HC-One Limited

Elmwood Nursing Home

Inspection report

32 Elmwood Road
Croydon
Surrey
CR0 2SG

Tel: 02086894040
Website: www.hc-one.co.uk/homes/elmwood/

Date of inspection visit:
02 August 2016

Date of publication:
07 September 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Elmwood Nursing Home is a purpose built residential home that provides nursing care and support for up to 60 older people, most of whom are living with dementia. At the time of our inspection 46 people were using the service.

Our inspection took place on 2 August 2016 and was unannounced. At our last inspection in January 2015 the provider met the regulations we inspected.

There was a registered manager in post at the time of our inspection but they were on annual leave during our visit. 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.

Prior to our inspection of Elmwood Nursing Home we received information from the service notifying us of a serious injury that had occurred to one of the people living at the home. We are carrying out a separate investigation in to the circumstances surrounding this incident. Once we have concluded our investigation we will notify the provider of what action we intend to take, if any, as a result of our findings.

Some of the people in the home required a high level of support to meet their needs, often needing the assistance of two care workers to move them safely. Staffing levels did not take into consideration the needs of people and were not appropriate. These did not fully protect people from the risks of poor or inappropriate care. Staff were concerned that the time they spent with people was compromised and not conducive to delivering high quality care they so desired for people.
The recruitment procedures were appropriate at the time of our inspection.

The provider was aware of the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) to help ensure people's rights were protected. However, people's mental capacity assessments were not completed. When a person was found to lack capacity the reasons for making decisions on people's behalf were not clearly recorded.

People and staff were asked for their views on how to improve the service. However, there was no evidence to see how feedback was used to improve the service. Staff did not always feel listened to and supported by their manager.

The provider had systems in place to help them understand the quality of the care and support people received. However, actions and recommendations made were not always put into place.

There was an activities programme at Elmwood Nursing home and the activity coordinator tried hard to ensure people had the opportunity to be involved in meaningful pastimes to help stop them from feeling

lonely or isolated, but we found people living with dementia may have benefited from more personalised engagement and stimulation.

The deputy manager and members of staff understood their roles and responsibilities to follow processes and protect people from harm. People told us they felt safe. They said staff were kind, caring and respected their privacy and dignity. People's rooms contained personal belongings and items that were special or of personal value to them.

Staff spoke with people in a kind and sensitive way. They were helpful and polite while supporting people at mealtimes to make sure people had sufficient amounts to eat and drink. People and their relatives were positive about the food at Elmwood Nursing Home. Special dietary requirements were catered for and people's nutritional risks were assessed and monitored.

People received their prescribed medicines at the right times, these were stored securely and administered safely by registered nurses.

People had access to healthcare services when they needed it and received ongoing healthcare support from GPs and other healthcare professionals.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing, recording people's capacity to consent to care and governance. You can see what action we told the provider to take at the back of the full version of this report

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. People were not fully protected against unsafe or inappropriate care. Staffing levels were not appropriate to the needs of people. They did not fully consider the dependency needs of people who used the service.

Risks to people's wellbeing were identified and support plans developed to respond to these, but risks were not always appropriately managed.
Staff were knowledgeable about how to recognise signs of potential abuse and followed reporting procedures. Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not fully effective. People had received training in the requirements of the Mental Capacity Act 2005 but in practice did not reflect this by undertaking mental capacity assessments to determine individual's capacity to make decisions.

People were looked after by a stable team of trained staff who had the necessary knowledge and skills.

People were supported to have adequate nutrition. For people at risk of poor nutrition or dehydration, there were suitable measures in place to monitor and ensure people were sufficiently nourished and well hydrated.

The staff team ensured that people's health care needs were met. Staff worked with the GP and other health consultants to ensure people had access to relevant services.

Is the service caring?

Good

This service was caring. Staff showed dedication and commitment and worked hard to deliver compassionate sensitive care.

