Kingsley Care Homes Limited

Heron Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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

Heron Lodge is registered to provide accommodation, nursing and personal care for up to 30 older people, some of who may be living with dementia. There were 29 people living in the home at the time of our visit.

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.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People did not always receive care that took into account their individual needs and preferences and how these could be met. Systems for monitoring and improving the quality and safety of the service, having regard to the accuracy of records and for seeking the views of others, were not always operating effectively. You can see what action we told the provider to take at the back of the full version of this report.

Systems were in place, including staff training, to protect people from the risk of abuse. There were risk assessments that staff followed to help mitigate risks to individuals and their environment.

There were enough staff to keep people safe. Although there were enough to keep people safe, there were not always enough at night to respond to people's needs in a timely manner. There were recruitment procedures in place to ensure that staff deemed suitable to work with people were employed.

The CQC is required to monitor the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and report on what we find. We found that the home was not always working in line with the requirements of the MCA.

People received enough to eat and drink, although not everyone was offered the same choice of meal. People had timely access to healthcare.

People told us staff were compassionate. However, staff did not always interact with people effectively or missed opportunities to do so. Staff did not always interact with understanding of people living with dementia.

The service did not consistently meet people's social needs and personal preferences. The provision of activities was not always varied according to people's interests. There was little stimulation for people who stayed in their rooms.

There were several areas where audits or observations had not picked up issues with regard to person centred care and staff competency.

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?

Good

The service was safe.

Staff knew how to report concerns and understood safeguarding procedures.

People were supported to take their medicines by staff who were trained to administer them.

There were enough staff to keep people safe. Staff were recruited safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training relevant to their jobs, and where there were gaps, training was being organised. However, improvement was required with regard to checking staff competency.

People received sufficient to eat and drink, although they were not always able to choose what they ate.

People had timely access to healthcare.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always interact with people effectively. Some practices did not promote people's dignity and independence.

People were able to have visitors at any time, and they were made welcome.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records were not always accurate, and did not always reflect people's preferences.

Staff did not always deliver care which reflected people's individual preferences, in a timely way.

Activities provided were not always of a variety reflecting people's interests.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Auditing and monitoring systems were not effective at identifying all areas that required improvement.

Staff felt supported by their registered manager and worked well together.

Heron Lodge

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 11 October 2016 and was unannounced. It was carried out over a day by one inspector 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 care service.

Before the inspection, we reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. Prior to the inspection, the provider also completed a Provider Information Return (PIR). 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.

During this inspection, we spoke with five people who lived at the home, five visitors to the home, and three members of staff including a nurse and three care workers. In addition, we also spoke with the registered manager, the area quality assurance manager and the cook. We spoke with a healthcare professional who visited the service regularly.

We observed how care was delivered throughout the day. We reviewed care records and risk assessments for three people who lived at the home and checked six medicines administration records with associated audits. We looked at other records such as staff training records, and reviewed information on how the quality of the service was monitored and managed.

Good

Is the service safe?

Our findings

People we spoke with who lived in the home told us they felt safe; one person said, "I feel safe because the staff come when you call them and if I had any concerns I would talk to one of them." This was confirmed by other people we spoke with.

Staff understood how to protect people from harm. Staff told us that they had training in safeguarding and were able to tell us some types of abuse there were. The registered manager of the home had referred relevant notifications to the appropriate safeguarding authorities where necessary. Staff told us they felt comfortable to raise concerns to the registered manager if they felt they needed to. One member of staff told us how they would report any incidents relating to poor practice or abuse by staff members, and told us about the whistleblowing policy. We saw that the contact number for safeguarding was placed in staff and communal areas throughout the home, such as noticeboards and the administration office. This indicated that the organisation promoted reporting concerns for people's safety, and staff or others could contact the local authority safeguarding team easily.

