Avante Partnership Limited

Riverdale Court

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Inadequate
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

The inspection took place on the 10 and 11 of December 2014 and was unannounced. At the time of our inspection there was a new manager in post who was in the process of registering with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service and shares the legal responsibility for meeting the requirements of the law; as does the provider.

Riverdale Court is a large care home located in the London Borough of Bexley. The home is registered to provide accommodation and support for up to 80 people and specialises in caring for people living with dementia. At the time of our inspection there were 80 people using the service.

During our inspection we found that the provider had breached several regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the back of the full version of this report.

Summary of findings

People were not protected against the risks associated with the unsafe management and storage of medicines. We found gaps in the recording of medicines administered to people and staff were not always aware of the protocols or procedures in place to manage medicines errors or incidents.

Risks to people using the service were not always recorded or managed appropriately and people were not involved in the planning and reviewing of their care or decisions relating to identified risks.

The provider failed to ensure appropriate systems and procedures were in place to protect people against the risk of foreseeable emergences.

The provider did not have processes in place to assess and consider people's capacity and rights to make decisions about their care and treatment where appropriate in line with the Mental Capacity Act 2005 (MCA 2005). Care plans and records did not contain mental capacity assessments where people's capacity to consent was in doubt.

People were not always supported appropriately to eat and drink sufficient quantities to maintain a balanced diet and ensure their well-being. Care plans and records did not always reflect people's nutritional needs.

People were not always treated with dignity and respect and their wishes with regards to their care were not always recorded within care plans or acted upon by staff. Care plans and records showed little evidence that people were involved in making decisions about their own care and lifestyle choices.

Care plans were not always reflective of people's individual care and preferences and assessments were not always conducted in line with the provider's policy. People's cultural needs, religious beliefs and sexual orientation was not always recorded to ensure that staff took account of people's needs and wishes.

There were safe staff recruitment practices in place which ensured that people were cared for by staff who were appropriate for their role minimising risks to people using the service.

There were safeguarding adults from abuse policies and procedures in place to protect people using the service from the risk of abuse. Staff were knowledgeable about how to report concerns and how to support people when anxious or distressed.

People were supported by staff who had received appropriate training to meet their needs. Training records demonstrated staff were provided with suitable training to ensure their development needs were met.

People's concerns and complaints were listened to, investigated and responded to in a timely and appropriate manner. People and their relatives knew how to make a complaint and some people who had complained told us their concerns were resolved.

The provider had policies and processes in place to monitor and evaluate the quality of care and support people received. Action plans were in place and monitored by the new manager on a frequent basis where issues had been identified ensuring remedies were actioned.

Incident and accidents were recorded in line with the provider's policy and detailed actions taken and outcomes which identified learning for the service. Records of incidents and accidents demonstrated that notifications to the Care Quality Commission and safeguarding authorities were appropriately made.

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 using the service were not recorded or managed appropriately. Reviews of care plans and identified risks were not completed in line with the provider's policy.

People were not protected against the risks associated with the unsafe management and storage of medicines. Staff were not always aware of protocols in place to manage medicines errors or incidents.

The provider failed to ensure appropriate systems and procedures were in place and followed to protect people in case of emergency.

There were safe staff recruitment practices in place which ensured that people were cared for by staff who were appropriate for their role.

Safeguarding adults from abuse policies and procedures were in place to protect people from the risk of abuse. Staff knew how to report concerns appropriately.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider failed to assess and consider peoples capacity to make decisions about their care and treatment in line with the Mental Capacity Act 2005 (MCA 2005). Care plans and records did not contain mental capacity assessments where people's capacity to consent was in doubt.

There were processes in place to ensure that where appropriate Deprivation of Liberty Safeguards (DoLS) were followed.

People were not supported appropriately to eat and drink sufficient quantities to maintain a balanced diet and ensure their well-being. Care plans did not always reflect people's nutritional needs.

People were supported by staff who had received and had access to appropriate training to meet their developmental needs.

