Care Quality Commission

Bamfield Lodge Limited

Bamfield Lodge

Inspection report

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Date of inspection visit: 24 February 2015
Date of publication: 24/04/2015

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

This inspection took place on 24 February 2015 and was unannounced. The previous inspection was carried out on 13 March 2014. There had been no breaches of legal requirements at that time.

Bamfield Lodge is registered to provide accommodation and personal care and nursing care. The service comprises of four units over three floors. The top floor unit provided care to people who were living with dementia. At the time of our inspection there were 59 people using the service.

A registered manager was not in post at the time of inspection. 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.

Summary of findings

Systems were in place to safely manage people's medicines however improvements needed to be made in this area. Some people's medicines were not given at the time recorded.

Not all staff received training to help them understand their obligations under the Mental Capacity Act 2005 and how it had an impact on their work. However some staff we spoke with confirmed they had an understanding and were awaiting training dates.

Not all staff had attended Deprivation of Liberty Safeguards training (DoLS). This is legislation to protect people who lack mental capacity and need to have their freedom restricted to keep them safe. Two people using the service were subject to a DoLS authorisation. All documentation was appropriately completed that safeguarded the person's human rights.

There were not sufficient staff to enable them to perform their roles effectively. Some people received their medicines later than prescribed and staff were not always available to support people to keep them safe. Some people who used the service and their relatives told they felt there was not enough staff on duty at certain times of the day. People were observed unsupervised in shared areas when they required support.

Not all records were completed to manage people's on going health needs to ensure they were met. Risks associated with nutrition and hydration were not always managed effectively as the records were not always completed fully or correctly.

We saw care files contained sections for medicines, mobility, nutrition and other care needs. The care plans were reviewed mostly monthly, although there were some gaps were found.

The care plans we viewed contained information about people's likes and dislikes as well as their needs.

We found the provider had systems in place that safeguarded people and staff understood the policy and guidance. People we spoke with told us they felt safe living in the home.

Staff meetings and manager meetings took place with the service manager on a regular basis. Minutes were taken and any actions required were recorded.

Safe recruitment processes were in place and appropriate checks were made before people started work in the service.

Quality and safety in the home was monitored to support the registered manager in identifying any issues of concern. There were systems in place to obtain the views of people who used the service and their relatives.

We found several beaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which now correspond to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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

Some people did not receive their medicines in line with the time and instructions of their prescription.

There were not enough staff at peak times, for example at meal times. People were left unsupervised in shared areas.

Some people that lived in the home told us they felt safe. However feedback was inconsistent and some relatives raised concerns about safety

Safe recruitment processes were in place before people started work.

Is the service effective?

Requires Improvement

The service was not effective

Not all records were completed to manage people's on going health needs. This included the effective recording of people's fluid intake and care records.

Some staff training was not up to date including The Mental Capacity Act 2005. Some people's care documentation lacked evidence of 'best interest' meetings that took place.

Systems were in place to manage people's on going health needs. GP's undertook regular visits as did other external professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

Some people's dignity was not always maintained. One person's dignity was compromised in a shared area. People's opinions were sought however one person felt they were not always acted upon.

People told us staff were caring and supportive and observations that we made of staff interactions confirmed this.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Changes in people's care needs were not always responded to quickly.

Some people's wound management plans were not comprehensively completed to guide staff how this needed to be managed. Or to monitor its healing progress.

The care plans we viewed contained information about people's likes and dislikes as well as their needs.

Summary of findings

People and their relatives that we spoke with felt staff had a good understanding of their individual needs and know how to support them on a daily basis.	
Is the service well-led? The service was not well led A manager was in post at the time of inspection, however they were not registered. Some staff told us they didn't feel supported by the management team. Although two staff told us they could gain support at any time from the management team. Not all staff received one to one supervision. There were quality assurance systems in place and people's views were sought although two relatives felt they were not always acted on. Systems were in place to monitor the quality of the service and identified some areas we had highlighted at this inspection.	**Requires Improvement**

Bamfield 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 24 February 2015 and was unannounced. The inspection was undertaken by four inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. The PIR is a form that asks the provider to give some information about the service, what the service does well and improvements they plan to make. We reviewed the information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us. We also reviewed the information that we had about the service including information of concern that we had received. This information included concerns around insufficient staffing levels.