People were treated with respect, and their dignity and privacy was respected.

The majority of staff were familiar with the people they cared for and were committed to helping them achieve a good quality of life.

Is the service responsive?

Good

The service was responsive. People's individual needs were considered. People's care needs were identified, assessed and documented within their care plan.

Activities were available so people could be supported to follow their interests and prevent people from feeling isolated or lonely but people living with dementia may have benefited from more personalised engagement and stimulation. People's needs were reviewed and monitored on a regular basis.

There was a complaints process in place to respond to any complaints or concerns.

Is the service well-led?

Requires Improvement

The service was not always well led. The culture of the home was not open and transparent. Staff felt afraid to speak up, their views were not always listened to and considered, or action taken as appropriate.

The provider had systems in place to help them understand the quality of the care and support people received. It was not clear how the service listened to people and staff, learned lessons and acted on recommendations to improve the quality of care for people.

Elmwood Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 unannounced inspection took place on 2 August 2016.The inspection was conducted by two inspectors and a specialist advisor who is a clinical nurse.
Before our inspection we reviewed the information we held about the service which included statutory notifications we have received in the last 12 months and the Provider Information Return (PIR). The PIR is a form we asked the provider to complete prior to our visit which gives us some key information about the service, including what the service does well, what they could do better and improvements they plan to make. We also reviewed all of the information we held, this information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by.
Over the day we observed staff supporting people in the communal areas and how people were cared for. Some people were not able to fully share their experiences of using the service because of their dementia needs. We used the Short Observational Framework for Inspection (SOFI) to observe the support provided for people at the service. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During our visit we spoke with 10 people who used the service, one relative and one visiting health professional. We spoke with 14 staff members including nurses, care assistants and staff that supported the service such as domestic, kitchen, administration and activities. We reviewed care records for seven people. We checked four staff recruitment files and the records kept for staff allocation, training and supervision. We reviewed how medicines were managed and the records relating to this. We looked around the premises and at records for the management of the service including quality assurance audits, action plans and health and safety records. After our inspection visit the provider sent us additional information including the most recent quality assurance report and additional details about staff training and competency checks.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe living in the home. One person said, "Staff know their job and use this equipment safely." We saw the premises were well equipped with suitable equipment that maintained people's safety, these included wheelchairs and hoists.

We observed that staffing levels were not always sufficient to respond appropriately to the needs of people present. Staff on duty confirmed that as a result of insufficient staff present they were "stretched to the limit trying to provide good quality care." Some people required a high level of support to meet their needs, often with assistance of two care workers. On one unit there were thirteen people being cared for by two carers and one nurse. Ten people required two carers to deliver personal care and use the equipment to move the people safely, and nine people required assistance at mealtimes. A staff member said, "We need more staff to give good quality care, we really want to give our best, but nobody listens". During our inspection we saw that an additional carer was reassigned to help out on the ground floor unit and assist people at lunch. In the communal areas we noted there was a lack of staff presence to monitor and support people because staff were busy undertaking tasks and supporting people with personal care in their bedrooms. We saw that staff worked for long periods without breaks, they said "We place the people at the heart of the service and really care." During our observations we saw that people living at the home did not have staff present to interact or engage with them for long periods or to promote their safety in the lounge.

Care plans showed that a number of people were unable to use their nurse call bell and frequent checks were recommended, however, we noted from records that checks were not done at the frequencies recommended. One staff member told us it was not always possible to complete the checks as recommended due to staff resources. Other practices we observed reflected insufficient staffing levels. We observed a person requiring personal care assistance waiting for an excessively long period to have their wet clothing changed. Although lunch started before one o'clock a number of people who remained in their rooms did not have staff available to assist them with lunch until nearly an hour later, at this stage the majority of people had finished their meal.