Is the service caring?

Inadequate

The service was not always caring.

People were not always treated with dignity and their wishes with regard to their care were not always recorded within their care plan or acted upon by staff.

Care plans and records demonstrated little evidence that people were involved in making decisions about their own care and lifestyle choices.

Summary of findings

Staff were not always knowledgeable about people's life histories and preferences and did not always demonstrate an understanding of people's choices and individual personalities.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Documentation was missing from care plans and care plan and risk assessments were not reviewed in line with the provider's policy.

Care plans did not provide guidance on people's individual care needs and preferences. People's cultural needs, religious beliefs and sexual orientation was not always recorded to enable staff to take account of people's needs and wishes.

People's reported concerns and complaints were listened to, investigated and responded to in a timely and appropriate manner.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Although the provider had procedures and systems in place to evaluate and monitor the quality of the service provided, procedures were not always followed or were effective. At the time of our inspection the new manager had action plans in place to address issues we identified.

Incident and accidents were recorded in line with the provider's policy. Records of incidents and accidents demonstrated that notifications to the Care Quality Commission and safeguarding authorities were appropriately made.

Riverdale Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Prior to the inspection we reviewed information we had about the service. This included reviewing previous inspection reports, statutory notifications and enquiries. A notification is information about important events which the provider is required by law to send us. We also spoke with local authorities who are commissioners of the service and local safeguarding teams to obtain their views.

The inspection was unannounced and consisted of a team of three inspectors, a specialist advisor 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. There were 80 people using the service on the day of our inspection. We spoke with 28 people using the service and 12 visiting relatives. We looked at the care plans and records for 14 people using the service and seven staff records. We spoke with 17 members of staff including the head of pharmacy, manager, deputy manager, provider's admiral nurse who works with people and their families, team leaders, care staff, maintenance workers, chef and kitchen staff, domestic workers, and activity co-ordinators.

Not everyone at the service was able to communicate their views to us so we used the Short Observational Framework for Inspection (SOFI) to observe people's experiences throughout the day. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

As part of our inspection we looked at records and reviewed information given to us by the provider and manager. We looked at audits and incidents logs, service user and relative meeting minutes, staff meetings and records related to the management of the service. We also looked at areas of the building including all communal areas and outside grounds and observed how people were being supported with activities of daily living throughout the course of our inspection.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at the home. One person said "The staff are kind to me and make sure I am well." Visiting relatives we spoke with told us they were happy with the care and support provided and felt that their relatives were safe. One person told us "I know they are safe here. They cannot go out unaided and staff make sure of that." Another person said "I know they are safe and their belongings are safe too." Although comments from people and visiting relatives were positive we found that people were not always safe.

Medicines were not stored, recorded and managed safely. Medication administration records (MAR) were not completed or recorded appropriately. We looked at four MAR sheets and noted three had not been signed by staff when medicines were administered. There were no records to indicate whether people had received their medicines at the correct time. This meant that there was a risk of errors which could place people at risk of harm.

Medicines records included a photograph of the person, their known allergies and details of staff members authorised to administer medicines. There were written protocols in place to deal with medicines incidents. However two staff members we spoke with who administered medicines were not aware of the protocols or procedures in place to manage errors with administering medicines. This meant that staff may not respond appropriately to medicines errors to ensure people were safe and risks were minimised.

Medicine reconciliation records compared people's medicine orders for all medicines they were receiving. However records of medicine stocks did not always match the actual number of medicines kept in stock. This meant that people may be at risk of running out of their medicines. There were protocols in place for the use of as required (PRN) medicines however records were not always personalised for individuals and two medicines records we looked at did not include a protocol for applying topical creams prescribed by the GP. This meant that people may be at risk as their creams may not be applied appropriately by staff.