We spoke with 12 people who lived in the home. We also spoke with 13 members of staff that included senior members of staff, the manager and the regional manager. Five relatives were visiting at the time of our inspection and we were able to speak with them.

We reviewed the care files and associated care records of seven people who used the service and reviewed documents in relation to the quality and safety of the service, staff training and supervision.

Inadequate

Is the service safe?

Our findings

At the time of our inspection staff told us that no-one was able to look after their own medicines, all were looked after and given by staff. We saw some people being given their morning and lunch time medicines in a respectful way. On the day of our inspection one nurse was on duty on the nursing floor, some people did not receive their morning medicines until after 11 am although they were recorded as having been given at 8 am. This meant that people did not receive their medicines at the times they needed them and the records were inaccurate so the effectiveness of medicines could not be correctly monitored. Some medicines which should be given on an empty stomach were not given until after breakfast. This could make them less effective.

Some people were offered their lunch time medicines in the middle of their meal. This increased the risk that people may either decline their medicine or may stop eating their meal once it had been interrupted. We saw one person decline a medicine for treatment of diabetes, which was offered while they were eating their meal. Staff said they would try again later.

We saw examples of two people prescribed medicines to be given covertly. This meant that, if the person declined their medicines, staff could disguise them in food or drink to make sure they were taken. However there was no evidence that staff had checked with their pharmacist or GP whether it was safe to give the person's medicines using this method. Some medicines could be less effective or harmful if they were disguised, for example by mixing with food supplements.

Suitable storage arrangements were in place for medicines. Records showed that medicines were stored at a safe temperature. Medicines requiring additional security were stored correctly and records showed they had been looked after safely. However some medicines awaiting disposal were not stored securely and could be accessed by people who were not authorised to do so.

We saw where people were taking medicines such as Warfarin, which has specific guidance about administration to be followed; there was no guidance for staff regarding drinks to be avoided. When we asked staff where they would access information about this none of the staff we spoke with were aware of this. For example certain drinks can increase the effect of warfarin, leading to bleeding problems. People taking Warfarin should avoid or drink only small amounts of cranberry juice and alcohol, both of which were available in the dining room.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Suitable arrangements were in place for the ordering of medicines. Records showed that people's medicines were available for them. The pharmacy provided printed medicines administration records for staff to complete when they had given people their medicines. Records showed that people had been given their medicines as prescribed. We saw three examples where people had been prescribed a medicine requiring regular blood tests to check the correct dose. We saw records of these checks and staff had recorded they had given the correct doses.

Some people we spoke with told us they received their medicines when they should. Comments included; "I feel settled here and safe, nice good staff, I get my tablets regularly and staff stay with me until they are sure I take them, I am not sure what they are for, I just trust them" and "They give me my tablets, that is so wise, otherwise I might forget to take them".

Not all people were able to tell us if they felt safe living in the home. Those who could told us "I am safe here, there are always people around, if I were to fall I know there would be someone to help me". Another person told us "I feel safe enough". People who were unable to tell us of their experience we observed staff interactions and people were relaxed and comfortable in the company of staff.

Two relatives told us they were worried about the safety of their relatives; one told us their relative had left the unit unseen and the other told us their relative had sustained a fractured femur in a fall when pushed by another person. We checked records and both incidents had been reported appropriately and followed up. However other relatives said they were quite sure their relatives were safe; one commented that staff had put pressure mats on the floor and on an armchair so that they can be alerted when their relative, who is prone to falls, gets up from the chair or bed. This demonstrated the service considered assistive technology to support people's safety.

Inadequate

Is the service safe?

The provider had arrangements in place to respond to suspected abuse. Staff received training in safeguarding adults and a clear policy was in place for staff to follow. We asked staff if they knew what to do if they suspected someone was being abused. All staff told us they would report suspected abuse to the manager or the person in charge. They also said they would contact the regional manager if necessary. Staff said, "I'd take it all the way to the top. You can't leave these things" and "I'd report to a senior. If they weren't able to deal with it I'd keep going up till the problem was solved." We asked staff if they were aware of external organisations they could report abuse to; all staff were unclear about the role of the local authority safeguarding team. Staff told us, "I'd go somewhere like CQC."

Care files contained risk assessments specific to the individual. These included assessments for falls, choking and any activity of daily living that posed a potential risk. We saw nationally recognised tools were used for assessing the risk of people developing pressure ulcers and malnutrition. Most of these were reviewed monthly.

Most staff told us there were not enough staff on duty. Care staff told us "No. There are not enough staff on duty" and "There is supposed to be one care assistant and one senior on duty, but the senior does the medicines round and that can take between one and two hours. We have 15 people on this floor and I've had to ask for help that takes people [staff] away from other areas."

Sufficient numbers of staff were not always available to meet people's needs. Visiting relatives told us, "They don't manage to get people up till 12 o'clock sometimes because they're so short-staffed" and "They said the tool they use says they only need two staff." "I can't fault the care from the care assistants", "We've said time and time again there's not enough staff, we just get told there's enough staff." Many relatives we spoke with said the home was short-staffed. Relatives told us that they were late for appointments because meals were late and said, "People with diabetes need their meals regularly but they're not always getting it." Another visitor commented: "There are more staff now than a year ago but it is still difficult to find someone if needed", whilst two others thought staff were sometimes 'pushed' for time. They felt their relatives were never neglected.

Nearing the end of our inspection we observed one member of staff on the ground floor was working alone while another care staff was undertaking the medicine round. This care staff was serving tea to people on the ground floor and at the same time answering call bells as they occurred. This meant that the soup, which was in a glass jug, would have been cold by the time the last person was served and staff on the unit said this was a regular occurrence. This member of staff told us "it's all go here its only me and the senior carer but they are doing the medicines". We confirmed this when we spoke with the senior member of staff. Other staff we spoke with confirmed they had worked on their own on the ground floor. Staff said, "It's hard at mealtimes and chaos when someone falls."

Staffing levels at peak times were insufficient. During lunchtime in Snowdrop unit we observed two care staff. The third, who was covering the shift, was elsewhere. The senior care staff was undertaking the medicines round. This left one staff member to serve meals to people in the dining room plus those in their rooms. We were told that this was usual practice. The member of staff who was undertaking the medicines round at this time was interrupted from their duties to respond to people's needs twice. For example one person attempted to pull the tablecloth to move their plate closer. The member of staff was alerted to this by a member of the inspecting team as no staff were in the vicinity. During this time the medicines trolley was left unlocked which meant there was a risk that people could remove medicines inappropriately.

We observed one healthcare professional attempt to provide treatment for one person, who became increasingly agitated. No staff were around at the time. When a member of staff arrived to help, they could not encourage this person to accept the treatment. The healthcare professional said they would return another time. The person wanted to get up and go for a walk and staff let them do this. The person's care plan which stated, "Supervise [name] when walking." This was because they were at risk of falling. Staff did not supervise this person walking. Later we saw this person constantly tapping the person sitting next to them and shouting, "Stop doing it, stop it now." Staff were not around to support people to ensure their safety and well-being.

One registered nurse told us their main duties should be related to the nursing area on the middle floor. However they told us they undertook nursing duties across the whole home as required that included the residential

Inadequate

Is the service safe?

(non-nursing) area. For example they provided immediate support to anyone who had a fall. They also supported a person's diabetic needs four times a day and undertook wound management care in areas other than the nursing units. This took time away from their normal duties as one nurse was on duty for the whole home. The manager confirmed this and told us "the district nurse team are very busy so our nurses support these duties". We advised the manager they should ensure the district nurse team is confident and agree, for the nurses to undertake the activities that would normally be undertaken by them.

