Bupa Care Homes (GL) Limited

Park Avenue Nursing Home

Inspection report

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Ratings

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

Overall summary

This was an unannounced inspection carried out on the 12 March 2015.

Park Avenue is located in the Oakwood area of Leeds. It provides nursing care for up to 43 older people, some of whom are living with dementia. It is close to local amenities and is accessible by public transport.

At the last inspection in September 2014 we found the provider had breached one regulation associated with the Health and Social Care Act 2008. We found people did not always experience care and support that met their needs and protected their rights. Care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare.

We told the provider they needed to take action and we received a report in December 2014 setting out the action they would take to meet the regulation. On this visit we checked and found improvements had been made regarding this breach. However, we found other areas of concern.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Summary of findings

Staff were trained in the principles of the Mental Capacity Act (2005), and could describe how people were supported to make decisions to enhance their capacity and where people did not have the capacity, decisions had to be made in their best interests. However, we found the service was not always meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

This demonstrated a breach of Regulation 18 (Consent to care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 (Need for consent) 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 the report.

There were effective systems in place to ensure people's safety and manage risks to people who used the service. Staff could describe the procedures in place to safeguard people from abuse and unnecessary harm. Recruitment practices were robust and thorough. Appropriate arrangements were in place to manage the medicines of people who used the service.

People were cared for by sufficient numbers of suitably trained staff. We saw staff received the training required to meet people's needs well. However, staff supervision and appraisal were not carried out regularly to ensure staff had opportunity to discuss their role.

People's needs were assessed and care and support was planned and delivered in line with their individual care needs. People had detailed, individualised care plans in place which described all aspects of their support needs.

Health, care and support needs were assessed and met by regular contact with health professionals. People were supported by staff who treated them with kindness and were respectful of their privacy and dignity.

People told us they enjoyed the food in the home and there was a good variety of choices available. We saw people were given good support when they needed assistance with their meals.

People who used the service said they had enough to do to make sure their social needs were met.

Staff were aware of how to support people to raise concerns and complaints and we saw the provider learnt from complaints and suggestions and made improvements to the service. However systems in place to monitor the quality of the service were not always effective. This demonstrated a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the end 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?

Good

The service was safe.

We saw robust safeguarding procedures were in place and staff understood how to safeguard people they supported. There were effective systems in place to manage risks to the people who used the service.

People's medicines were stored safely and they received them as prescribed from staff who were trained to do so.

There were sufficient staff to meet the needs of people who used the service. Recruitment practices were safe and thorough.

Is the service effective?

Requires Improvement

The service was not always effective.

We found the service was not fully meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS).

Health, care and support needs were assessed and met by regular contact with health professionals.

Staff said they received good training which helped them carry out their role properly. Staff supervision and appraisal were not carried out regularly to ensure staff had opportunity to discuss their role.

People said they enjoyed the food in the home.

Is the service caring?

Good

The service was caring

Staff understood how to treat people with dignity and respect and were confident people received good quality care.

Staff and people who used the service had a good rapport and had developed good relationships.

People had detailed, individualised care plans in place which described all aspects of their support needs.

Is the service responsive?

Good

The service was responsive

People's needs were assessed before they moved in to the service and whenever any changes to needs were identified.

People were provided with a good range of activity. They told us they had enough to do and enjoyed what was on offer to them.

Summary of findings

There were good systems in place to ensure complaints and concerns were fully investigated.

Is the service well-led?

Requires Improvement

The service was not consistently well- led.

The provider had a quality assurance system in place. However, the systems in place were not always effective.

Accidents and incidents were monitored by the registered manager and the organisation to ensure any trends were identified and acted upon.

People spoke positively about the approach of staff and the manager. Staff were aware of their roles and responsibilities and knew what was expected of them.

The registered manager had informed CQC about some significant events that had occurred but they had failed to inform CQC about all reportable events.

Park Avenue 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 inspection took place on 12 March 2015 and was unannounced.

At the time of our inspection there were 42 people living at the home. During our visit we spoke with nine people who used the service, eight visitors, the activities co-ordinator, the cook, a student nurse and ten members of staff which included the registered manager and regional manager. We spent some time looking at documents and records that related to people's care and the management of the service. We looked in detail at three people's support plans.

The inspection was carried out by two adult social care inspectors, a specialist advisor with a background in nursing and an expert-by-experience who had experience of older people's care services and dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, we reviewed all the information we held about the home, including previous inspection reports. We contacted the local authority and Healthwatch. We were not aware of any concerns by the local authority. Healthwatch feedback stated they had no comments or concerns. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Good

Is the service safe?

Our findings

People who used the service said they felt safe at the home. Comments included: "We're all happy here. We do have some fun" and "I had got nervous at home, I feel better here." One person told us there was a nice atmosphere in the home. Visitors told us they felt their family members were safe. One said, "I am sure [Name of person] is safe here. It's like visiting friends." Another said, "When you leave you don't have to worry, you take that memory of how good the staff are with you." We saw positive interaction throughout our visit and people who used the service appeared happy and comfortable with the staff.

One visitor told us there was a person who used the service who could get agitated at times. They said the staff dealt with this well with a calm approach. We saw staff's actions when a person became upset. The staff member approached the person calmly, began talking and sat at one of the tables with them. The person became calm and said, "You're a lovely girl. Just to sit and talk to you, it's lovely." Staff spoke of how they diffused situations where people who used the service became distressed or showed behaviours that challenged the service. One said, "There is information about residents' likes, dislikes and past lives in their files. When you know those things it's easier to get people talking and distract them."

Staff said they were aware of their roles and responsibilities regarding the safeguarding of vulnerable adults and the need to accurately record and report potential incidents of abuse. They were able to describe different types of abuse and were clear on how to report concerns outside of the home if they needed to. Staff had received training in the safeguarding of vulnerable adults. Staff we spoke with said the training had provided them with good information that helped them understand the safeguarding processes, including reporting systems. Staff said they treated people who used the service well and that any untoward practices would not be tolerated and reported promptly. They said they would have no hesitation in reporting any concerns and felt confident to do so if needed. They said they were confident the registered manager would respond to any concerns reported.

We looked at three care plans and saw risk assessments had been carried out to minimise the risk of harm of to people who used the service. The risk assessments were linked to care plans and activity involved in care delivery. The assessments identified any hazards that needed to be taken into account and gave staff guidance on the actions to take to minimise risk of harm. These included risks associated with the use of bed rails, moving and handling, falls, pressure ulcers and nutrition.

We saw there were systems in place to make sure the premises and equipment was maintained and serviced as required. We reviewed environmental risk assessments, fire safety records and maintenance certificates for the premises and found them to be compliant and within date. We found all floor coverings were appropriate to the environment in which they were used. All floor coverings were of good quality and properly fitted thus ensuring no trip hazards existed. All radiators in the home were covered, or were of a cool panel design, to protect vulnerable people from the risk of injury. We saw that upstairs windows all had opening restrictors in place to comply with the Health and Safety Executive guidance in relation to falls from windows.

We looked at the staffing rota and spoke with the manager. The home operated two 12 hour shifts covering the day and night periods. In addition the day shift utilised a six hour shift to expand the staffing levels during periods of high activity. During each span of duty, care was led by a registered nurse and supported by care workers. In addition a cook was employed to deliver all aspects of food preparation and menu planning. A domestic worker carried out all cleaning duties. An activity coordinator was also employed. We spoke with the manager about the method of calculation of the staffing requirements and were told this was influenced by the assessed dependency of each person receiving care. We looked at a sample of people's dependency rating and in particular took note of people receiving one-to-one care and higher levels of observation.

Through our observations and discussions with relatives of people who used the service and staff members, we concluded there were enough staff with the right experience and training to meet the needs of the people living in the home. All the staff we spoke with said there were enough staff to meet people's needs, and they did not have concerns about staffing levels. People who used the service and visitors said there were enough staff day or night. One person said, "There are always plenty of staff."

We saw that people who used the service were responded to promptly whenever they requested assistance. We saw

Good

Is the service safe?

the communal areas of the home were always supervised to ensure people's safety. People who used the service said they never had to wait long for assistance when needed. One person said, "I have a call bell which I've used when I've been poorly. They come quickly."

We saw that the provider was employing effective staff recruitment and selection systems. We saw there was a clear process which ensured appropriate checks were carried out before staff began work. These checks helped the service to make sure that job applicants were suitable to work with vulnerable people. We saw the manager had secured photographic identification in the form of either a driving licence or passport and that checks had been made to ensure staff were legally entitled to work in the United Kingdom. We saw evidence that the provider had used the employer checking service with the UK Visa and Immigration service for a person who may not have had the right to work in the UK. Work permit details and Visas were kept in staff files. We saw from records the provider had a robust system to ensure all registered nurses had a current Personal Identification Number (PIN) issued by the Nursing and Midwifery Council (NMC) to signify they were entitled to work.

We looked at a sample of medicines and records for people living at the home as well as systems for the storage, ordering, administering, safekeeping, reviewing and disposing of medicines. We saw medicines were administered in a safe, effective and timely manner in accordance with prescriptions. Medicines were stored safely and correctly and there was evidence of audit. Controlled drug (CD) checks were made weekly and stock checks for individual CD's on their administration. People who used the service told us that staff looked after their medicines. One person said, "They show you the tablets and say 'this is for this, this is for that'." Another person said, "If I say I've got a headache they would get me a paracetamol."

Requires Improvement

Is the service effective?

Our findings

Throughout our inspection we saw that people who used the service were able to express their views and make decisions about their care and support. People were asked for their choices and staff respected these. One person said, "They know what we like." However, we saw one member assist people with yogurts during the mid-morning drinks round without gaining their consent and similarly assisted people in the quiet lounge at lunchtime without gaining consent or checking that the person wanted and was ready for more. We brought this to the attention of the registered manager.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. At the commencement of our inspection we were told that of the ten applications to the local authority for DoLS no authorisations had yet been received. However, during our scrutiny of care files we found one person at the home was subject to DoLS which had been in place for 14 weeks without the registered manager being aware. Discussion with the registered manager demonstrated the absence of a robust mechanism for checking the receipt of authorisations from the local authority and for ensuring they as the managing authority were aware. Before our inspection was completed we spoke again with the manager who told us a checking procedure was in place.

Whilst ten applications for authorisation to deprive people of their liberty had been made our observations of the environment and people's care plans suggested the provider utilised a number of methods which may constitute a deprivation of liberty for a greater number of people. The front door was locked. Internal doors between floors were, for reasons of safety, locked. Some people had sensitivity mats at the side of their beds to alert staff if the person was vacating their bed. We saw five occupied bedrooms with gates across the open doorway. Some care plans recorded diagnoses and other indications of reduced mental capacity. Some people were under observation for prescribed periods of time with others receiving long periods of one-to-one care. Whilst each element of restrictions may not constitute a deprivation of liberty, an accumulation of restrictions being experienced by some people may amount to unauthorised deprivation of their liberty.

The provider was not following the legislation regarding the Mental Capacity Act and there was a risk they may be exercising control over people's care and movements without the legal framework being in place to allow for this. Discussion with the manager showed they had a plan to systematically review three people per week and make application to deprive people of their liberty as defined by the Mental Capacity Act (MCA) 2005. Whilst this plan was not being adhered to the manager assured us there would be a greater focus on the issue going forward.

This demonstrated a breach of Regulation 18 (Consent to care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 (Need for consent) 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 the report.

We asked staff about the MCA. They were able to give us an overview of its meaning and could talk about how they assisted and encouraged people to make choices and decisions to enhance their capacity. They spoke of making sure people were supported and given time to make decisions such as what to wear, what to do and what to eat and how they did this. Staff spoke about always making sure everything they did with people was in their best interests. We saw the provider had a written policy on the use of restraint. We spoke with the registered manager about the use of restraint. They were able to demonstrate their knowledge and knew the difference between lawful and unlawful restraint practices. We spoke also about the use of bed-rails. Answers we received demonstrated that when people had capacity they were consulted on the use of bed-rails and understood the action was proportionate to the potential harm. Where there was a lack of capacity or the person's capacity fluctuated, family members were consulted before bed-rails were used. Training records showed staff had received training in the Mental Capacity Act 2005 (MCA) and specifically on the Deprivation of Liberty Safeguards (DoLS).

Records showed that arrangements were in place that made sure people's health needs were met. Communication with both healthcare professionals and relatives in separate communications logs was very clear and provided an excellent record of the action taken. We saw one person who used the service had lost weight and in response to this the person had been referred to their GP

Is the service effective?

and food supplements and enrichment of food introduced. Another person had been admitted to the home with a pressure ulcer. The records showed the staff were working closely with the Tissue Viability Nurse (TVN) in agreeing the treatment and prevention of further ulceration. Records showed there had been marked continuous improvement of the ulcer.

We saw from the records that another person had lost a significant amount of weight and while this was being monitored by staff at the home it was the TVN who prompted the staff to refer these concerns to the person's GP. The day before our visit, the GP had advised close monitoring of diet and fluid intake for this person. Our review of these records showed they were incomplete and had not been filled out in full. However, throughout the visit, we both observed fluids and diet being regularly offered and consumed by this person and there was no indication of dehydration. We discussed this with the nurse in charge. They acknowledged this oversight and assured us the person was taking a good diet and adequate fluid intake. They agreed to remind staff of their responsibilities to accurately complete the charts.

We saw other records of diet and fluid charts which appeared to be completed and fluid balance maintained. A staff member told us that when anyone needed a fluid balance chart or food diary that they encouraged people to maintain a minimum of 1000 mls of fluid a day and all amounts of fluid and portion size of meal was recorded as offered and all actually consumed recorded.

People who used the service said their health needs were met. One person said, "They get you a doctor whenever you need one." Another said, "If you're not feeling yourself they come and talk to you, cheer you up. If you're ill they do something about it." Relatives we spoke with said that they had no concerns with their relatives accessing health professionals. We saw for one person that their weekly weight review and nutritional risks screening records had shown continuous weight gain over the last three months.

We looked at the training matrix which showed the staff team had accessed a range of training courses and refresher training was being provided at a high level of compliance with the provider's recommended timescales. We also looked at a random sample of six individual staff files and found they contained evidence that an appropriate programme of training was completed. Mandatory training was provided on a number of topics such as safeguarding vulnerable adults, manual handling, first aid and medication awareness. Additional training was provided on topics such as the reporting and recording of incidents and dealing with challenging behaviours. Specifically we saw catering staff had received food handling and safety training. Staff had access to a range of policy and procedure guidance about how to carry out their work.

Staff spoke highly of their training and said they felt it prepared them well for their job. They said they felt well supported in their role and that the nursing staff and registered manager were always available to answer any questions they may have. Staff said they received regular supervision meetings which gave them opportunity to talk about their job role, receive feedback on their performance and identify any new training needs. They said the registered manager used these meetings to check what they had learned through training and how they put this into practice, for example, their dementia training.

We spoke with the registered manager about the frequency of staff supervision meetings and appraisals. We were told that supervision meetings should occur every six to eight weeks but these were currently not up-to-date. Our scrutiny of records demonstrated the frequency and quality of supervision meetings was significantly below this target. The manager assured us of their intention to give the matter their urgent attention. Likewise the frequency of yearly appraisals was behind schedule. The absence of up-to-date supervision and appraisal records meant we were unable to inspect a meaningful learning and development plan for any of the staff.

People spoke positively of the food and menus in the home. One person said, "It's alright here; you get good food." Other comments included: "The food is nice", "Nice meals, lovely" and "The food's good." People told us they had enough to eat and drink. One person said, "You can ask for snacks, if I want toast I just ask them and they go and get it." We saw there was a 'night bite' menu available between 6.30pm and 6.30am. This listed a number of things including beans on toast, fruit, sandwiches and cake that were available on demand.

We observed the lunch time meal on both floors in the home. We saw on the ground floor, the tables were set with tablecloths, place mats, cutlery, glasses and serviettes. There were no condiments on the table, however one person received salt when they asked for it. On the first

Requires Improvement

Is the service effective?

floor people ate their meals in the lounge area, sat at small tables, some of which were set with cloths and table decorations. Service was well paced though not rushed. People were not left seated at tables without receiving their meals, and were able to have desserts when they were ready for them. Downstairs there was no music to add a sense of atmosphere or occasion to the mealtime. However, on the first floor, the radio was playing and we saw people seemed to enjoy this, tapping their feet and talking with staff about the music that was playing. People were not assisted with their meals without being asked, and where assistance was refused this was respected.

People were given the support they needed and encouraged to be as independent as they could be. Staff gently tried to encourage people to eat their meals and offered alternatives if people didn't want what was on offer. Some people were assisted to eat by staff and we saw they did this in a dignified and supportive manner.

We spoke with the cook who told us the provider had constructed menus which reflected a balanced diet. The menus rotated on a four week cycle thus giving people variety. All recipes available identified calorific values and where food contained high and low fat and salt content. Wherever possible fresh ingredients were used and foods such as soups were prepared on site rather than relying on commercially produced food. The service provided a cooked breakfast each day along with a cooked evening meal. Whilst a cooked lunch had been prepared on the day of our visit we understood the convention was to offer sandwiches, soup or a light snack at midday. During the day hot drinks were prepared along with homemade cakes. Fresh fruit was available on demand. The cook had an up-to-date list of people's dietary needs including people who requested a particular portion size. The cook was able to detail for us those people requiring soft or normal diets. They told us of people with diabetes and those with lactose intolerance. Our observations of care plans demonstrated the cook had an excellent understanding of people's food requirements.

Good

Is the service caring?

Our findings

People who used the service spoke highly of their experience. They said they enjoyed living at the home. People we spoke with all used words such as "lovely" and "very nice" to describe the staff. Other comments included: "I get on well with all of them" and "She's a lovely girl, that one. Lovely." Relatives of people who used the service were also complimentary of the service. People's comments included; "What we have here is a family atmosphere", "The staff know what they're doing" and "The care here is not far off excellent. No one has a 'couldn't care less' attitude.'"

Staff interactions with people who used the service were warm and genuine, with staff taking opportunities to have conversations with people and approaching them when they showed any sign of discomfort or needing assistance. Where assistance was given it was patient and person-centred. People who used the service said that they had a good relationship with the staff. One person said, "The staff come and talk to me. I can't remember what about but they do chat." Another person said, "I get on well with all the staff."

People looked well cared for, clean and tidy. People were dressed with thought for their individual needs and had their hair nicely styled. We did however; see two people who were wearing creased trousers. People appeared comfortable in the presence of staff and enjoyed the relaxed, friendly communication from staff. We saw staff assisted people when required and care interventions were discreet when they needed to be. Staff responded well and in a dignified manner whenever a person who used the service asked for assistance or asked a question.

Staff we spoke with said they provided good care and gave examples of how they ensured people's privacy and dignity were respected. They said they ensured care was provided discreetly with curtains and doors closed. They also said it was important to speak to people in a respectful and dignified manner such as using people's preferred names. Another said it was important to make sure people looked nice. They also said, "It's important to look after people as if they were your own Nana." Staff said they received training in privacy, dignity and respect during their induction. One staff member said, "We're very hot on it here and the manager makes sure of it."

We looked around the home with the registered manager and looked at some bedrooms. We noted that staff always knocked on doors prior to entering, thus respecting people's need for privacy. However, we noted that people's confidential care records were not always stored to maintain people's privacy. The registered manager agreed some new lockable storage was to be ordered to ensure this. We saw people had been able to make choices about the decoration and furnishings in their rooms. Many rooms contained personal treasured items and family photographs.

People who used the service were involved in making decisions and choices about their care and support. We saw staff regularly asked people if they needed anything and offered choices such as where people wanted to sit, whether they wanted to go back to their rooms and what they wanted to do.

One person who used the service was able to speak with us about their involvement in care planning. They said, "They come and talk to me about my care." A relative we spoke with said they felt involved in their family member's care, saying they received information whenever their family member was unwell. Staff said they found the care plans useful and that they gave them enough information and guidance on how to provide the support people wanted and needed. Staff spoke confidently about the individual needs of people who used the service. It was clear they knew people and their needs well.

Records we looked at showed the registered manager carried out six monthly care evaluations with family members of people who used the service. This showed there was effective two-way communication in place to make sure people's needs were met with the full involvement of the person and their relative.

A review of ten care plans evidenced people who used the service had close family ties and therefore had no requirement for the appointment of an advocate. A discussion with the registered manager demonstrated they had a thorough understanding of when any form of advocacy would be required. We did not see any information relating to advocacy support displayed in any communal area of the home.

We saw four care plans where it was recorded whether someone had made an advanced decision on receiving care and treatment. The care files held 'Do not attempt

Good

Is the service caring?

cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form. We spoke with staff that knew of the DNACPR decisions and were aware that these documents must accompany people if they were to be admitted to hospital.

Good

Is the service responsive?

Our findings

Records showed that people had their needs assessed before they moved into the service. This ensured the service was able to meet the needs of people they were planning to admit to the service. We saw that pre-admission documentation, recently introduced, was very clear, comprehensive and helpful and easy to read.

We looked in detail at the care plans for three people who used the service. Care documentation was generally very difficult to navigate, too wordy and frequently documented the use of 'Not known' which resulted in important information being lost in certain sections of the care plan. For example, one person had a diagnosis of Parkinson's disease which had been omitted in one section of the care plan but documented in another. Staff we spoke with said they were familiar with the care planning system but were looking forward to the new documentation the care provider was about to introduce. Staff said they had received training on the new documentation and we saw a blank copy which they were getting ready to use.

We saw evidence of monthly care plan evaluation which included skin integrity, falls and risks. This appeared to be carried out on time with changes both recorded and the care plan amended to reflect changing needs. Daily care records were relevant, up to date, signed and dated/timed. We saw charts for 30 minute observations of people's whereabouts, continence records, personal care records and behavioural charts were completed properly. Staff told us they were encouraged to complete these as they delivered people's care. Nursing staff told us they checked and signed these charts to make sure care was delivered as planned.

People who used the service said they had individual choice at the home and their choices were respected. People told us they could have a bath or shower whenever they wanted one and they were free to rise and return to bed when they wished. People told us that they could go to their rooms during the day if they wished.

There was an activity co-ordinator in post. We saw people were offered a range of social activities which included: sing-a-longs, entertainers visiting the home, pamper sessions, afternoon teas, film afternoons and one-to-one time. Records were kept of the activity offered to people and how they responded to or enjoyed the activity. On the morning of the visit staff including the activities coordinator circulated regularly in the living room and chatted with people who used the service. There was music playing, mainly songs from the 1950s and 1960s. We saw several people tapping their feet or fingers in time with the music. The television was also on with the sound switched off. It was unclear why this had been left on.

We asked people who used the service how they liked to spend their time. Comments we received included: "Sometimes there's bingo and singing. I don't think I'm ever bored" and "Sometimes they have singers in." One person told us a priest visited the home and conducted a service to make sure their spiritual needs were met. We spoke with the activities coordinator about what they had planned for the day of the inspection. They told us, "This morning is my first day back after some time off, so I've been talking to people, doing one to one. This afternoon there's the meeting so I haven't got anything planned."

We saw people who used the service were involved in developing the activity programme. The activities coordinator said "Every resident has a map of life in their file, and there's information in there about what they enjoy and what they used to do, so I try to use that information." We were told that ladies appreciated the 'ladies afternoon' where they had tea and did nails and chatted. We were also told that there was a similar afternoon for male residents with activities that engaged them. We saw the activities coordinator and staff used opportunities such as delivery of care and putting laundry away as an opportunity for one to one time with people. One staff member said "It's not just about that. It's about chatting to them, making it a one to one."

People we spoke with or their relatives told us they had no complaints. People told us that if they had any concerns they would feel confident to speak with the staff or manager and were confident that their concerns would be heard and addressed. One person said, "If I was worried I would talk to the staff. That's the first thing that I would do." A visitor said, "When my relative first came here the manager said to come and see her whenever I need to, she'd sort out any problems. I find her down to earth; I think she would sort things out."

The home had systems in place to deal with concerns and complaints, which included providing people with information about the complaints process. We saw the complaints procedure was on display in the home. We

Good

Is the service responsive?

looked at records of complaints and concerns received in the last 12 months. It was clear from the records that people had their comments listened to and acted upon. The registered manager said any learning from complaint would be discussed with the staff team so that lessons could be learned. We saw from staff meeting minutes that any feedback on concerns and complaints was discussed with staff in order to prevent re-occurrence of issues.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post who was supported by a deputy manager, a team of registered nurses and care staff. Visitors expressed a high level of confidence in the registered manager, one said, "We see the manager about all the time."

On the day of the inspection the registered manager was holding the first 'relatives support meeting' to address needs that relatives may have. It was attended by six visitors and appeared to be a catalyst for the start of a support network. People shared experiences and offered help to one another, either anecdotal or suggestions of practical assistance they could give each other. The registered manager encouraged feedback and asked what assistance the relatives wanted in developing the group. She told the relatives about the Admiral Nurses who were also able to offer support with regards to dementia care. Visitors all participated in the meeting which had a pleasant and productive atmosphere. All remarked on having found it useful.

Staff spoke highly of the management team and spoke of how much they enjoyed their job. Comments such as; "I love working here" and "It's a great place to work" were received. Staff said they felt well supported in their role. They said the nursing staff worked alongside them to make sure good standards were maintained. They said the registered manager maintained a highly visible presence in the service and was often 'out and about' around the home making sure of high standards. Staff said they were informed of any shortfalls in service delivery and expected to deliver a quality service. Staff said they were aware of the policies and procedures in place about raising concerns. They said they felt comfortable to raise concerns and were aware of the whistle blowing procedures they could use. