cared for and monitoring their health. They contacted the emergency services and the person's next of kin. They reassured the person and their next of kin and made sure the ambulance crew who arrived at the service had the information they needed to take over the care of the person.

We Recommend the provider consult recognised good practice guidance for improving the environment to help orientate and support people living with the experience of dementia.

Requires Improvement

Is the service caring?

Our findings

We observed some interactions between the staff and people who lived at the service which were not appropriate, kind or caring. Some of these indicated the staff had little or no respect for the people who they were supporting and in some cases their interactions resulted in people having a negative experience. For example, we witnessed a situation where one person told a member of staff that a blanket which another person had was theirs. The member of staff told the person it was not theirs and belonged to the person who had the blanket. However, they then removed the blanket from the person it belonged to without speaking with that person and gave it to the person who had asked for it. The same member of staff was assigned to support a person with their lunch. Throughout the lunch they repeatedly stood up and walked away from the person without telling them what they were doing, eventually leaving the person and not returning even though the person had not finished their lunch. Whilst supporting the person they held forkfuls of food up to the person's lips whilst they were still chewing. The person shook their head and put their arm up as a barrier between the member of staff's arm and their mouth. The member of staff wagged their finger in the person's face and said, ''Do not punch me, punching is not nice.'' We reported this inappropriate behaviour of the member of staff to the provider's operations director who agreed to take action.

We overheard a member of staff telling one person, ''You are so needy.'' The member of staff also laughed at another person who was asking for care. One person asked the same member of staff whether they could have a chocolate bar which was on the table in front of them. The member of staff said, ''You are not allowed it until you have your lunch, I have told you that.'' The member of staff also responded by raising their voice across the lounge asking ''what?'' when a person called out ''help!'' We overheard the same member of staff asking a person of the opposite gender, ''can I have a kiss today?'' They then walked away from the person. The same member of staff later made a kissing gesture with their lips in front of the face of another person. This was not professional or appropriate behaviour from the member of staff. They had not approached either person in a caring way and their other communication with these people was abrupt and at times rude. We reported these inappropriate interactions to the provider's operations director who agreed to take action.

Throughout the day we saw the staff approach people, start to undertake a task and then walk away or attend to another task without explaining what they were doing. Some members of staff tended to give people instructions rather than speaking with them. For example, telling people to ''move forward please'' when they wanted to place a cushion behind them or to ''open your mouth'' when they were supporting someone to eat. The staff moved people who were in wheelchairs without asking their permission or explaining what they were doing. The staff also bought people into the lounge and dining room and left them in wheelchairs facing other seats or the wall whilst they attended to other tasks.

We witnessed the staff supporting someone to move from their armchair to a wheelchair using a hoist. They did not explain what they were doing or where the person was going. They told the person instructions, such as ''stand up'' and ''hold here'' referring to the hoist. But at no point did they explain why the person was

being moved or check on their wellbeing and comfort. As the person was being lifted their clothes had been caught up exposing their side, back and underwear. The staff did not make any adjustments or attempt to cover the person's exposed body. The staff supported other people to move using hoists. They did not explain what was happening to these people either or where the person was going. For safety reason, two members of staff are required to support people when they use a hoist to move. When moving one person, one member of staff walked away twice to attend to other tasks in the room, which included adjusting an empty chair and repositioning other furniture.

The support people were given at mealtimes did not always respect their dignity or choices. For example, people who required support in their rooms or the lounge were taken a tray of food by a member of staff. Each person was taken a tray containing their soup, main course and dessert (which was crumble and custard). Three different members of staff were supporting people with their lunch in the lounge. None of the staff acknowledged that different parts of the meal had gone cold and served this at the temperature it had been left at, in one case an hour after the person had been brought their tray. We saw that trays were made up and left in the kitchen before they were taken to people. Some of these had been stored in the kitchen for up to 20 minutes before they were served up. One person who was eating their meal independently had become confused between their main course and dessert using the same cutlery for both. As a result they had mixed some of their curry with their dessert. A member of staff offered them a second spoon but did not offer them a new dessert or offer any other assistance to resolve the problem or prevent the person mixing their food further.

In the dining room, the staff had served up bowls of soup for people who had not arrived. Three bowls of soup were left unattended for over half an hour before people entered the dining room for their lunch. Two other people who were seated were served their soup but required support from a member of staff to eat this. They waited for over half an hour before the staff sat with them to support them. People were not given a choice of drinks at lunch time and were served by staff without any consultation.

We observed the staff wiping people's faces without asking their permission or explaining what they were doing. At one point a member of staff used a spoon to scrape food off someone's chin.

At one point a member of staff asked a person if they would like a cup of tea or coffee. They then immediately said, ''Oh no, you are not allowed coffee, your (relative) has told us not to give you any.'' We looked at the person's care plan. There was no information to indicate the person was not permitted to drink coffee. The person was not bought any hot drink following this interaction.

We witnessed another member of staff standing up next to someone they were supporting with their meal. The provider's operations director also observed this and told the member of staff to sit down, although they did not explain why this was important, they just told the person, ''It is easier if you sit.'' Before people ate, the staff placed protective aprons on everyone. No one was asked if they wished to have a protective apron and the staff did not tell people what they were doing before they placed the apron on people. In one example a member of staff started to put the apron on a person, then walked away to attend to another task leaving the apron half on the person covering part of their face. They returned several minutes later and finished putting the apron on without any communication with the person.

Other interactions we witnessed were not unkind, but were not sustained and the staff did not spend time talking with people. For example, the staff entering communal rooms asked people, ''Are you alright?'' but they did not wait for a response or give people an opportunity to start a conversation. The provider had arranged for a student from overseas to spend time gaining work experience at the service. The day of the inspection was the student's first day. They spoke hardly any English and had to refer to their translation

book throughout the day. The permanent staff left the student alone with people who lived at the service in the lounge on a number of occasions for up to ten minutes at a time. During one period they were left with six people and during another period of ten minutes they were left with eight people. During these times people spoke with the student who either told them they could not understand them or just walked away. At one point a person had become distressed and said, ''someone is trying to kill me.'' The student told the person, ''I cannot speak English'' and walked away. They did not alert other staff to the fact the person had become distressed.

The staff regularly spoke with each other over the top of people's heads or across the room when they were assigned to be supporting an individual. Some of the phrases they used indicated that they were focussing on tasks rather than the people who they were supporting and some of the language they used did not show respect for people. For example, one member of staff was overheard saying, ''We will finish her later'' when referring to supporting someone. Another member of staff told others, ''I need to start feeding now'', when referring to supporting people with their lunch. We heard two members of staff discussing one person across the room with each other. The person had requested a dietary supplement drink. The staff discussed how they would not allow this person to have the drink until they had tried some food.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's privacy was not always respected. There was a large board on display in a communal corridor with details about people's needs. The board contained red, amber and green stickers relating to people's nutritional needs, mobility and pressure care. Although coloured stickers were used, the information was displayed so that people who lived at the service and their visitors could read this and may have understood what the different colours meant, therefore they would know personal and confidential information about people's needs.

The provider's head office was located on the second floor of the building. Staff working at the provider's head office used the service's dining room to eat their lunch. People were not consulted about this.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they found the care at the service good. One person said, ''The staff are good, I would recommend this home to others.'' One relative told us they found the staff kind and caring. People told us they were able to have visitors whenever they wanted and we saw this to be the case. One person told us, ''I am happy in the home, I have the things I need and the staff treat me well.'' Some people had personalised their bedrooms with belongings, furniture and ornaments.

We observed some kind and caring interactions. These included one member of staff explaining about different parts of a person's meal and what they would be eating. We also heard some members of staff taking an interest in what people were doing, for example commenting on colouring they were doing. The staff administering medicines explained what they were doing and made sure people were happy taking their medicines.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive care and treatment which reflected their individual needs and preferences. The care plans for seven people recorded that they were to be offered a shower once a week. We looked at the care records for these people from 16 January 2016 to 29 February 2016. Two people had not been given any baths or showers, three people had been given one shower in that time, one person had been given four showers, but none since 6 February 2016 and the other person had been given five showers. When we spoke with the staff about how and when they offered people showers or baths, they told us people would not want more than one shower a week because it was ''too cold.'' When we asked them if people would like to have a shower each day they repeated that it would be ''too cold'' for people to be offered a shower each day. They told us that they gave people a ''thorough wash'' when they did not have a shower.

The care plans for four people we looked at stated the person would like to go to bed between 6pm and 7pm each evening. The care plan for a fifth person said they would like to go to bed at 4pm and the care plan for a sixth person said they would like to go to bed at 7pm. There was no evidence within the care plans that this was the person's choice and in some cases people did not have the capacity to make decisions about future events such as a regular bedtime. The staff told us that they tried to make sure everyone was in bed by 8pm, although they could not tell us whether this was people's choice or not. They told us this was in order to make sure everyone was in bed by the changeover of staff. The staff said that if someone refused they would not make them go to bed, but they encouraged everyone to be in bed by that time and helped those that could not express a choice to go to bed. One member of staff told us, ''I think it is too late for people to stay up after this time.''

On the day of the inspection some people remained in bed. The staff told us that one person had been left in bed because they were ''loud and aggressive.'' The person had been left in bed with a television on. The television was small and positioned a long way from their bed. The staff told us that it did not matter because the person could not understand English and the television was ''just moving images.''

There were three shared bedrooms, meaning that six people who lived at the service shared a room with another person. There was a curtain which could divide the beds but there was only one hand wash basin in each room and there was no privacy curtain around this. We looked at the care plans for two of the people who shared a bedroom. There was no evidence that they had been consulted about this or made a choice about this. We were told that a third person who shared a room liked to watch television but that the person they shared with did not. Therefore there did not appear to be consideration given to the individual needs and preferences of the people who were sharing bedrooms.

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

People had their needs assessed when they moved to the service and care plans had been created to tell the staff how to meet these needs. The care plans were appropriately detailed and included people's

preferences. People's needs were regularly reviewed. Where people did not have capacity to make decisions, there was evidence that people's relatives had been involved in planning their care. There was evidence of some consultation with people who were able to make decisions. Some of the people who we spoke with told us they were happy with the care they received.

People appeared clean and well cared for. They were wearing clean clothes and their hair and nails were cleaned. The service was warm and people were provided with blankets and additional clothes.

Where people were at risk of developing pressure sores this had been assessed and there were clear care plans in place. The provider used equipment to help protect people's skin. We looked at the care plans for two people who had wounds and pressure sores. There was clear information which tracked the progress of the wound and showed how these had been cared for.

The provider had a plan of social activities. However, this was not clearly advertised and the information about activities on the day of the inspection was inaccurate. There were some special events organised. However, for the majority of the time people told us they took part in individual activities. During our inspection people were reading papers, colouring and completing puzzles. People told us they were happy doing this and they looked content. There were various resources available for people to help themselves including knitting, games, books and puzzles.

The provider had a complaints procedure and people told us they knew what to do if they had a complaint. People told us they felt complaints were listened to and acted upon. The provider had a record of complaints and the action taken to investigate these. The information included responses to the complainant about the action taken. The provider audited complaints to make sure action was taken to prevent or reduce the risk of events leading to the complaint reoccurring.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager at the service. They were on leave at the time of the inspection. The provider told us that there were systems in place for managing the service in the absence of the registered manager, which included contact with the operations director who was a registered nurse. The staff on duty on the day of our inspection included one nurse and six care assistants. The nurse was responsible for carrying out nursing interventions, administering medicines and, on the day of our inspection, dealing with a medical emergency. Therefore there was no one responsible for managing and supervising the care assistants. We observed a number of incidents where people's needs were not being met and they were put at risk. For example, some of the interactions from staff were inappropriate and unkind. In addition we found cleaning chemicals left unattended and presenting a risk to people.

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

The provider liaised with relatives and other stakeholders about the service. There were regular relative meetings and we saw evidence of communication with relatives about changes to the service.

The registered manager was appropriately experienced and qualified. The staff told us they found the manager supportive. Some of the things they said were, ''The manager is strict but good, she knows what she is doing'', ''The home manager is very strict on training, we have to do it'' and ''I feel supported, I can talk to the manager about my work and anything I need.''

There was a range of checks and audits which the manager and staff undertook regularly. These included checks on clinical procedures and practices, health and safety, records and infection control. The audits highlighted areas for improvement and the action that needed to be taken.

The provider analysed complaints, accident and incidents. They created a report to show any themes to these and any action that needed to be taken to improve the service.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not ensure the care and treatment of service users was appropriate, met their needs and reflected their preferences. Regulation 9(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not ensure that service users were treated with dignity and respect. Regulation 10(1) The registered person had not ensured the privacy of service users. Regulation 10(2)(a)

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 The registered person did not ensure that care and treatment was provided in a safe way for service users because they had not done all that was reasonably practicable to mitigate risks. Regulation 12(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not have systems and processes to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk from carrying on the regulated activity. Regulation 17(2)(b)