The manager told us they were recruiting an extra nurse to support the service. However they confirmed the staffing dependency tool they used indicates they have more staff than needed. However the observations made during the inspection identified that there were not enough staff available at all times to meet people's needs. The manager and regional manager told us the extra nurse provision was determined as 'desirable' and not essential. A staffing dependency tool called 'Chess' was used. This calculated electronically the number of hours each person required to meet their individual level of need each day. Then it calculated the numbers of staff that was needed each day to achieve this.

Senior staff told us that they felt there were always enough staff on duty. If someone called in sick a replacement would be sought from within the staff team. If this was not possible they would get cover from an agency worker. They also told us as they were supernumery on the rota they would support the care routines. However some care staff told us this did not always happen and frequently there would only be two staff instead of three, which meant that when medicines or paperwork was being done, there was only one staff member left to care for all the people in that unit. This care staff said they worried about this. We spoke with staff who confirmed they had been called in to cover staff shortages. Staff said, "It's a shame we can't spend more time with people but we are just so busy."

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities)Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe recruitment procedures were followed before new staff were appointed to work with people. Appropriate checks were undertaken including an enhanced Disclosure and Barring Service (DBS) check. The DBS ensured that people barred from working with certain groups, such as vulnerable adults, would be identified. A minimum of two references were sought and the registered manager told us no member of staff would start working in the home before all relevant checks were undertaken.

We found the home warm, clean and free of odours. We found the products and equipment used in infection control, located in several areas of the home. This included guidance about good hand washing, hand disinfectant dispensers, gloves and aprons. Staff were observed to use personal protective equipment (PPE) such as aprons and gloves as required to reduce the risks of cross infection.

Most of the equipment in the home was serviced according to the manufacturer's recommendations. However, we saw one hoist which had not been serviced. Staff told us, "I don't think that one's used anymore." The manager confirmed this. Equipment which is not in use should be labelled to prevent it being used. The manager agreed to do this.

Requires Improvement

Is the service effective?

Our findings

Not all records were completed to manage people's on going health needs to ensure they were met. Where people required hourly observations to be carried out, we saw observation forms in their room folders. However the records were not always completed fully, particularly at night. We saw one person's care file said to conduct hourly observations, however, their room folder said random checks of at least every 30 minutes. We saw one day's records only, and there was nothing recorded between 3pm and 6pm. Therefore it was difficult to ascertain if the observations had actually been undertaken and their care accurately monitored. Repositioning charts did not always identify how often people were to be repositioned. Therefore people could be at risk of skin breakdown and developing pressure ulcers.

Risks associated with nutrition and hydration were not always managed effectively as the records were not always completed fully or correctly. For example some fluid charts which did not indicate a target amount for people to be offered. We saw one person's fluid charts recorded they had 85ml total fluids one day, 650mls another and 670mls another. NHS recommended fluid intake is 1.6 to 2 litres a day. Records of fluids taken were either not totalled, or had been totalled incorrectly. We saw several food and fluid charts across all units where nothing was recorded after 5.30 pm. This could mean people were not offered anything to eat between 5.30 pm and 9.30 am the next morning. We raised this with the manager as a concern that people with diabetes were not having regular meals. The manager assured us there were sandwiches and other snacks available for people to eat at any time and this was likely to be a recording issue. This posed a risk of people not receiving sufficient amounts of food and fluids as proper records were not kept to monitor this.

Not all people's care plans had been updated or reviewed in line with the organisation's policy. For example documentation stated reviews should be undertaken monthly or before, if people experience a change in their needs. Some reviews had not been recorded and some information had been written in different sections of people's care plans. This posed a risk that staff may not have the most up to date information to support people consistently. The manager said "everything to me is a priority but I know not all records are up to date. We have done a lot since I have come here".

