Bupa Care Homes (CFHCare) Limited

Wombwell Hall Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Inadequate
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

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

We visited the service on 14 July 2014. The inspection was unannounced. Wombwell Hall Nursing Home is registered to provide nursing and personal care for up to 120 older people. The service provided dementia and end of life care in addition to care for people who were experiencing a variety of illnesses such as stroke, Parkinson's and conditions that affected their ability to move independently. The service was provided from four separate buildings (units). Each unit accommodated up to 30 people. There were 117 people living in the home at the time of our visit. There were separate facilities on site for the provision of administration, catering and laundry.

Summary of findings

There was registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

People had variable experiences of the service they received. While some people were very happy, others were not. In addition, our own observations and the records we looked at did not always match the positive descriptions some people had given us.

The service was not safe because there were not always enough staff; people were not adequately protected from the risk of infection and medicines were not always administered safely or stored securely.

The provider protected people from abuse. However staff did not always take account of the requirements of the Mental Capacity Act 2005 for people who lacked capacity to make a decision. Each person had an assessment of the mental capacity when they moved to the home, however these were not decision specific and had not been reviewed or updated. This showed that staff and the management team had not understood that mental capacity assessments should be relevant to specific decisions, at the time the decision needed to be made.

The provider operated safe recruitment procedures. However the provider did not have a system to assess and monitor staffing levels against the needs of people and make changes when people's needs changed. Rotas showed that staff absence was not always covered. Some people we spoke with were concerned about the low numbers of staff and we found evidence in staff rotas for the four weeks before our visit that numbers of care staff had fallen below safe levels at times in each of the units.

Although people told us they felt safe at the home their safety was compromised because some areas of the premises and some equipment was not cleaned effectively. For example we found dirty commodes in some people's rooms.

Improvements were required for the service to be effective because meal times were not managed effectively to make sure that each person received the support and encouragement they needed to eat their meals. For example, we saw there were times when there were no staff in the lounge/dining area to assist people who lived on 'Copperfield'. There were systems in place to protect people from risk of harm through malnutrition or dehydration. However, advice and training offered by the dietician was not always implemented. People told us they enjoyed their meals and described the food as, "Very good" and "Excellent". Staff were provided with training, including induction and essential training, to make sure they had the knowledge and understanding to provide effective care and support for people. Nursing staff were supported to continue their professional development (CPD). All staff received regular supervision and appraisal to make sure they were competent to deliver appropriate care and treatment.

People were supported to manage their health care needs. Nursing staff carried out regular health checks on people who lived in the home and these were recorded. People told us they were able to see a GP whenever they wanted to. Referrals were made to health professionals such as chiropodists, speech and language therapists, occupational therapists and dieticians when people needed additional support with their health care needs. A visiting optician was assessing people's sight during our visit.

Improvements were required for the service to be caring because staff did not always provide the support people needed to maintain their privacy and dignity. For example, it was the usual practice in the home to leave people's bedroom doors open when people were in their beds. Although people who were able to speak with us said they preferred them open, many people were not always able to recognise issues of dignity and privacy due to cognitive impairment. Staff permitted opticians who were visiting the service to carry out eye tests in communal areas of the units and at dining tables while people were eating their lunch. However, staff were careful to protect people's privacy and dignity when personal care was given.

People were treated with kindness and compassion during their interactions with nursing and care staff. People's care was planned with them or their representatives to make sure all their needs were understood by staff who provided their care and treatment. People's personal information was treated confidentially and records were stored securely.

Improvements were required for the service to be responsive because people did not always receive the support they needed when they needed it. Staff were

Summary of findings

largely focussed on completing tasks rather than responding to and engaging with people who lived in the home. For example, we observed that one person sitting in a wheelchair, the foot rests were not in place and the persons feet did not rest on the ground. They remained in this position for three hours. There were times when people spoke or called out to staff who were walking by or were in another part of the room and they did not get any response because staff appeared too busy with other tasks they were performing.