Staffing rotas and levels were not altered to reflect changes in the home. For example, the nurse on one unit was also undertaking additional duties, these included as acting manager as well as administering medicines to people on the unit. We noted they were frequently interrupted for telephone and personal queries. Staff shared with us that staffing levels were also compromised at night. At night there was one nurse on duty on each unit and one carer present, the needs of people were high, for example, two people had additional one to one hours support during the day, but there was no consideration at night for their high dependency needs. Nursing and care staff described occasions in the past 12 months of when staffing levels were even lower with just one staff present on a unit.

When we looked at care records for people we saw the dependency tools reflected the high dependency needs people presented with. The deputy manager told of the service plan to follow in emergency situations such as loss of heating, flood, fire evacuation and loss of utilities. This meant that the registered provider had plans to respond to a significant event. Although it was acknowledged that low staffing levels increased

the risk posed in emergencies, emergency plans did not reflect the staffing levels needed in these situations. Three staff members remarked that the service needed to learn lessons from experiences and increase staff levels when there was any increased risk such as service disruption.

The lack of appropriate staffing levels was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff demonstrated an understanding of what abuse or neglect was and how to report concerns and told us they received regular training about how to keep people safe. Staff were knowledgeable in recognising signs of abuse, and felt able to report concerns to the manager or person in charge of the service. Staff told us they liaised with people's relatives, their social workers and other healthcare professionals involved in people's care when they had any concerns about a person's safety or welfare. Care records showed that dialogue was good in keeping relevant people informed of concerns. Staff told us, and records confirmed they received regular training about how to keep people safe and to make sure they were up to date with reporting systems and national guidance.

Risks to people were identified and plans put in place to minimise them. These covered areas such as dependency needs, falls, continence, manual handling and nutrition. The service used recognised tools such as Waterlow this gives an estimated risk for the development of a pressure ulcers, and the Malnutrition Universal Screening Tool (MUST) which is a screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. These tools helped to develop peoples care plans. The service had a policy to evaluate risk assessments on a monthly basis or whenever there were changes to ensure these reflected current risk. On one unit we saw this was not always done. For example, one person's MUST assessment was reviewed once in 2016 and this was in July. The deputy manager said, "We do care plan audits which covers these," we saw from audits that this shortfall was identified for action but it has not been actioned by the nurse within the timeframe.

Care staff demonstrated a good knowledge of the risks presented and were confident of managing these appropriately. For example, there was equipment such as pressure relieving mattresses which were used for people who had or were at risk of developing pressure sores. The pressure of these was checked daily to ensure they worked efficiently, there were also repositioning records in place which staff used to record when they made position changes. Two members of staff confirmed that on occasions when there had been a shortage of staff this has increased the level of risk as they have not been able to monitor people effectively. Risk assessments were specific and risks were kept under review. One person presented with challenging behaviour episodes and had one to one support during the day. Incident charts and positive behaviour plans were in place to help staff manage these appropriately. We saw these plans were reviewed frequently, and some were discontinued when no longer required. The majority of staff we spoke with demonstrated they were aware of the assessed risks and management plans within people's care records.

Bed rails were used where it was identified people were at risk of falling out of bed, and relatives were involved when the person was unable to agree to consent of their use. We saw staff provided the care as detailed in people's risk management plans. For example, people with low body weight or at risk of poor nutrition had fluid and food intake monitored and food supplements were also supplied. Staff liaised with speech and language specialists if there were swallowing concerns. Staff confirmed they worked together as a team, followed the recommendations given to them such serving only pureed food and using thickeners for all drinks served. Our observations were that people with swallowing issues were served appropriately prepared food and drink.

We spoke with the maintenance person. He took responsibility for ensuring equipment was serviced and

well maintained, and he kept records of these actions.

The service followed safe recruitment practices. We looked at the personnel files of four members of staff. Each file contained a checklist which clearly identified all the pre-employment checks the provider had obtained in respect of these individuals. Staff records included up to date criminal record checks, at least two satisfactory references from their previous employers, photographic proof of their identity, a completed job application form, a health declaration, their full employment history, interview questions and answers, and proof of their eligibility to work in the UK.