Before the inspection, we received concerns following an investigated complaint, that recording of accidents was not always accurate and detailed. This was because it was unclear exactly what had happened, and which staff had been involved. The registered managed told us they were working on improving accident recording, and the recent records we looked at were accurately written. Accidents and incidents had been recorded, as well as action taken to further mitigate risk of reoccurrence. We saw that where details were recorded in care records, there was guidance in place for staff to follow which minimised risks.

Care records documented individual risk assessments for people covering issues such as moving and handling, health conditions, tissue viability and individual fire risk assessments. We observed people being assisted to mobilise safely in line with care records, using equipment appropriate to the person's need. We saw that risk assessments in place for moving and handling were detailed in people's care records. There were also risk assessments in place for the use of equipment. However, we did review one care record which stated that the person used bed rails, and there was not a risk assessment in place for this. This posed a risk that the person had not been properly assessed for the risks associated with using bed rails, such as becoming trapped in between them, or fall over the top. We discussed this with the registered manager, and staff completed this risk assessment on the day of our visit. We checked some other records relating to these risk assessments for other people, and found they had been completed.

There were systems in place for managing risks concerning people's skin integrity. Staff told us about what concerns they would report with regards to people's skin if they were at risk of developing a pressure area. We saw that where people required support to reposition, staff recorded that they had carried this out. However, one person living in the home told us that they had not been supported to change position during the night, but we saw that staff had nonetheless recorded that this happened every two hours. The registered manager said they would immediately investigate this.

We found that equipment for detecting, preventing and extinguishing fires was tested regularly. A fire drill had been completed earlier in the year; and we saw that in a recent action plan that the registered manager planned to make these more regular. All of the electrical equipment in the home had been checked for safety. A gas safety check had recently been carried out, and the regional manager told us what checks they had in place for water safety and the prevention of legionella. We saw that lifting equipment was serviced as required and environmental maintenance and associated risk assessments were in place.

We received mixed feedback from people about staffing levels. One person told us, "I feel safe because the staff come when you call them." However, we had some concerns regarding whether there were enough staff at night to meet people's needs. A person told us about the care they had received the night before our visit, "I have to wait for my bell to be answered, I am turned two to three hourly during the night I buzzed my bell at 1am. I waited half an hour for someone to come." The person went on to say that after the staff had assisted them that they were left without access to their bell. The registered manager said that they would urgently investigate this concern. One member of staff told us that if two people required support at the same time from two members of staff, this was not possible to provide as there were only three staff on at night. We also saw that a member of staff had raised night staffing levels as a problem during a recent team meeting.

The service had recently introduced a dependency tool, as dependency needs changed regularly. This was used to calculate the hours of care required to meet people's needs. The rota we saw confirmed the staff numbers that the registered manager had told us. The registered manager also told us how they had been working on deploying staff most effectively within the home.

The registered manager told us that the home was able to use their own staff a lot of the time when they needed extra support due to absence. Visitors to the home and healthcare professionals said that they had not had any concerns about staffing levels and the availability of staff to provide support and assistance when needed. During our visit, call bells were responded to promptly and we observed that there were staff present in communal areas during the day.

The organisation had safe recruitment policies and induction processes. This included appropriate checks such as references and a criminal records check. This showed that only people deemed suitable were working at the service.

Medicines were stored, managed and administered safely by staff who were trained to do so. The medicines administration record (MAR) for each person contained a front sheet with a photograph to aid staff in identifying people when administering medicines. This meant that the risk of staff giving the wrong medicines to people was minimised. There was also detail of any allergies and how people preferred to take their medicines. We checked five records and saw that there were no gaps in the records. We checked the records for medicines which were associated with higher risk, and therefore needed to be signed off by two members of staff, and found these to be administered safely. We also checked a random sample of medicines that were not in blister packs. We found that the balance corresponded with the amount received and given.

There was a protocol for the administration of 'as required' medicines in place as well as an additional recording sheet. One family member told us, "Staff seem to know what [relative] needs. They said [relative] had got a headache and the staff got some paracetamol for them." There were associated risk assessments in place, which helped to prevent the risk of over-medicating. For example, medicines that could affect people's behaviour were only used as a last resort. Medicines were sometimes given within a communal area, and we observed the staff to be discreet when administering and discussing them.