Medicines were not stored safely. There were policies and procedures in place to monitor the medicine rooms and refrigerator temperatures twice daily. However we noted that medicines room temperatures were not always recorded twice a day with several gaps noted in the records. Refrigeration temperatures were also not recorded and records we looked at showed that temperature readings had not been recorded for four days in December 2014. The refrigerator was not locked or secured and contained medicines for people who used the service. This meant that medicines were not always stored safely and correctly and posed a risk that medicines were not stored within a safe temperature and were fit for use.

An oxygen cylinder was not secured safely in the nurse's room. We spoke with the deputy manager who was unsure when the cylinder was last checked and was unable to find any records in relation to this. This posed a risk of personal injury and a fire hazard as the oxygen cylinder was not secured as guided by best practice. Medicines were not disposed of appropriately. We saw that sharps bins located in medicines rooms were not labelled and were full with inappropriate items protruding from them such as gloves and medicine packaging. This could pose a risk to people using the service and staff.

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

Arrangements were not in place to respond quickly to people requiring support. During the afternoon we observed that the call bell system had rung in one of the occupied bedrooms. The alarm sounded for approximately ten minutes. We asked staff why they had not responded. They told us they were unable to gain access to the room as it had been locked from the inside and only the team leader had the key to gain entry. The staff member later returned and told us that team leader did not have the key but the suite manager did. They entered the room and found the person well as they had accidently pulled the alarm. This posed a risk in the event of an emergency because staff would not be able to attend to people quickly.

Risks to people were not always recorded or managed appropriately. Care plans contained mandatory documents and risk assessments dependant on individual needs. For example one risk assessment recorded that the person was at risk of self-neglect with regards to nutrition, however this

had not been reviewed since June 2013. Food and drink care plans and food and fluid charts were subsequently put in place however they did not reflect the risk of nutritional self-neglect documented on the person risk assessment.

A risk assessment in place for one person with behaviour that may challenge did not detail the behaviour or actions to taken by staff to prevent or reduce the risk. Another care plan detailed how the person could become physically aggressive toward staff supporting them but no risk assessment had been completed or guidance for staff on how to manage, approach and defuse the behaviour. Behavioural charts were in place to monitor the person's behaviour however these had not been completed or reviewed since July 2014. Another person's risk assessment indicated that they were at risk of falls. A falls risk assessment was in place but had not been reviewed since September 2014. A body map completed in August 2014 detailed how the person had suffered a fall which caused injury, however this had not been reviewed or detailed what actions had been taken by staff or the treatment provided. This meant that people were at risk of unsafe and inappropriate care and support that did not meet their needs or preferences.

This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The homes fire risk assessment recorded that the fire alarm was tested on a weekly basis by maintenance staff. We saw that the fire alarm system was checked by external engineers in November 2014. We asked maintenance staff when the last fire drill or evacuation had been conducted. They showed us records of two occasions in April and September 2014, when the fire alarm system had been activated accidentally. The record documented details of staff members and people using the service who were evacuated from the building, however they could not confirm whether regular practiced fire drills and evacuations had been conducted. Staff we spoke with recalled evacuating the home in September 2014 but could not recall taking part in regular fire drills.

We spoke with the manager who was new to the home. They told us that staff employed by the service had completed training on fire safety; however they were unable to locate any evidence of when the last fire evacuation drill or else any discussion of emergency scenarios had been carried out. This meant that the provider failed to make sure appropriate systems and procedures were in place to protect people against the risk of foreseeable emergencies.

This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Comments we received from people and their relatives about staffing levels within the home were mixed. One person said "The staff are very nice, they can't do enough for me. Wherever I need them they always seem to be around." A visiting relative told us "Staff seem to be so busy. There isn't enough interaction as they are always busy." We also spoke with visiting professionals to the home. One professional said "Staff are really dedicated but they are at times under pressure due to a lack of staff particularly in areas where people have challenging behaviour and competing needs."