One malnutrition universal screening tool (MUST) had not been completed and was left blank in the person's file. Another person's Waterlow score, which measures the risk of someone developing pressure ulcers, dropped from 26 to 16 in one week and was calculated by two different staff. This would be a significant change and care provided based on this assessment may not have met the person's needs. This was confirmed by the manager as likely incorrect recording. Therefore there were inconsistencies in the way the scores were compiled and some records were not completed fully to ensure risks to people were minimised.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a section in the care files for consent and capacity and although some people lacked capacity to make decisions for themselves, we did not see that best interest meetings were held in every case. These are meetings are held with people, their relatives and supporting medical professionals. All people involved would consider the decision to be made for someone who is unable to make the decision themselves. We saw comments that best interest decisions were made, however we did not see how these decisions were arrived at and who was involved in all the files that we viewed.

Falls risk assessments were in place but were not used effectively to review people's needs. One person had been assessed in October and November 2014, but not since. We saw two people had fallen several times but did not see any referrals to the falls clinic or GP for further investigation and advice. One relative told us a referral for physiotherapy, which staff led them to believe had been made, had not been made .Therefore people's change in needs were not always responded to quickly.

Systems were in place to manage people's on going health needs. Staff told us G.Ps and other healthcare professionals visited frequently and people confirmed this. We saw a district nurse and a podiatrist during our inspection.

Requires Improvement

Is the service effective?

People told us their medical support needs were met. One person told us "if I am not well they always call the GP". People's care files contained records of professional visits from G.P's, paramedics, district nurses and other healthcare staff.

People who had nutritional support needs were assessed and were weighed weekly. Care records showed that people had maintained a stable weight and when required some were referred to their GP for further advice and support.

People's mobility needs were assessed and recorded in their care files. The assessments gave guidance for staff regarding the number of staff required to support the person and any equipment used.

The home's supervision planner confirmed some staff had not received one to one supervision in line with the organisation's policy of six times per year. Supervision is an opportunity for staff to discuss their work and training needs. For example some staff had not received any since October 2014 and the manager confirmed they all should have received one in January 2015. Staff confirmed that some staff had not received any at all since the manager had been in post.

Some staff told us they had completed Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards training (DoLS). MCA is legislation to protect people who may not be able to make certain decisions for themselves. We saw information in people's support plans about mental capacity assessments and DoLS authorisations that had been granted. These safeguards aim to protect people living in care homes and hospitals from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely. One relative was able to tell us why their relative was subject to this authorisation and what it meant. This demonstrated the service gave people and their relatives the information they required and had acted in accordance with legal requirements to protected people's human rights. However records showed some staff had not received training. A member of staff we spoke with about this confirmed our findings. Some staff we spoke with were aware of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The staff were able to tell us why this legislation was important. Comments included; "I always ask people 'Do you want a bath or a shower' and some people are independent" and "I ask people if they want any help."

Training was provided in order for staff to undertake their role effectively. Some staff were in need of updates that included; medicines, manual handling, food hygiene, fire training and safeguarding adults and infection control. Evidence was viewed to show that medicines training was booked for staff for 9 March 2015. The member of staff we spoke with said "yes some people's training is out of date I am putting together a priority list that covers everything and everyone will receive this regularly. Another member of staff will soon be trained up and will help me on the training required in the home". Some staff said they had completed dementia training and they were able to request additional specialist training if they felt it would be of benefit, such as training about epilepsy. Staff said, "We do so much training" and "The training is pretty good and we get outside trainers come in."

People we spoke with told us "Staff definitely have the skills, it shows in every way, they say "would you like me to?... "Before everything they do anything and don't just do it". A visiting relative told us they thought the staff had the right skills and training to care for their relative. They said "If they become unwell a doctor is called straight away. The food has always been good, but [name] is not eating well at the moment and is being given fortified drinks as they are losing weight".