Some people in the home received covert medicines, and we could see that risk assessments were in place for this. The decision to administer covert medicines had been discussed with the GP, and the pharmacist to ensure medicines were being given safely.

Medicines management, in terms of ordering, returning, storing and administering, was audited regularly to ensure that people had received treatment as the prescriber intended, and any errors were picked up on. The registered manager carried out in-house medicine audits and staff had reported and recorded any errors, which the registered manager acted upon appropriately. A healthcare professional who worked with the home told us that staff were competent in picking up any areas of risk, such as a suspected infection.

Requires Improvement

Is the service effective?

Our findings

One visitor we spoke with said, "The nurses have all been really good." Another told us, "They [staff] seem to have the right skills." We spoke with the registered manager about new staff inductions, which they reported included shadowing, training and supervisions. The organisation supported new staff to undergo the care certificate. This is a national set of care standards for new care staff to learn and adhere to. Staff told us that the registered manager had checked and signed off their competencies before they were able to work alone with people.

Staff received mandatory training which included manual handling, infection control, food hygiene, safeguarding, first aid and fire safety. The nurse who we spoke with explained how they kept up to date with best practice by accessing study materials online. They also confirmed that all nursing staff were due to receive catheterisation training this year. The home had then employed district nurses to deliver this. A relative said, "[Relative's] catheter care is attended to pretty well. A [staff member] received training and then did it under supervision." Not all nursing staff had previously received any training in catheterisation, although people living in the home had required this. This meant that with the further training for all staff, they would be better equipped to meet the needs of people living in the home.

A member of staff we spoke with who was undergoing an apprenticeship with the organisation, explained how their course had positively helped them to communicate with people living with dementia. Three staff members we spoke with told us that they felt that they would benefit from more face to face training in dementia care. One member of staff said, "I need more training, more experience." They explained that they felt they required more understanding of dementia and this would help them to deliver good care to the people. We observed that there was inconsistency in the way in which staff interacted with people. This meant that some people living with dementia did not receive the appropriate engagement and stimulation they required.

We observed that staff did not always interact effectively with those people who were living with dementia. For example, staff did not always reassure people, and did not always provide opportunities for interaction and stimulation. This reflected what staff had told us regarding that they felt more training was needed in dementia care. We saw that staff all received dementia training via the computer, however some staff had received further training via their apprenticeships. This meant that not all staff, including nursing staff, had received the same standard of training. There was not enough training received so that staff could always meet everyone's needs effectively. We also concluded that the registered manager had not always thoroughly assessed staff competency to perform their role to make sure that their practice was safe and appropriate. The registered manager told us that the organisation will be taking up the programme with Stirling University Best Practice in Dementia Care Programme to further train staff in good dementia care.

Previous to our visit, we were made aware of concerns around moving and handling. We saw that the registered manager had investigated these appropriately. However, one person told us, "They pull me about like a piece of meat at a butcher's shop. The staff struggle with my sling and it becomes a real struggle." The registered manager did tell us that the person also found it difficult to move around due to their condition.

During our visit, we did see staff using safe manual handling procedures with various equipment for example, a stand aid. We asked the registered manager if they carried out regular competency checks on staff regarding their manual handling. They said they did not but would consider doing so in the future.

All of the staff we spoke with said that they received supervision regularly. This is a formal meeting with the registered manager or senior staff, where care staff can discuss their role and any concerns or further training needs. They said that they could discuss anything, and the registered manager and their seniors were approachable for support at any time.

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 so that they can 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). We checked whether the home was working in line with the MCA.