People's needs were assessed with them before they moved to the home to make sure the home was suitable for them. Their individual preferences, interests and aspirations were taken into account in the way care and treatment was planned and delivered. People were provided with a choice of suitable and meaningful activities to suit their individual interests. Their religious and cultural needs were responded to and met. For example, links had been established between the home and local religious groups to obtain support for people from local churches, temple and Gurdwara (The Sikh place of worship). Ethnic menus were also provided.

People were comfortable with the management and staff in the home. There was a clear complaints procedure available to people and their representatives to make sure they knew how to make a complaint if they were unhappy with any aspect of the service. People and visitors we spoke with felt able to raise any concerns with staff or the management.

Improvements were required for the service to be well-led because quality assurance and monitoring systems had not been effective in identifying shortfalls in the service. For example, the provider did not have an effective system for monitoring and reviewing people's dependency levels to ensure that there were always enough staff. Staff absence was not always covered which meant that there were times when people's needs were not met.

Our observations and discussions with people, staff and visitors, showed us that there was an open and positive culture in the service. People and their relatives were encouraged to express their views about the home through residents and relatives meetings and satisfaction questionnaires. These were taken into account in improvement plans for the home. Staff were clear about their roles and responsibilities. The staffing and management structure ensured that staff knew who they were accountable to.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's safety were not always managed effectively: People were not adequately protected against the risk of infection. Medicines were not stored securely or administered safely and at the right time.

Although staff had undertaken Mental Capacity Act training (MCA) and Deprivations of Liberty Safeguards (DoLS) training, improvements were needed to ensure this was implemented correctly to make sure that people's rights were protected.

There were not always enough staff to meet people's needs. However, the provider operated safe recruitment procedures and people were protected from abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Meal times were not managed effectively to make sure that people received the support and attention they needed. Advice and training offered by the dietician was not always implemented. However, there were systems in place to protect people from risk of harm through malnutrition or dehydration.

Staff were provided with training, including induction and essential training, to make sure they had the knowledge and understanding to provide effective care and support for people who lived in the home. Nursing staff were supported to continue their professional development (CPD). All staff received regular supervision and appraisal to make sure they were competent to deliver appropriate care and treatment to people who lived in the home.

People were supported to manage their health care needs

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not always protected where bedroom doors were routinely left open when people were in their beds. Opticians carried out eye tests in communal areas of the units and at dining tables during lunch. However personal information was treated confidentially and records were stored securely. Staff were discreet in their conversations with one another and with people who were in communal areas of the home.

Staff were kind and patient with people. People or their representatives were involved in planning their care. People's care was planned and continually reviewed to make sure all their needs were understood by all the staff who provided their care and treatment.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's day to day needs were not always met. People did not always get the care and attention they needed because staff were very busy and made tasks their priority rather than the people who lived in the home.

People's needs were assessed before they moved to the home to make sure the home was suitable for them. People's individual care plans provided the information staff needed to enable them to provide personalised care to people. Their religious and cultural needs were met and they were provided with a range of suitable activities they could choose from, in accordance with their individual needs and interests.

People's concerns and complaints were encouraged, explored and responded to in good time.

Is the service well-led?

Requires Improvement

The service was not always well led

Quality assurance and monitoring systems were not effective in identifying shortfalls in the service. There was no system for assessing staffing levels against people's needs; this meant there were not enough staff on duty at certain times.

There was an open and positive culture in the service. People and their relatives were encouraged to express their views about the home through residents and relatives meetings and satisfaction questionnaires. Their views were taken into account in improvement plans for the home. Staff were clear about their roles and responsibilities.

Wombwell Hall Nursing Home

Detailed findings

Background to this inspection

The inspection visit was carried out by two inspectors, a specialist nurse adviser who specialised in safeguarding people in health care settings and an expert by experience who had experience of caring for people who used this type of service. An expert-by-experience is a person who has personal experience of using, or caring for someone who uses this type of care service.

We spent eight hours at the home. During this time we spoke with 23 people who lived there and 11 relatives across the four units. We made observations and talked with staff, the manager and deputy manager. We provided feedback at the end of our visit.