People received their prescribed medicines at the right times. All medicines were stored securely and administered by registered nurses. Protocols for 'as required' medicine were in place, giving guidance to staff on the type of medicines to give and when people needed to receive them. We found no recording errors on medication administration records and we saw monthly medicine audits were carried out.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The deputy manager explained that to his knowledge two people were subject to DoLS authorisations and later a copy of the authorisation was shown to us. The deputy manager informed us they had applied for DoLS authorisations for everyone living at the service because keypads were used to keep people safe. We were shown a file containing the applications; we noted most had been made to the local authority in 2015. When we looked at people's care records we did not see any assessments relating to peoples capacity to make decisions about their care. We asked the deputy manager what evidence there was to support people's DoLs application and if other considerations had been taken into account such as the use of bed rails or covert medicines when used. The deputy manager explained the GP completed do not attempt cardiopulmonary resuscitation (DNACPR) decisions and made an assessment of people's capacity in these circumstances but no other decision specific mental capacity assessments had been recorded in people's records. We were concerned because without the relevant documentation in place so it would be hard to assess if a person's capacity had deteriorated, was unable to make complex decisions or had fluctuating capacity due to ill health.

On some care records we noted that consent to care was discussed on admission, and there was involvement of relatives. However, where people lacked capacity best interest decisions made on their behalf were not always recorded. We did not see any best interest decisions recorded for people consenting to their care. We asked the deputy manager about this, who said there was no best interest documentation. Throughout the inspection we saw examples of staff making decisions that were in the best interests of people they knew well, for example using hoists to assist mobility and assisting with eating and drinking. Our judgment was that staff did act in the best interest of the people they supported but they had not followed due processes to record the assessments.

.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had an on-going programme of training. This included a comprehensive induction that incorporated the framework of the Care Certificate. The Care Certificate is an identified set of 15 standards and outlines what health and social care workers should know and be able to deliver in their daily jobs. These include equality and diversity, person centred values, fluids and nutrition, safeguarding adults, basic life support, health and safety, medication and infection and prevention control. There was a dedicated e-

learning point for staff to use for their mandatory courses and this training was monitored centrally. Mandatory courses included safeguarding, infection control, fire drills, food safety in care, health and safety and understanding equality and diversity. Records indicated that 65% of training had been completed and was current however there were certain courses such as safer people handling and fire drills that were recorded as either near to expiry or had expired. Although we did not speak to the manager about this we saw that staff had been reminded about the completion of their mandatory training in a recent staff meeting and systems were in place to identify those staff who still needed to complete their training modules, we will look at staff training again at our next inspection.

People told us they enjoyed the food and the choice was good. We observed that people enjoyed their meals and were offered additional portions if they requested them. One person said, "The food is lovely here." Another told us, "I enjoyed my lunch." People who had swallowing problems were served softer or pureed diets and thickened fluids in accordance with meal plans, care plans showed these support needs. People sitting in communal areas and in their rooms had drinks and snacks accessible to them in the corner of lounges, however, some people needed prompting and there was a lack of sufficient staff present to prompt and remind people to do this. Kitchen staff held personal information about people's dietary needs, which reflected our observations at meal times. Staff involved in food preparation understood the importance of knowing the individuality of people whether this related to risks, such as allergies or swallowing difficulties, or preferences, such as providing alternatives to the meal options served at lunchtime.

We observed the lunchtime experience. People were seated for a long period at the dining tables before lunch, this was their own choice. Lunch arrived on a hot trolley. People present in the dining room were served their meals promptly by the two carers, those present were mostly independent in eating, this provided an opportunity for social interaction with others however staff were too busy to encourage and promote conversation. The activities co-ordinator also assisted one person who needed prompting and encouragement. People were served drinks of their choice. There was a good choice of meals, salmon or pork was offered with vegetables of choice. One person said she liked neither choice and asked for a baked jacket potato. Meal presentation was excellent, staff checked people were enjoying their meals and all four people present enjoyed their meals. Nine people were served lunch in their bedrooms, the times of meals were staggered due to availability of staff. This was not conducive to a positive experience as it was task focused rather than person centred. We observed some positive interactions between staff and people during lunch in the dining room, however, the overall experience on the unit was not fully effective in ensuring people enjoyed their mealtime and opportunities were not always taken to promote choice and social interaction. One carer stated they would like to be able to give more quality time at mealtimes if they had sufficient staff.

People had access to health care services and received ongoing health care support where required. The deputy manager told us people were registered with a local GP who visited weekly. A communication book was used to help exchange information and staff understood the importance of daily handovers. We saw that the outcomes of GP consultations and medicine reviews were recorded. There were also records made of follow up actions required such as referrals to other health or social care professionals such as chiropody and dentistry, these were done in a timely manner.

Although the service provided care and support for people living with dementia there was a lack of appropriate provision for dementia care. In the lounge and dining areas there was little to provide stimulation and interest for people with memory loss. For example, there was nothing to support people reminiscing such as old pictures, signs and household items which can be very helpful in assisting people to access past memories. Care staff acknowledged they understood the dementia needs of people but

recognised each person presented differently and "one size did not suit all."

We recommend that the service explores current good practice guidance from a reputable source in relation to supporting staff to effectively manage the specialist needs of people living with dementia, and the range of approaches and interventions which can be considered in meeting people's individual needs.

Good

Is the service caring?

Our findings

People were cared for by kind and understanding staff. One person told us, "I have been very happy, my friends come in regularly." Another person said, "A great place, the staff are cheerful and brighten up our day." People able to express their views told us they were well looked after by staff who understood their needs, and were happy with the care and support they received. One person told us "It is okay living here, the food is good and staff are pleasant."

The majority of care staff displayed caring compassionate qualities, and demonstrated they understood how to respond to the complex needs of a person with advancing dementia. Staff told of dementia training and of how this prepared them to appreciate the challenges faced by people with dementia. A relative told us, "Some staff are very attentive and know how to deal with dementia clients".

People had comfortable accommodation that offered privacy and comfort, and people that chose to have personal possessions and family mementos displayed in their rooms. Staff respected people's choice for privacy as some people preferred to remain in their own rooms and not to participate in planned activities. Staff treated people respectfully, for example they encouraged one person to try the meal they specifically prepared for them. We observed the positive impact of this approach as the person enjoyed the lunch. A large number of people took their meals in their rooms. Staff made efforts to offer a relaxing and comfortable mealtime environment in dining areas, which potentially increased people's food intake and social interaction. This made people's mealtime experience more enjoyable and helped to minimise eating difficulties for people living with dementia.

People told of entertaining relatives and friends in the comfort of their rooms. A person said, "Staff are caring and respect our privacy, they do not intrude and enter our rooms unless they are invited in." We observed that staff treated people with respect and saw many examples of how staff made people feel safe and relaxed. People's privacy and dignity was maintained, staff kept bedroom and bathroom doors closed when providing personal care and sought people's permission to enter their bedroom. However, we observed a practice by one carer providing one to one support for a person that was not so respectful. The person was restless and liked to wander in the corridor, the carer was observed requesting the person to sit down in the chair in the lounge rather than supporting them to safely move around the service. This practice was brought to the attention of the person in charge.

Some people were not able to communicate their views to us about the service. We observed the care and support being provided in two communal areas. Staff were familiar with people and knew how best to support them. Interactions between staff and people using the service were positive and reflected that staff had developed good relationships with people. We saw staff spent time with people and engaged them in conversations while others participated in organised activities. Staff used respectful ways to support and reassure people and demonstrate that they cared about them. For example, we saw a member of staff spending time and giving a person support and encouragement by using a reassuring tone of voice. The person responded well and become more engaged with others.

Various activity programmes were organised and took place to provide stimulation and enjoyment to people in the home but there was room for improvement in this area. An activities coordinator recognised the difficulties presented by persons with cognitive impairment. They told of trying numerous activities but found the person responded best when they engaged them in soft ball activity or group games. The activities coordinator also spent some one- to-one time with people who remained in bed, but they told us they recognised there was much work to do in this area, opportunities were limited when there was one activities coordinator, care staff were fully occupied with supporting people with other areas of need such as personal care and continence care. The activity coordinator told us of their plans to get support from local church volunteers, and felt this would add to the experiences for people.

People's diverse needs were planned for. There was information in care records to help staff understand how to best support people and meet their individual religious and cultural needs. For example, care records gave details of the support needed by a person with a particular religious need and how to observe their beliefs regarding their nutritional needs. Where the person requested same gender care staff for personal care this was respected according to staff, records also confirmed this

Records showed that some people and their relatives were involved to some extent in advanced care planning. This was recorded so they would be cared for in accordance with their wishes as they approached the end of their life. People's wishes for issues such as their funeral arrangements were also recorded. Care records overall on end of life wishes overall were inconsistent and lacked essential detail on end of life wishes. The deputy manager told us of plans proposed to improve this area, and the local palliative care team were due to begin work with staff to introduce best practice guidance and training for staff in end of life care. Special forms were in place to show if people did or did not wish to be resuscitated in the event of a healthcare emergency, or if it was in their best interests. These agreements were recorded following meetings between the person and their GP and relatives where relevant.

Good

Is the service responsive?

Our findings

Staff knew how to meet people's individual needs, and records and progress notes recorded that staff were responsive to individual needs.

People were assessed to receive care and treatment that met their needs, and care records showed that before people moved into the home their needs were assessed through the provider's pre- admissions assessment process. This helped ensure that people's individual needs could be suitably met in the home's environment and by their staff. There were numerous examples seen of the responsiveness of the service. For example we saw in care records a person became ill during the night. A qualified member of staff assessed and recognised the person's condition necessitated hospital treatment. They called an ambulance promptly and the person was admitted to hospital for treatment. One person told us, "I was not well, staff called the doctor and told him, I was seen quickly and my problem was solved." We saw from referrals and pre admission assessments the information included background information which helped staff understand the person and their individual needs. One social care professional told us that the staff provided a service in accordance with the person's individual needs.

Care plans contained information on how people's needs should be met. Staff were knowledgeable about the people they were looking after and were able to talk about their individual needs, preferences and daily routines. Staff knew about the content of people's care plans and how they preferred their care to be delivered. There was good continuity of care experienced, this was due to staff retention and individual staff members working well together as a team. Information sharing was generally good within the staff team through handovers. Staff told us they responded flexibly, so, that if there was a change in a person's circumstances; they were able to meet their needs without delay. Changes to the care plans were implemented where needed. For example records for a person showed they initially used a standing hoist for transfers, but following deterioration in their weight bearing capacity a full body hoist was needed and two staff were required.

Care plans were reviewed on a monthly basis in line with the provider's policy and where people's needs had changed the home responded by consulting with relevant health and social care professionals to ensure accurate guidance was available to staff. The acting manager told us the home operated a 'Resident of the day' scheme. This was a special day for the resident, their individual needs and preferences were considered with their participation and reviewed to ensure it was responsive to their needs. However, records indicated the last time this occurred was in May 2016.

Each person's care plan was based on their needs, abilities, likes, dislikes and preferences, Care records were mostly consistent but there were disparities between units. Care records showed interventions and outcomes which demonstrated it was responsive to people's changing needs. We saw from records that following assessments referrals were made to specialist services as appropriate. People's diverse needs, independence and human rights were supported and respected and people had access to equipment which enabled greater independence, for example walking frames and wheelchairs.

We observed and staff told us a high number of people were living with various stages of dementia, some were cognitively impaired. Staff encouraged and supported people to undertake activities of interest to them. We observed that people enjoyed music from their era; this was played at a suitable volume. However, on the day of our inspection, there was limited activity undertaken on some floors due to the numbers of staffing present. There was an activities coordinator in post who was enthusiastic about the role. They had taken up appointment recently and made some progress in developing suitable stimulating activities, but acknowledged there was much more work to be done. There were a range of activity materials available at the service and people had access to them whenever they wanted. We observed games such soft ball, and sensory equipment. The activities coordinator was playing a game with some people which involved catching a ball. This provided positive stimulation to the people involved and helped them use their upper arms. Outside entertainers were invited to visit on a regular basis, there were also events outside the home. The coordinator told us they planned to continue to develop and improve the program of activities at the service. This included a development of a regular newsletter and the organising of events such as summer fetes and parties.

The service had a complaints procedure in place. The service had a procedure which clearly outlined the process and timescales for dealing with complaints. Complaints were logged and monitored at provider level.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was not present at the time of inspection. The deputy manager was in charge but he was also responsible as lead nurse on one unit, and for administering medicines. We observed he was frequently disrupted in his role with queries from callers.

Quality assurance systems were in place. The provider carried out regular quality audits and the service conducted internal audits such as care plans, risk assessments, medication and health and safety. From the paperwork available to us it was apparent that where issues had been identified and recommendations made, these were not always acted upon. For example care plan audits had identified documents that were missing or needed to be updated but there was no evidence to show how this had been actioned. We spoke to the deputy manager who explained that they would normally carry out checks as part of the care plan audit to ensure actions had been completed. However, recently this had not been achieved because of his split managerial and nursing duties. We understood the service had been without administrating support for some time and that some of the audits had previously been carried out by them. We met with the new administrator in post who explained they has only been in post for a short time and were still unfamiliar with some aspects of the service including audits, service procedures and accessing policy documents. Other records such as resident of the day appeared to be incomplete and missing and we were unable to locate statutory notifications to the CQC involving DoLS authorisations.

We were also concerned that the provider had not adequately identified and assessed staffing levels based on people's dependency needs which presented a risk to people using the service and staff. We had seen that a previous incident at the home had occurred when staffing levels were low however improvements in staffing were not evident and we could not see what had been done to mitigate the risk in this area.

This was a breach under Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

People and staff were not always actively involved in developing the service. We were shown a document dated June 2016 with relative feedback; however there was no information on how concerns and suggestions had been acted upon to make improvements to the service. We were shown evidence of a very small staff survey where three staff members had been asked their view in June 2016, again there was no follow up action points to confirm how suggestions had been considered or acted upon. We looked at staff supervision and saw that although these were carried out regularly they did not appear to provide the opportunity for staff to be actively involved in the service by recording their suggestions and feedback. When we spoke with staff they told us the work environment did not always feel open and transparent and they did not always feel able to speak up and raise concerns with management. They told us they felt their views were not always listened to when they did as the culture was not inclusive. The area operations manager visited the service regularly to audit and monitor the service but staff told us they were not spoken with confidentially or asked their views. Staff told us they did not feel they were offered any opportunity to share their concerns in confidence without retribution.

Regular staff meetings were held. Senior staff including nurses, housekeeping and maintenance attended a daily "flash meeting" with the manager. This provided the opportunity to discuss the needs of people who used the service, share information, raise any concerns.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not always act in accordance with the requirements of the Mental Capacity Act and associated code of practice. 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not always assess, monitor and mitigate the risks relating to the health, safety and welfare of people who use the service. Regulation 17 (2) (a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not have procedures in place to deploy sufficient numbers of suitably qualified, competent and skilled staff to cover routine and emergency work at the service. Regulation 18 (1)