There were not always sufficient numbers of staff available to meet people's needs promptly. We noted that people were often alone in the communal areas and several people on one of the floors were left alone to walk the corridors and into some of the bedrooms. Staff administering medicines told us that they often felt rushed. One staff member said, "There is not enough staff. There are three care workers and one team leader on duty but when the team leader does the medication round it can become difficult to cope as people need our attention." We observed a medicines round on one unit and saw a member of staff trying to administer medicines to one person whilst trying to assist two other people.

We spoke with the manager about current staffing levels within the home. They told us that staffing levels were determined by the number of people using the service and their needs and they were currently fully staffed according to the providers staffing tool. However following a recent review of staffing numbers they had requested an increase in staff due to some people's complex needs which the provider agreed. Records showed a recent increase in staffing levels in particular on the top floor of the home where people's needs were sometimes greater. The manager informed us that staffing levels were being continually reviewed to reflect and meet people's needs.

Inadequate

Is the service safe?

There were safe staff recruitment practices in place. Staff files contained pre-employment checks such as disclosure and barring checks, references from previous employers, photographic evidence of identity, job application form, employment history and proof of eligibility to work in the UK. This ensured that people were cared for and supported by staff who were appropriate for the role and minimised risks to people using the service.

There were safeguarding adults from abuse policies and procedures in place to protect people using the service from the risks of abuse and avoidable harm. We observed staff were knowledgeable about how to communicate with people and support them when anxious or distressed. Staff we spoke with were able to explain how people might communicate if they were distressed or being abused and knew what signs to look for. Staff demonstrated good knowledge on how to report concerns appropriately and understood the provider's policies regarding safeguarding adults from abuse and whistle blowing.

Regular health and safety checks were conducted. We saw certificates from relevant external engineers confirming that checks had been carried out on the home's gas safety systems, water systems, equipment, lifts, sluices and mechanical baths. We also saw that portable appliance testing had been conducted and that the local authority environmental health team had rated the home five stars for food hygiene. The premises were kept clean and were adequately maintained. People's rooms and communal areas were tidy and free from odours.

Requires Improvement

Is the service effective?

Our findings

The provider did not have processes in place to assess and consider people's capacity and rights to make decisions about their care and treatment where appropriate and to establish best interests decisions in line with the Mental Capacity Act 2005 (MCA 2005). Care plans did not contain mental capacity assessments where people's capacity to consent to make decisions was in doubt. For example, one care plan recorded that the person lacked capacity to make decisions about receiving personal care, however we could not see that a capacity assessment had been completed or that this had been reviewed. We could not see that a best interests decision had been made about specific care that could be given.

Staff had received up to date training on the MCA 2005, however some staff we spoke with were unable to explain the process to follow if they were in doubt that someone was unable to consent and make decisions about their care and treatment. This meant that people may be at risk of receiving unsafe or inappropriate care and treatment as an assessment of their capacity to make decisions had not be conducted.

This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were processes in place to ensure that where appropriate Deprivation of Liberty Safeguards (DoLS) were followed. The manager made appropriate referrals to local authorities ensuring that people's freedom was not unduly restricted and where restrictions were in place for people's safety there were records to evidence this was done. We found that the manager had taken appropriate actions to comply with DoLS authorisations in place at the home. A visiting professional and best interest assessor told us that they had visited the home several times and believed the home were making the appropriate level of referrals for DoLS assessments. They told us that the manager had a good understanding and knowledge of DoLS.

People's nutritional needs and preferences were not always met. Comments from people about the food served at the home were mixed. For example one person told us, "Mealtimes are chaos. Chaotic and noisy and the food is cold when it should be hot." Another person said, "They ran out of food at breakfast. No bacon, sausage and porridge. There was only toast left." "I don't go hungry but it isn't always what I like," However some other people told us the food was "Excellent, just like home food, it's lovely," and "I enjoy the food here, there's cooked breakfasts and you get a choice". A person said "You can't fault the food here at all. We like to get together to eat well." However we found that people's nutritional needs were not always met.