We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. The PIR was information given to us by the provider. This enabled us to ensure we were addressing potential areas of concern. During our visit we looked at records in the home. These included a sample of people's personal records and care plans in three of the units, six staff files and a sample of the home's audits, risk assessments, surveys, staff rotas, policies and procedures.

We contacted health and social care professionals before our visit. These included GPs, local authority and health service commissioners, hospice nurses and local authority care managers, to obtain feedback about their experience of the service.

Some people who lived in the home were not able to tell us about their experience. To help us to understand the experiences people had, we used our Short Observational Framework for Inspection (SOFI) tool. The SOFI tool allowed us to spend time watching what was going on in the service and helped us to record how people spent their time, the type of support they were given and whether they had positive experiences.

At our last inspection on 20 June 2013 we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in the essential standards of quality and safety we looked at. We undertook a follow up visit on 6 January 2014 when we found the service had reached the required standard.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Inadequate

Is the service safe?

Our findings

People told us they felt safe at the home. They said, "I am safe." and, "There is nothing to worry about here". All relatives told us they felt their family members were safe in the home. People who were able to engage in conversation with us told us there were no restrictions on their freedom in the home.

Staff knew how to protect people from abuse. They were able to describe their safeguarding training and understood the various types of abuse to look out for to make sure people were protected. Information was displayed on notice boards about who to report any concerns to if they suspected that any kind of abuse was taking place. There were systems in place to make sure that safeguarding alerts were raised with other agencies, such as the local authority safeguarding team, in a timely manner if needed. Nursing staff told us that they alerted the unit manager of any safeguarding issues. Senior staff at the main administration office then alerted the local authority safeguarding team and the care quality commission. For example, a recent safeguarding alert was raised for a person had been admitted to the home with severe pressure ulcers. Staff also had access to a whistleblowing policy

Staff told us that they had undertaken training in safeguarding of vulnerable adults together with Mental Capacity Act 2005 training (MCA) and Deprivations of Liberty Safeguards (DoLS) training. Despite having had training in MCA, this was not being implemented appropriately. The MCA states, the starting assumption must always be that a person has the capacity to make decisions, unless it can be established that they lack capacity. Mental capacity is time and issue specific and any assessment carried out must be relevant to the decision in question, at the time the decision needs to be made. We saw that people had MCA assessment forms in their files that had not been fully completed and had not been reviewed for more than 3 years. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider told us that there had not been any applications to the local authority to deprive anyone of their liberty.

People told us confirmed that the risk assessments had been discussed with them. Each person's care plan contained individual risk assessments in which risks to safety were identified such as falls; mobility and skin integrity and the use of wheelchairs. There was also a health and safety checklist. Guidance about any action staff needed to take to make sure people were protected from harm was included in the risk assessment. Records showed that risk assessments were reviewed each month. Where people's needs changed, staff updated risk assessments and changed how they supported people to make sure they were protected from harm. For example where people were identified as at risk of developing pressure ulcers, specialist equipment such as pressure relieving mattresses and cushions were obtained.

Reduced staffing levels that occurred from time to time had a negative impact on people's safety and welfare. Staff rotas for the four weeks before our visit showed that there should have been a minimum of seven staff on duty in the morning and five in the afternoon in each unit. There were times when care staff numbers had fallen below these levels in all the units. This included the day before our inspection visit. One person on Macawber unit had a pressure ulcer; their care plan showed they should be repositioned every two hours to relieve pressure on the affected area. We saw that there were only five records of this person having been repositioned over a 24 hour period on 13 July 2014. Staff were unable to confirm that this person had been repositioned in accordance with their care plan.

Whilst people generally spoke positively about the service they told us that there were times when they had to wait a long time for the attention they needed. People said, "There's always a shortage of staff here". "Staff are kind and helpful, but sometimes you have to wait too long for assistance". Visitors told us, "Staff don't have time to stop and chat with people." and "They are always very busy, no time to engage with people socially". One person told us that they felt most problems in the home came down to, "A lack of staff and shortage of equipment".