Staff were able to tell us about different people's capacity. We saw a mental capacity assessment which had been completed for one person, and that this was thorough. However, we checked in three other people's care records and found conflicting information about their mental capacity. Where they had received a mental capacity assessment, they were deemed to have capacity to make decisions in general. The capacity assessment carried out was not decision-specific. The registered manager had applied for a DoLS authorisation for them, and in this application, they were deemed not to have capacity. The decisions for which they were deemed not to have capacity were not recorded, which meant there was not enough detail. We brought this to the registered manager's attention and they said they had spoken with the DoLS team in the local authority, and withdrawn some applications. They also said they would review all of the care plans for the MCA and DoLS information to ensure that it was consistent.

One person told us, "The male night nurses talk to me about what they are going to do". Staff confirmed to us that they asked for consent before carrying out any care, and we observed staff asking for consent during our visit.

Where people received their medicines covertly, we saw that it was recorded that staff had consulted the family about it. However, there was no formal 'best interests' meeting to show that the family and the health professionals involved, had agreed on the covert medicines being in the person's best interests. One family member did tell us about a best interests decision they had discussed and made with the home and health staff, that their relative preferred not to return to hospital. The service was not always consistent in working in line with the MCA and DoLS.

People were not always given consistent choices across the home of meals, and we received mixed feedback about the quality and availability of food. People, visitors and staff told us that the food provided was of a good standard at the home. We saw that food was cooked freshly on the premises. The cook showed us the list of different people's dietary requirements and they were able to describe these to us.

There was some inconsistency in the way that people were given a choice of food. One person said, "The food generally is good, sometimes they give me a choice." This was reflected by another who said, "I find the

food very good." However, one person told us, "The food could be better, it is either savoury mince or chicken casserole." A visitor we spoke with said that they felt the staff did not make the same effort to offer people choices when they were cared for in bed.

Staff told us that they asked people what they wanted, out of a choice of two meals, in the morning. Given that many people were living with dementia, we asked if they used any communication aids to support people, and what staff did if people had forgotten what they had chosen. They said that if someone refused, they then offered them something else. A staff member told us, "Sometimes assumptions are made", regarding staff choosing for people. They said that this was due to not always spending the time to support people to make decisions, and communicate effectively those choices. We did observe a staff member showing people the desserts at lunchtime for them to make a choice.

A visiting relative said, "[Relative] eats and drinks enough." However, one person told us they did not feel they received enough to eat because they were not offered second helpings. They said, "The food is nice, but there's not enough of it." This person's relative confirmed that they felt this to be the case, and the person should be offered more food. We saw in the person's care plan that they had been weighed regularly, and that their weight had been stable. We concluded that although the person received enough to eat to keep their weight stable, they were not given the option to have more food which they said they would prefer.

We saw that people were offered drinks regularly throughout the day and had them in their rooms. Staff recorded people's drink and food intake when they were assessed to be at risk of not eating or drinking enough. People were regularly reassessed for their nutritional needs and we looked at the records which confirmed this in the care plans.

Some people's care plans contained inconsistent information about their dietary needs. For example, one person's guidance sheet from the speech therapy team specified that they should have normal food, but on the softer side and cut up. This was to mitigate the person's increased risk of choking. The person told us that they received pureed food, and did not like always receiving this. The staff told us this person had a soft diet, and this was written in the kitchen and in their care record. They confirmed that the soft diet that was given to the person was pureed food. However, we could see in the information from the speech therapy team that food on the softer side, cut up, or fork-mashable rather than pureed food, was advisable. The staff team had not followed the exact guidance recommended as well as the person's preferences to provide food that met both of these. It also demonstrated to us that where people were able to make informed decisions, this was not always supported, and that staff had inconsistent information about people. This was not responsive to individual preferences.

People had support to access healthcare when they required. A healthcare professional we spoke with after our visit confirmed that staff followed their recommendations effectively. They told us that if people needed any on-going referrals, staff did this in a timely manner. A healthcare professional we spoke during our inspection said that staff made referrals appropriately, and they had a good working relationship with them.

Requires Improvement

Is the service caring?