People were not always supported appropriately to eat and drink sufficient quantities to maintain a balanced diet and ensure their well-being. We observed lunch time in two of the dining rooms. People were seated at set tables for lunch which was served at 1pm. Lunch arrived on a heated trolley shortly after this time, however food was not served until 1.25pm as staff took time to carry out food temperature checks prior to serving. We noted that none of the people in the dining room had finished their meals. People told us they did not enjoy it as it was cold.

People were not offered choices. Menus displayed on some tables had two options for lunch, however we saw that people were not offered a choice by staff when food was served. In one dining room we saw there was little interaction from staff and support for people who had difficulties in cutting their food or eating their lunch was not offered frequently or in a timely manner. We noted there were nine people seated in one dining room and three staff. During the meal we observed that people were left unsupported by staff for approximately five minutes. During this time one person required support to have a drink as they were coughing.

Care plans did not always identify people's specific nutritional needs and how they could be supported by staff to eat a nutritious and healthy diet. For example one person's care plan stated that they were diabetic and required a low sugar diet. However their dietary needs were not recorded within their nutritional assessment. We also noted that their weight and body mass index were not monitored monthly in line with the provider's policy. There was a risk that the person's nutritional needs would not be identified or met by staff providing support.

This was in breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

We spoke with the cook and kitchen staff and saw meals were prepared fresh at the home. They were aware of people's preferences and dietary requirements. They showed us daily meal sheets which recorded meals on offer that day, the name of the person using the service, their selections and dietary needs. They told us that three people using the service were diet controlled diabetics and they prepared sugar free meals to meet their needs. For example they used sugar free jelly when preparing trifles, sweeteners when making custard or offered people sugar free yogurts for desert. Foods stored in fridges were appropriately labelled at the point of opening or preparation. Fridge, freezer and hot cabinet temperature checks were recorded daily. A daily, weekly and monthly kitchen cleaning schedule was in place and this had been signed by staff to confirm that cleaning tasks had been completed. Kitchen staff were appropriately trained and skilled in food safety and catering, infection control and safe food handling.

People and their relatives told us staff had the appropriate skills to meet their needs. One person said, "The staff are very good. They know what to do and what I need help with." A visiting relative told us, "They know my relative well and when they are unwell. The communication is very good, they always keep me informed."

People were supported by staff who had the necessary skills and experience to meet their needs. Staff told us they received regular supervision and annual appraisals to support them to do their jobs effectively. Staff files we looked at confirmed this. Staff told us they received training that helped them to meet people's needs effectively and enhanced their knowledge. Staff new to the service completed an induction programme which included working with experienced members of staff, completing mandatory training and time spent getting to know people who used the service and how best to meet their needs. Training records confirmed this.

We spoke with the provider's visiting 'admiral' nurse. Their role was to offer support and guidance to people using the service and their visiting relatives. They told us they conducted regular training for staff on dementia awareness and how best to support people who may display behaviours that may challenge. Training records confirmed this.

Inadequate

Is the service caring?

Our findings

Comments we received from people using the service about the care and support they received were divided. For example, one person told us, “They certainly do care. They look after me.” and another said “Some staff are all right, I’ve nothing against them.” One person said “I expect they would help me if I needed it” and another commented “Some staff are very good and some aren’t.” Another person said “I have no complaints.” Comments from visiting relatives were also mixed. One relative told us that their family member was new to the home and commented, “Staff don’t seem to interact with families at all. There has been no personal touches yet.” Another relative said “They talk to my relative and are caring. If I’ve noticed anything wrong, they come straight away to rectify it.” However we found that staff did not always treat people with respect.

Care plans showed very little evidence that people were involved in making decisions about their own care and lifestyle choices. For example one care plan recorded that the person had expressed to staff that they felt left out and last to be supported with personal care. We noted that contact was made with the person’s family to discuss this however there was no further evidence of actions taken in response to the person wishes of being supported earlier in the mornings. Another care plan showed no evidence of the person or their family’s involvement in their care plan. We also noted that no needs assessment had been completed, personal information had not been recorded, end of life care plan had not been completed and the consent form requiring the person’s agreement regarding their care and treatment had not been completed or signed.