We observed there was limited interaction between staff and people during lunchtime. Staff were focussed on serving meals. One person called out for a drink several times, no one responded because all the care staff were busy serving. Another person became distressed but staff were too busy to attend to them promptly which resulted

Inadequate

Is the service safe?

in further distress for them. There were periods of time when there were no staff in the lounge or dining rooms to supervise people or provide assistance. At 14:45 in Pickwick unit, we observed that one person was shouting out in their bedroom, staff did not respond to them. We were told that there were two nurses and three care staff on duty at the time, two care staff were supporting other people and one member of care staff was having their break. We observed there were not enough staff on duty, to make sure people's needs were met. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were at risk of harm because medicines were not stored securely or administered safely and at the right time. On Copperfield Unit at 10:30, we observed that the morning medicines were still being administered although records for most people showed these should have been administered at breakfast time. This was a potential health risk for people who required their medicine at meal times. People who were given their medicines late in the morning had very little time before they were given their lunch time medicine. One of the medicine trolleys had been left unattended in the corridor and was not locked. We discussed this with the senior nurse. The trolley had not been locked throughout the whole time when medicines were being administered. Not all medicines had been signed for when they had been administered to show that people had been seen to take them. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were at risk of infection because measures were not taken to ensure adequate standards of hygiene. Some commodes in people's rooms had not been cleaned thoroughly. There were dirty commode pans on a rack in an open sluice room. The provider advised us that the night staff cleaned the commodes on the night shift. We were shown daily cleaning sheets. These listed ticked off items including commodes to show they had been cleaned. However, staff did not record that each individual room commode had been cleaned which meant that this could not be monitored effectively. We also found a soiled hoist harness which was brought to the attention of staff and removed. In one of the bathrooms we found splashes of fresh blood on the bathroom floor which was also brought to the attention of senior staff who ensured that the area was cleaned. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider operated safe recruitment procedures to make sure that only suitable staff were employed to care for people. Staff recruitment files included completed application forms which had staff members' education and work histories. People applying to work at the home were required to attend an interview. Each file contained evidence of appropriate pre-employment checks such as criminal record checks, and references. Proof of identity such as passports, driving licences and birth certificates were provided by the candidate and checked by the service. All nurses PIN numbers were regularly checked to ensure that the nurse was on the active register of the Nursing and Midwifery Council (NMC).

Requires Improvement

Is the service effective?

Our findings

People told us they had, "Excellent food." and "Staff are good." Two relatives who we spoke with said that the staff were excellent. One person said, "The staff are wonderful and cannot do enough for me". Another person said that they had dreaded coming here, but loved it now, because of the staff.

In the PIR the provider told us that 18 people who used the service had been assessed as at risk of malnutrition or dehydration. We contacted NHS dieticians who advised the service about how to provide support to people who were at risk of malnutrition. They told us that they visited the service to see patients who had been referred to them and said that, "The advice we provide is generally followed through". They had provided some training on malnutrition screening but this had not been well attended. We saw that there were times when there were no staff in the lounge/ dining area to assist people who lived on 'Copperfield' and some people did not eat their meals on Pickwick and Macawber units. Staff did not prompt or encourage these people eat and eventually the meal was taken away. We saw that food and fluid charts were not always completed where people who were at risk required their intake to be monitored. People who had their meals pureed were not offered a choice of meal.

However, most people had positive things to say about the food. Meals were home cooked, freshly prepared and well presented. People were asked to choose their lunch time meal each morning. They said they had enough and they were offered choices. A varied ethnic menu was provided on one unit. One person told us, "I prefer bacon sandwiches"; these were made for them. We found that overall people had positive experiences, although we observed that the serving of the lunch time meal was disorganised. Care staff served meals to people who wished to stay in their own bedroom, together with serving meals to people in the lounge/dining areas of the units.

Fortified milk and high calorie foods such as cream were available in the kitchens on each unit. Staff told us they added these to foods and drinks where people were at risk of malnutrition. A relative told us how keen the staff had been to let her know when their mother had finally gained a kilo, after spells of eating very little. Drinks were readily available throughout the day and people were offered a choice of hot and cold drinks at regular intervals. Care records we looked at showed that people's nutritional needs were assessed and weights were recorded regularly to make sure that people were getting enough to eat and drink.