Menus were in place and flexibility and choice was available. People told us, "There's plenty of choice of food." Relatives told us, "The chef is brilliant, it's all home-made cooking just like people remember it, and it's fantastic." We saw fresh fruit available in the dining room on the ground floor. Sherry and cartons of fruit juice were left for people to help themselves at lunchtime and staff asked people what they would like to eat. People could choose between two options. Staff served food to people on a covered plate and warned them the plates were hot. Some people were able to eat independently; when staff walked through we observed they cut food up for someone who needed this help. One person did not eat their meal, staff asked if anything was wrong and if they would prefer something

Is the service effective?

else. However we observed one person dropped their knife on the floor and staff did not notice this, nor did they notice the person ate their dinner with a fork and a spoon as a result.

Requires Improvement

Is the service caring?

Our findings

People's dignity was not always maintained. We observed one person from the corridor, who had a catheter bag strapped to their leg. We suggested a member of staff cover the person to preserve their dignity. The blanket was not big enough to cover the person fully and as the care staff pulled the blanket down, it revealed the person was not fully dressed. The member of staff explained the person's family preferred them to remain in their night clothes. We saw this person's care file and did not see any such explanation. Another relative said: "Staff do respect my relative's privacy, but not sure about dignity because occasionally their nails are dirty, their hair needs washing plus the fact that they are not wearing their dentures and this would horrify them as they have always taken a pride in their appearance". A person told us "They know how to care for me, they just know what to do, they ask me before they do anything and always knock before they come in".

Some relatives felt their suggestions were not listened to. For example they told us they made suggestions and said, "It's full of good intentions but nothing happens." Relatives gave us examples of the suggestions they had made; we checked to see if these had been carried out, however, they had not. The suggestions included dating juices in the fridge and labelling concentrated juices to prevent them being used in concentrate form.

Staff respected people's decisions in relation to their care routines. We saw people's care files recorded when people were offered care or treatment and this was declined. We saw one person's care file which recorded they refused declined to be repositioned. We observed one person that refused didn't want to have their blood pressure measured; staff tried to explain what they were doing to the person but respected their decision when they continued to choose not to. This monitored by staff and we were told GP advice would be sought if refusals continued.

People's opinions were sought at residents meetings and documented on a communal notice board. One person told us "I go to the meetings and speak up; I always say what I think". The notice board in the corridor was called 'you said we listened'. For example some people asked for a microphone to be used at meetings so they could hear. It stated a karaoke machine was purchased for this purpose.

Some people we spoke with told us staff respected their privacy and dignity and treated them with respect. A member of staff came into the dining room and put some music on during lunch. They asked people if it was ok and asked if they wanted it louder. We observed two members of staff proceeding to provide personal care. They knocked on the door before entering and introduced themselves. They ensured the curtains and the door were closed and spoke with the person throughout, explaining what they were doing before closing the door.

Staff were seen to interact with residents in a caring manner, although most interactions were task orientated and responsive. Terms of endearment were used and residents reacted positively to this. However, one relative said although they were at first taken aback when they saw a member of staff hugging their relative but they felt it was well meaning and it did not seem to bother their relative. When speaking later with this member of staff they said: "I respect and treat all ladies as I would my mother and all gentlemen as I would my father".

People told us staff were caring and supportive. People said, "It's very nice indeed, I would give it top marks", "Staff are very pleasant", "Nothing seems too much trouble for them", "My room, the food, everything is very good. Relative's we spoke with also spoke positively about the staff and the way they carried out their responsibilities. Relatives told us, "Staff are really good" and "The care assistants are angels without wings.", "Staff do the best they can but I think they are not supported", "Staff are brilliant, nothing is too much trouble" and "I love it here but there's lots of issues to sort out."

Throughout the day we saw caring and friendly interaction towards people from staff. We saw one person was upset and a member of staff comforted the person sensitively and they responded in a positive manner. People told us, "Staff are kind and will help in any way, they listen when I talk to them". "Staff are kind and do anything I want; they chat with me while they are doing things". Another person said: "They ask me when I want to get up and if I want them to do anything for me; I am happy to let them do it".

People and their relatives confirmed they were able to receive visitors at any time and were always welcome. One person told us "yes they make them cups of tea as well".

Requires Improvement

Is the service responsive?