Staff did not always respond to people sensitively and in a timely way when offering support and people were not always treated with dignity. For example we saw one person returning to their room after a visit to the home’s hair salon. They were inappropriately dressed and when we spoke to the member of staff we were told that their top had got wet when washing their hair. However the staff member had not supported the person to ensure and maintain the person’s dignity. We saw several people wandering around the home. One person approached us and told us that they were bored but we did not see any engagement from staff. We saw people sitting or sleeping in communal lounges and in dining rooms on their own with no interaction from staff.

Staff did not always demonstrate an understanding of people’s life histories and preferences. Staff we spoke with were unable to tell us about the important events and choices in people’s lives and about people’s individual personalities. One member of staff told us that people’s names displayed on their room door helped them to know who they were supporting as they were unfamiliar with people living at the home. Another member of staff told us they were unsure of the names of some of the residents that were seated in the lounge.

This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with told us that they did not always have their requests or choices acknowledged or respected. One person said "Things are not always done the way I like but I know staff are busy." Another person told us "They don't always listen. Sometimes you just have to make do."

Care plans were not always reflective of people's individual care and preferences and assessments were not always conducted in line with the provider's policy to ascertain people's care and support needs. For example one care plan did not contain an assessment of the person's physical and mental health needs although it was recorded that the person displayed physical aggression toward staff on occasions. There was no detailed plan in place to guide staff on how they should respond to the person's behaviour so it was not possible to see how effective interventions were or any actions that had been taken. This meant that people may be at risk from inappropriate care as their needs had not been assessed and behaviour was not monitored or responded to in a consistent way.

Accurate records were not maintained. Records were in no particular sequence, documentation was missing and had very little or no evidence that care plan and risk assessments were reviewed. For example one care plan did not contain any personal details at the front of the file or the name and picture of the person who it related to in line with the provider's policy so there was a risk the record would not be easily identifiable and staff would not know who the care plan related to. Another care plan recorded that monthly reviews had been conducted but no information was recorded about the review process or documented any changes made as a result. Of the 14 care plans we looked at nine did not contain a 'Do not attempt cardiopulmonary resuscitation (DNAR) form. No involvement from people using the service or their relatives was documented and no date for the DNAR to be reviewed was recorded on the form as best practice guides. It was therefore not possible to determine if people were involved in the discussion or that their relatives had been involved where appropriate.

Staff we spoke with were not always aware or knowledgeable of people's likes and dislikes or activities they enjoyed. Although there were systems in place to record people's life and social histories, care plans were task orientated and did not explore in detail the connections with people's life history before they lived at the home. Care plans did not always record people's cultural needs, religious beliefs and sexual orientation to ensure that staff took account of people's needs and were able to relate to them appropriately.

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

The home provided a range of meaningful activities that people could choose to engage in. People we spoke with told us they enjoyed some of the activities on offer at the home. One person commented, "I can choose if I want to get involved or not. Some of the activities are good and others I'm not interested in." Another person said "I love the garden. I've put a lot into it and even bought plants."

Relatives spoke positively about activities on offer. One said, "There are plenty of activities and outings to museums, fetes and even the Christmas lights." Another told us of events and entertainers that visited the home and the provider's monthly publication Which advertised the activities and events on offer for the month ahead.

People's recorded concerns and complaints were listened to, investigated and responded to in a timely and appropriate manner. People and their relatives told us they knew how to make a complaint and some people told us they had complained about various matters which were resolved. The home had a complaints procedure in place which was located in communal areas within the home. We spoke with the manager about the management of complaints. They showed us the complaints file which included a copy of the complaints procedure, complaints recorded and correspondence relating to complaints received. We saw that following a complaint made by a visiting relative in September 2014, the manager met with the relative to discuss their concerns. The manager told us the meeting was helpful and the matter was fully resolved to the satisfaction of the relative. Records we looked at confirmed this.