The provider employed a trainer at the home. This trainer was available to organise staff training and induction in the home. Staff also received training about people's specific needs such as dementia, end of life and diabetes. Staff lifted and moved people around the home safely and competently. This demonstrated to us that staff were receiving training which enabled them to deliver care and support safely. All staff had received essential training such as moving and handling, infection control and food safety. Staff also attended training on end of life care. The manager worked closely with hospice nurses to make sure that staff had all the information they need to support people effectively at the end of their lives. Nursing staff confirmed that they were supported in their professional development. During our visit we saw a number of newly recruited staff attending their induction training course in the training room. The induction training took place over five days. Rotas showed that new staff shadowed experienced staff for their first few shifts to give them time to get to know people and observe how to carry out their role.

Staff received effective support and supervision to make sure they were able to develop their knowledge and skills. Supervision and appraisal records were in staff recruitment files. Staff told us that they were supervised when they started work at the service. They said that staff worked as a team and it was a good place to work. Care staff told us they had regular supervision sessions and were able to discuss their work. Nursing staff told us they received clinical supervision and that this included training in administering medication and catheter care. Nursing staff also attended a weekly clinical review meeting where nursing practice and any updates were discussed. This showed that nursing staff were supported to continue their professional development (CPD).

We saw that people felt comfortable to discuss their health needs with staff and ask their advice. People were supported to manage their health care needs Records showed that people had regular appointments with other health professionals such as chiropodists, dentists and opticians. A visiting optician was assessing people's sight during our visit. Nursing staff carried out regular health

Requires Improvement

Is the service effective?

checks on people who lived in the home and these were recorded. People told us they were able to see a GP whenever they wanted to. Care plans contained information about people's health needs and medical conditions along with guidance for staff. Visitors confirmed that GPs were consulted frequently and whenever needed. One person said that huge efforts had been made to get their friend's pain controlled on admission and mentioned the doctor being, "Here every day." until she was pain-free, "as you see her now".

Requires Improvement

Is the service caring?

Our findings

Most people who were able to talk with us about their experience told us they were generally satisfied with the way they were cared for in the home. They said they were treated "like family" and "first class." One relative told us they were always made to feel welcome. Two other relatives stated that they would be happy to live here themselves. Other visitors were less satisfied with the service. They told us, "The care is good but you have to keep on top of it". They said they had sometimes needed to remind staff about portion sizes and podiatry referrals.

Some people's privacy and dignity was not always protected. People who lived in two of the units were experiencing dementia and were not always able to understand when their privacy or dignity was not maintained. The usual practice in the service was to leave people's bedroom doors open during the day, including bedrooms where people were nursed in bed, unless the person requested for their door to be shut. This meant that people could be seen in their beds by all who walked past. Some people whose doors were open told us they preferred it this way. However a number of people were not able to communicate their preference and this had not been recorded in their care plan.

We observed a visiting optician check people's vision in full view of other people, visitors and staff whilst lunch was being served. People were having their eyes checked at the dining table whilst other people were eating their lunch. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's personal information was stored securely and staff were discreet in their conversations with people in communal areas of the home.

People we spoke with were not always able to remember if they had been involved in planning their care or if their care plans were discussed with them. One person said, "I leave all that sort of thing to my daughter". A relative told us that they knew about their mother's care plan and that they were aware of where it was kept and checked it regularly. Another relative said they were happy with the care that their family member was receiving and that the staff were attentive to the person's needs and that they kept them informed and discussed their family member's care with them. Relatives told us they had been consulted about their family member's likes and dislikes, and personal history, and said that the service kept in touch with them.

People's care was planned and regularly reviewed and updated to make sure their needs were understood by staff who provided their care and treatment. Each person had an individual care plan. These had been reviewed each month or more often if people's needs changed or they were unwell. Care plans were updated as people's needs changed. For example, where people needed more support with their personal care or mobility. Daily notes were completed for each person during each shift. Staff used these to record and monitor how people were from day to day and the care and treatment people received.