Our findings

People told us that the approach from staff was pleasant, "Some staff are very caring and courteous." A visiting relative told us, "The staff are kind and compassionate, they seem to understand [relative] more, the staff don't seem to hurry or get cross." Another visitor explained how compassionate the staff had been towards their relative who was cared for in bed. They had also found the staff to be very supportive towards the family.

Visitors told us they always felt welcome, one said, "They always make us feel welcome. Staff are very welcoming." People were supported to maintain close relationships with their loved ones.

We observed instances during our visit where staff did not always respond to people appropriately, for example if people were in obvious distress, they did not always provide reassurance. We saw that where one person cried out, this was ignored by the staff member in attendance. We saw that when staff were in the lounge, they did not always interact and people were sitting quietly, some withdrawn with no stimulation. We saw that staff repeatedly missed opportunities for stimulating interaction with people. We saw some instances where staff did not respond or offer assistance in a timely way to people requiring support with using the appropriate equipment to eat their meal. We saw that some interactions were purely task led, rather than focused on the individual.

Staff were able to explain how they offered people choice in instances such as personal care. For example, when people required support to make choices they showed them items of clothing to choose what to wear. However, we found that choices were not always communicated in a way that people could understand. There were no aids for communication such as pictures, to support people to make choices at mealtimes or concerning activities.

One person explained how staff respected their privacy, "Staff knock before entering my room even when the door is open, the nurses are patient." We observed that staff knocked on people's doors before entering. A visiting relative told us that staff always respected their relative's privacy and dignity during any personal care, saying, "It's very dignified, they always cover [relative] up."

However, during our visit we observed some instances of staff delivering support which compromised people's dignity. For example, we saw that one staff member was supporting someone to eat, and putting a great deal of food on the spoon and giving it to the person without talking to them. The staff member also scraped spilled food off the person's clothing cover, and put it back on the plate. We saw that during the morning when staff bought biscuits and hot drinks around, they placed biscuits directly into people's hand, without a plate or napkin.

We noticed that all of the tablecloths in the dining area were visibly dirty following breakfast and lunch, however they were not changed for tea time. We also saw that a plate cover fell onto the floor, and a staff member picked it up and placed it back on to a plated dinner. This was not only unhygienic, but showed a lack of respect and dignified behaviour towards people.

People were not always supported to maintain independence within the home. We saw one person who repeatedly tried to get up and walk around, as they were mobile. The staff member who was in the lounge repeatedly asked the person to sit down, at one stage gently pulling them down by the arm. We saw that the person was mobile according to their care records. The staff member told us that the person liked to walk around and that they did support them to do this. Staff also told us that they encouraged people to be as independent as possible when providing them with personal care.

All of the visiting relatives we spoke with had said that staff in the home always kept them informed of any changes in their relative's condition or their care. One relative said, "Staff have phoned us whenever there's anything." They went on to tell us that they had been involved in their relative's initial care planning. We asked people how they were involved in their relative's care. Relatives had been involved in an initial assessment of their family member's care, however they were not involved in on going reviews of people's care plans. One relative told us how staff had asked them what their relative preferred and how they would prefer to be cared for.

Requires Improvement

Is the service responsive?

Our findings

People's personal choices and preferences were not always respected. One visiting relative told us, "Sometimes there are too many male staff, as [relative] likes to be washed by a female but has to be washed by a male."

One staff member we spoke with said the care, "Doesn't always reflect the needs of people", giving examples of people not having choice to get up when they wish or have baths. They added, "They might get a quick strip wash when really they need a full shower or bath." This was reflected in what people told us. Two people told us that staff did not offer them baths or showers regularly, both saying they would prefer to have them more often. Other staff told us that they used a 'bath list' which determined when people were offered baths. The registered manager told us that they would discuss this with staff and look at becoming more flexible with regards to offering people baths.