Our findings

We saw care files contained sections for medicines, mobility, nutrition and other care needs. The care plans were reviewed mostly monthly, although there were some gaps found where some had not been reviewed or completed fully.

Care files contained documents covering a range of care needs. Some care plans were duplicated or not stored in the correct sections of the file. Two people were identified as having 'unpredictable' or 'challenging behaviour'. Care plans were not in place to give staff advice and guidance how to support people experiencing these behaviours in a consistent and personalised way.

Care plans did not reflect people's individualised needs. There were people with diabetes that required their blood sugar levels checking. We looked at the blood sugar readings for one person and did not see lower and upper levels identified to enable staff to know what this person's levels should be. There was no guidance for staff to follow should this person's blood sugar levels be outside the acceptable range. There were several dates recorded when this person's blood sugar levels were higher than usual. Staff were not able to tell us what action had been taken for this person to ensure they had any necessary treatment. This posed a risk that people's diabetes would not be managed safely.

Some people's wound management plans were not comprehensively completed. There were several instances where body maps were not used correctly. Most of the body maps did not have documentation to explain the size, appearance, explanation of how the injury/wound occurred or information about the treatment provided or the current state of the wound. People's wound management needs were not correctly assessed and managed and care plans did not inform staff about the progression or improvement of people's wounds or injuries.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care plans we viewed contained information about people's likes and dislikes as well as their needs. People and their relatives that we spoke with felt staff had a good understanding of their individual needs and know how to support them on a daily basis. This was confirmed when we spoke with staff.

People who required manual handling aids to support their movement received an assessment and equipment was provided. One person, who needed a hoist to support them, confirmed they had their own sling and moving equipment to enable staff to respond to their needs quickly.

Some people were able to tell us they had been involved in their care reviews. However most people we spoke with couldn't remember. One person told us they had been but couldn't remember when this was. One relative said there had been a review of their relative's care, which was long overdue and had been instigated by family as they had concerns about their care. While another told us they were routinely asked to be involved.

There was a dedicated activities team comprising of three members of staff who provided a service seven days a week including evenings. People told us, "There's generally something every day" and "We had a singsong yesterday and doing flower arranging today, there's things going on all the time." Other comments included, "We never get bored." "I like to do activities, they come to find me if I am not there". Relatives we spoke with however, complained the TV was left on and programmes they considered unsuitable were shown. Relatives also said the subtitles were left on the TV and people weren't able to read them. One relative said, "It's good to see they've got trips out, but people who can't go on trips are left out."

Activities were designed to stimulate people's physical and emotional needs. Activities included Zumba sessions; communal exercises with a trainer; sing-a-longs; outside entertainers; mini bus trips; walks; quizzes and bingo. On the day of our inspection various activities took place in different areas of the home. One area held flower arranging and another a movement and music group. People appeared to enjoy the activities taking place. One person described how their relative was supported to pursue their spiritual wishes. They told us they attended the church services and also watched religious services on the television.

The activities organisers were involved with meetings with people where they were able to air their views and make

Requires Improvement

Is the service responsive?

suggestions for any activity they would like to try. These meetings were minuted and circulated within the home and are available to relatives. A monthly newsletter is also produced giving news of events.

The provider had systems in place to receive and monitor any complaints that were made. The service had a complaints policy and procedure which gave people and staff clear guidance. Staff told us complaint forms and a communication book were available. We saw communication books placed in people's rooms with photographs inside of the senior people who cared for them. All the communication books we saw were blank. One relative said, "They've got communication books in the rooms but no-one knows what they're there for." Another relative said "complaints are not always responded to". Staff told us they were not given any feedback after any complaints or comments had been lodged. Residents, who were able, said they would complain either to family or a carer if they needed to. The complaints log that we viewed showed the complaints that were documented had been responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

People's views of the management of the service were mixed and people's comments included; "[name] is nice enough but we don't see enough of them. They are in the office and we have to seek them out. They say this will be done and that will be done but we are yet to see it". Relative's comments included; "The manager is new; there's been a few managers here." "It's a fantastic home, but there's a lack of communication between staff and management" and "There are so many changes it is unsettling". One relative told us they didn't know the manager. Another relative added that they were concerned with the management team and wondered what would happen if they weren't around to keep' nudging' them.