A Local authority care manager told us, "I find the manager, deputy manager; staff nurses and care staff are very supportive and caring to the clients. I find all the documentation always up-to-date. I had one client admitted to this home six years ago for end of life care, recently I have transferred them into residential care as care provided by the home is so good that the client's health and wellbeing had improved and we were able to reduce the care".

Requires Improvement

Is the service responsive?

Our findings

At times we saw that people did not receive the support they needed and people's day to day needs were not always met. People spoke or called out to staff who were walking by or were in another part of the room and they did not get any response because staff appeared too busy with other tasks. Care was often based around completing tasks rather than responding to the immediate needs of people who lived in the home.

We observed one person sitting in a wheelchair. The foot rests were not in place and their feet did not rest on the ground. The person was in this position for almost three hours before staff brought in a hoist to transfer the person into a more comfortable chair. One relative told us they had to carry out, "The fine details of care." This included cutting their family member's finger nails and cleaning their dentures. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At other times staff members communicated effectively with people who lived in the home. For example, we saw one person who was upset. A member of staff took the time to sit with this person, listen to what they had to say and answer their questions with patience and kindness. Staff supported people to make choices in their day to day lives. Staff explained what was on the menu and people were asked what they would like to have for lunch. People were asked if they would like to take part in activities, when they declined their wishes were respected. Two people who sat at the dining table during the morning told us they liked to do this because they "like to see people coming and going." We spoke with some people who were in their own rooms. They told us they were there because they wanted to be and they could go to the lounges if the mood took them.

People who were considering moving into the home were visited by a member of the management team who carried out a pre-admission assessment to determine if the home was able to meet their individual needs. We looked at records of these assessments in people's individual files and saw that these covered all aspects of people's personal and health care needs. The provider told us they consulted with health and social care professional who had been involved in the person's care and treatment as part of the assessment process where this was appropriate.

Assessments were reviewed with the person concerned and care plans updated as their needs changed to make sure they continued to receive the care and support they needed.

Individual care plans had been developed which were based on the initial assessment of people's needs. The service also operated a 'resident of the day' programme in each of the units which meant that all aspects of the care, treatment and day to day activities of the person chosen was reviewed on their day. This helped to make sure that care and treatment plans were up to date and any changes in people's needs were identified.

Staff told us they discussed how each person had been when they handed over to the next shift, highlighting any changes or concerns. Information was included in peoples care plans about their preferences about how they wanted their care to be delivered. For example, there was information about whether people preferred to have a male or female carer to assist them with their personal care.

Each person had a 'map of life' in their files' which contained information about the person's life history including their cultural and social history. This enabled the service to identify and meet people's needs in these areas. A social care professional who we contacted as part of this inspection told us that they had five Asian clients at Wombwell Hall and that the service had involved a local Asian charity, jointly working with Volunteer Bureau to support people with their social and emotional needs. The manager, deputy manager and activities coordinator had linked with local religious groups to obtain support for people from local churches, temple and Gurdwara.

People were provided with a range of suitable activities Including cookery club, gardening club, themed parties, games, film shows, reminiscence and spa afternoons. People were encouraged to take part in activities wherever possible but their decision not to take part was respected. The activity coordinator told us they spent a minimum of fifteen minutes each week with each person, including those who were nursed in bed. Activities were planned with their interests and abilities in mind. One person was encouraged to paint through the provision of space, time, and materials. The results were very pleasing and were on display round the home. Two visitors told us they felt that there should be more activities and that people should be taken out more. Another visitor said, "The activities do not

Requires Improvement

Is the service responsive?

always really work because they need one to one, which cannot be done here". However, they went on to say that staff do try and gave examples of singing, exercise, and music.