Requires Improvement

Is the service well-led?

Our findings

Although the provider had procedures and systems in place to evaluate and monitor the quality of the service provided we found that procedures were not always followed to protect against the key risks identified in this report. At the time of our inspection a new manager was in post and was registering with the CQC. The manager had several action plans in place to address issues identified including those found at the inspection and to rectify them. During our visit we saw that actions plans were being implemented and followed with some identified issues already resolved.

We spoke with the new manager about the methods and audit tools used within the home. They showed us quality assurance audits conducted on a regular basis within the home. We looked at one internal audit carried out by the provider on the 24 and 25 November 2014 which covered areas such as, care plans, meals, people's finance records, staffing handovers and complaints received. The report included recommendations for improvements. For example, it was recommended that staff were reminded to complete care plan documents and cross reference relevant information such as mobility issues and risks to ensure people were kept safe. We saw that the action plans in place following these audits were due to be completed on the 31 December 2014 which was after the date of our inspection. The manager told us they were working towards the improvements needed.

The new manager had also just completed a care plan audit and had provided it to senior members of staff at the home so they could make the updates required on peoples care plans and records. This audit had identified many of the issues we found at inspection.

The new manager also showed us a report from a recent infection control audit carried out at the home in December 2014. The audit covered people's rooms, clinical rooms, toilets, bathrooms and the kitchen. The report identified a number of shortfalls for example the lack of paper towels in bathrooms, the need for hand washing signs and redecoration that was required in various parts of the home. The manager told us they had actioned some of the minor points and were in the process of drawing an action plan with dates for other shortfalls to be remedied. We found the home to be clean at the time of the inspection.

The new manager also told us how they had taken steps to promote an open, honest and learning culture for staff and people using the service. For example they highlighted the need for further staff training in the administration of medicines after an internal audit identified recurrent errors. Training records we looked at confirmed this. They also told us of the recent partnership forged with the GP practice to promote a better service and outcomes for people living at the home. We spoke with the visiting GP who confirmed this and the work undertaken by the home.

People and their relatives were asked for their views about the service. People told us they were aware of 'resident and relatives' meetings which were held on a frequent basis. One person said "The meetings are usually very good. It's an opportunity to know what's going on and to air any issues I have." Records we looked at confirmed this.

Staff we spoke with told us the manager and senior members of staff were approachable and supportive. They told us the manager was open to suggestions and comments they made about the service. One person said "I fill comfortable speaking to the manager. They listen and offer support. I fill very supported in doing my job."

Staff members had regular team meetings which allowed them to discuss how care could be improved and the needs of the staffing team. Minutes of meetings held showed that staff had opportunities to discuss any concerns, issues or areas of improvement required.

Incident and accidents were recorded in line with the provider's policy and included details of actions taken and outcomes which identified learning for the service. The procedure was available for staff to refer to when necessary and records we looked at showed they had been followed. Records of incidents and accidents demonstrated that notifications to the Care Quality Commission and safeguarding authorities were appropriately made.

The home displayed the provider's customer charter, service user guide and philosophy of care in the entrance hall which detailed the home's aims, objectives and values. This provided people with information about the service they receive and what they should expect.

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 Regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not always take proper steps to ensure that people were protected against the risks of receiving care or treatment that is inappropriate or unsafe. The provider did not have appropriate procedures in place for dealing with emergencies to mitigate the risks arising for service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Regulation 12 (f) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not protected against the risks of unsafe management and storage of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not protected against the risks of inadequate nutrition and dehydration.

Regulated activity	Regulation

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 Regulation 9 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have suitable arrangements in place to ensure people participated in making decisions relating to their care or treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have suitable arrangements in place to obtain or act in accordance with people's consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Regulation 17 (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not ensure that people were protected against risks arising from a lack of proper information and accurate records.