Staff comments about the management were varied and they included; "It's not well-led" and "Lots of things just get passed on and we're not listened to." Staff gave an example of an issue they had raised which had not been acknowledged. One member of staff said "It's well led now, with the new manager and deputy." Two other members of staff said they did have confidence in the manager. They said there is good communication and they were able to talk to the manager at any time; they felt well supported. They also said they work well with their colleagues and are a good team. One member of staff said "I love my job! It's fantastic, so much better than it was. I can always ask the manager anytime for support".

We spoke with the manager throughout the day and they said "there is a lot of work to do here and we are at an early stage of our development. Things need to improve and I will support people all I can if I have support. I do know the care we provide is good". They told us how they were drawing up an action plan with their manager to address issues some of which were highlighted during the inspection. This was confirmed with the operations manager during our inspection.

The provider information return (PIR) was completed by the manager prior to the inspection. This document stated the experience of the manager had helped to develop a culture that was open, fair and transparent. This was confirmed by some people during our inspection. Some people we spoke with confirmed the manager had an open door policy and would approach them without an appointment if the need arose. It also stated staff received regular supervision and training. We found this was not always the case as staff did not always receive regular supervision.

The management team communicated with staff about the service. One forum for this was team meetings. Minutes were documented and any actions required were noted. We saw minutes dated 4 November 2014. The manager told us another meeting took place but the minutes were not yet available. The minutes we saw included discussions around future meeting plans, mandatory training, sickness, teamwork and care plans.

Relatives and residents meetings took place to gain people's views. Minutes were viewed dated December 2014, January 2015 and February 2015. Actions were clearly identified and covered; laundry, maintenance, activities, food and general feedback. December meeting minute's highlighted people felt positive about the new management arrangements and they felt concerns were being resolved quickly.

A system was in place that monitored the quality of the service. The manager undertook various audits that included: infection control, including cleaning schedules that were signed off by the housekeeping person. Action plans were compiled and detailed when they needed to be completed by. The care planning audit identified some of the areas we did during our inspection. For example it stated some people's care plans were not completed, missing care plans and some lack of reviews. The manager told us "this is work in progress and nine more will be completed by the end of March".

The manager undertook a daily 'walkabout' of the home to highlight any environmental concerns and then immediately report this to the maintenance team to resolve. Documentation that we saw confirmed this. Areas covered were checking corridors were clear of trip hazards, bedroom checks and checks were made of people's air pressure mattresses to ensure they were correctly set.

The regional manager undertook visits to the home. This was used as an opportunity for the regional manager and manager to discuss issues related to the quality of the service and welfare of people that used the service. The regional manager undertook a 'monthly visit report'. This audit ensured the manager had undertaken regular monitoring and reviews of the service in line with the

Requires Improvement

Is the service well-led?

provider's policy. Audits included; training, maintenance, meetings. medication, care plans and health and safety. All were recorded and any actions noted would be followed up the following month. Records that we saw confirmed this.

The manager audited incidents and accidents to look for any trends that may be identified. This ensured the manager was fully aware of any events that took place that may require actions or follow ups.

The manager was aware of when notifications had to be sent to CQC. Notifications had been sent in to tell us about specific incidents that required a notification in line with legislation. We used this information to monitor the service and to check how any events had been handled. This demonstrated the registered manager understood their legal obligations.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe keeping and safe administration of some medicines. Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing People were not always safe as there were not always sufficient numbers of suitably qualified and skilled staff to support their needs. Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People's care records were not always completed consistently or correctly to monitor and manage their long term health conditions. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 9 HSCA (RA) Regulations 2014 Person-centred care Some people's care plans were not fully completed. Referrals to external professionals were not always made quickly. Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.