People were not always able to choose what time to get up in the mornings. One person said, "It depends what time the staff come to me." One staff member confirmed that people were, "Made to get up at a certain time," when it was easier for staff, and they felt that this was wrong. They told us that the night staff were under pressure to ensure that as many people as possible were up for the day shift to start. They added that there were many people living in the home who required the support of two staff to get up, and there were only three staff on at night. They were unsure as to what time night staff began to wake people. This demonstrated that there was uncertainty about whether people were making choices about when to get up, and what times they were supported to get up.

We saw in staff meeting minutes that it had been discussed that night staff were to ensure that people were washed and shaved by the morning. We spoke with the registered manager about this and they told us that this referred to some people, who chose to get up early. They said they would perform a spot check during the night shift to check that this was the case. It was not clear how people's choices with respect to getting up and going to bed, were managed. There were no records of people's preferences with regards to getting up and going to bed, and staff had not recorded times that people were supported t get up.

Another person told us that when they rang their call bell at night, a member of staff came in, turned it off, and left again without offering support. A relative said, regarding staff answering call bells during the day, "They don't always come." We saw during lunch time, that one staff member said to somebody that they would come back and help them. We observed this person throughout the lunch time period until the person had finished their lunch, and we saw that the staff member did not return to them.

One relative told us that they felt that staff did not always carry out personal care thoroughly, in that the person did not always receive oral care. This visitor also said they checked regularly that their relative's catheter site and found that it was not always cleaned properly. They said, "Attention to detail is a bit lacking."

We saw that when the registered manager had completed a pre-assessment with one person, this had

included important range of movement exercises to be completed every other day by staff. The person told us, "I am meant to be having some regular therapy on my fingers but that hasn't happened yet." This information had not been transferred on to the electronic care plan that staff used, and the person confirmed that staff had never done these exercises with them. They said they had asked their relative to do this as they visited regularly, so therefore it did not have a large impact on their physical comfort. We discussed this with the registered manager, and they said they would ensure it was added to the care plan and a programme put in place.

Care records did not always show in detail people's preferences and interests. Staff were not able get a sense of who the person was from their electronic care plan, as they did not contain information about the people's likes, dislikes, preferences and histories. We looked at the paper records as well as the electronic care records, and found that for some people, information had been completed regarding their life history. Not all the relevant information had been transferred into the electronic records, which were the records that staff told us they used. This meant that knowledge of people that had been gathered, was not always shared effectively with the staff team.

One person, who was cared for in bed, told us that they did not see anybody to talk to when their relative was not there. Their relative told us that there were times when the person's television was left on loudly, on a channel that they did not want to watch. They said they felt this was very distressing for the person, and that staff had not been patient enough to spend the time asking the person what they wanted, or waiting for a response.

There was a dedicated member of staff for the provision of activities, and we saw activities taking place in one area of the home. The activities provided included board games and crafts. One relative gave an example of activities in the home, "They do jigsaws and making patterns on paper plates." A member of staff said, "There's not really enough for them to do." The PIR stated that, "The home is recognising people's hobbies and promoting independence through activities." However, during our visit we did not find that the activities reflected individuals' hobbies and interests, and promoted independence for individuals. There was no evidence that the organisation had based the activities on people's interests.

In other areas of the home, we observed that several people sat in the same chair throughout the day without stimulation, and staff did not encouraged them to be active. Where people wanted to walk about the home, staff did not always support them to do so. We saw that there was no stimulation or activities available for the majority of people in the home during our visit.

One person told us, "So many staff don't speak English. I can't understand them, it is very difficult at times." Another person living in the home told us, "The staff are very good here and supportive, but I wish the staff spoke better English and understood better." This was further confirmed by a visiting relative we spoke with who said that at times it was difficult to communicate with staff when they had poor English language skills. This meant that staff were not always able to communicate with people effectively, and therefore were not always able to provide individualised care.

We concluded that care was not focussed on individual needs and preferences, and staff did not always provide the level of support people required, in a timely way.

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

Visitors told us that they would raise a complaint if they wished, "If I was concerned I would speak to the

nurses." One visitor explained that when they had raised any concerns with staff, it had been amended immediately. They did go on to say that they did not always raise every little concern they had, as they acknowledged that staff were busy. We saw that the complaints procedure was readily available to people, and that any complaints that had been made, the registered manager had investigated and responded.

Requires Improvement

Is the service well-led?

Our findings

Auditing and monitoring systems did not adequately identify issues in relation to poor recording of care provision or staff skills and abilities in regard to dementia care. We found staff members, despite having received some training in dementia care, still did not always care for people with dementia in an appropriate way and this had not been identified by the organisation.

There were systems in place which had been recently developed to pick up any problems with the service, however they had not picked up all concerns. We saw that, during a recent mock inspection, the organisation had picked up various concerns that we also raised during our inspection. These included the limited interaction at mealtimes, as well as conflicting information in care records and some poor care practices. The action plan documented what action was to be taken to ensure improvement in these areas. We saw that the registered manager had implemented some specified improvements from this, for example in medicines administration. Other items on the action plan were ongoing.

We found that for staff whose first language was not English, that their competency had not always been assessed before they started providing care to people. This included their ability to converse and interact effectively in English as well as record information effectively. The registered manager had not identified the problems that people and visitors told us about staff's communication in English.

Care was not always person-centred and there was not a process for checking staff competencies regularly. People did not always receive care that reflected their preferences, and the audits in place had not picked these up.

Although we could see in team meeting minutes that improved recording had been discussed, the registered manager had not followed this up with regular competency checks on staff's recording. We found that the problems were ongoing. The registered manager had not carried out spot checks during different times of the night shift. Staff had not recorded times of supporting people to get up and people's choices were not always recorded. This meant that they could not be sure that people's choices of getting up were always respected.

People were not always asked what they thought of the quality of the service or the care they received. The staff had not actively engaged people with communicating their views to them. This included seeking people's views with regards to the food, the care and activities provided. Although there were meetings for people living in the home, we saw that information was not always communicated to them in a way that they understood. People who were cared for in bed did not receive the opportunity to attend the meetings and were not asked for their views.

There was no evidence that the views of visiting relatives had been sought. Staff had opportunities to give their views. However, we saw in meeting minutes that one member of staff had raised a concern about not having enough staff at night, however we saw no record of how this was responded to.

Care records had not been audited sufficiently to pick up on the inconsistencies and poor recording we found relating to people's care provision. We saw that some individual care plans had been audited, and that where gaps had been found, they were not always acted upon. Staff told us that key workers were responsible for the upkeep of people's care records, however the registered manager had not checked that this was happening effectively. The concerns we found regarding staff competencies around dementia care and communication had not been found or addressed. There was not a comprehensive system in place to ensure that staff were deemed competent in giving appropriate care to people.

These concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was visible within the home. One person told us, "Although I don't see her regularly I know who she is, she popped her head round the door today." A healthcare professional told us that they felt the registered manager was visible and involved with people. The staff we spoke with said that they felt there was good morale and a good staff team overall. They also said that they found the registered manager to be supportive.

We saw that the organisation had recently carried out a mock CQC inspection and put together an action plan as a result. There were some areas which had been improved, such as checking competencies of staff administering medicines. The registered manager had also planned improvements such as providing better care during mealtimes, using a toolkit for use of guiding staff in all aspects of the mealtime experience.

Visitors confirmed they were invited to meetings to do with the running of the home, and some attended.

The management team had notified safeguarding and referred any concerns to the relevant authorities. Where serious injuries had occurred, the registered manager had notified CQC as required.

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 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 did not always receive care that took into account their individual needs and preferences and how these could be met. Regulation 9(1) and 9(3)(b)(c)(d)(h)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems for monitoring and improving the quality and safety of the service, having regard to the accuracy of records and for seeking the views of others, were not operating effectively. Regulation 17(1)(2)(a), (c) (e) and (f)