People knew how to share their experiences or raise a concern or complaint and felt comfortable doing so. We saw that people were comfortable with the management and staff in the home. People who lived in the home and their visitors knew who to talk to if they had any complaints about the service. Some people said they would tell their relatives of any concerns, others named staff who they could talk to if needed. All the visitors we spoke with felt able to raise any concerns with staff or the management. A visitor said, "I have never had to go to the manager because any little niggles are always sorted out straightaway". Two other visitors told us they would be happy to live in the home themselves

People were given information about how to make a complaint when they moved to the home. The complaints procedure was also available in each of the units. This procedure told people how to make a complaint and the timescales in which they could expect a response. There was also information and contact details for other organisations people could complain to if they are unhappy about the service. We saw that complaints were recorded in a complaints log. A local authority care manager who we contacted told us, "I find the manager, deputy manager, staff nurses and carers are very supportive and caring to the clients. If any issues were raised by the family to me, I have managed to work through them with the management and staff to solve the matter". This showed that people's concerns and complaints were encouraged, explored and responded to in good time.

Is the service well-led?

Our findings

People who were able to engage with our questions said that they knew the manager but sometimes they meant the staff member in charge of their unit. One person correctly pointed out 'the boss' as she walked through one of the units. Relatives who we spoke with told us they felt that the home was well led and knew the manager by name. Our observations and discussions with people, staff and visitors, showed us that there was an open and positive culture in the service. However, we saw that nursing and care staff were focussed on completing tasks which meant that engagement with people who used the service was limited.

We found that not all risks were monitored or managed effectively. For example, infection control audits were carried out by the nurse in charge on each unit which meant that they were auditing their own practice. During our inspection, we identified shortfalls in this area where people were not adequately protected from risk of infection. Although there were quality assurance systems in the home and the area manager carried out monthly audits of the service, these had not been effective in identifying shortfalls in the service. The provider did not have an effective system for monitoring and reviewing the dependency levels of people who lived in the home to ensure that there were always enough staff on duty to meet people's needs and promote their health, wellbeing, privacy and dignity. Staff absence was not always covered which meant that there were times when people's needs were not met. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The home held quarterly resident and relative's meeting on each unit. This enabled people and their families up to date with what was going on in the home and ask any questions. Some relatives who attended the quarterly relatives' meetings and said they found them useful. There were notices posted in the units about dates of future meetings. This showed that people and their relatives were provided with a forum where they could express their views about the service. Customer satisfaction surveys were carried out annually to gain feedback on the quality of the service received. The provider told us in the PIR that returns from the survey were evaluated and the results were used to inform improvement plans for the development of the service. They also told us that that local authority and clinical commissioning bodies carried out quality monitoring visits and any feedback was used to inform improvement plans. Health and social care professionals who responded to our questionnaire told us they were satisfied with the service. The provider gave support to the manager to carry out their role. There was also support available at a regional level in specific areas such as training and development, human resources, sales and marketing and health and safety.

Communication within the service was facilitated through weekly clinical review meetings which were led by the home manager, deputy manager or clinical support manager. These were used to share information and review events across the home. A staff representative from each of the four units attended these meetings and reported back to their colleagues. Clinical review meetings were used to monitor the care and treatment provided in each unit in areas such as nutrition, wounds and pressure areas. A member of the management team also walked around each unit daily to carry out clinical audits. These were recorded and copies were kept in the manager's office.

We spoke with staff about their roles and responsibilities. They were able to describe these well and were clear about their responsibilities to the people who used the service and to the management team. The staffing and management structure ensured that staff knew who they were accountable to. Each unit was led by a senior member of nursing staff who was supported by the deputy manager and the clinical manager to carry out their roles, who in turn were supported by the manager.

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 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person did not take proper steps to ensure each service user received care that was appropriate and safe.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person did not have effective systems in place to monitor the quality of the service delivery.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The registered person did not have effective systems in place to protect people from the risks of acquiring a health care associated infection as appropriate standards of cleanliness and hygiene were not maintained.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe administration and recording of medicines.**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The registered person did not have suitable arrangements in place to ensure that people's privacy and dignity were maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person did not have suitable systems in place to ensure there were sufficient numbers of suitably qualified, skilled and experiences persons employed

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.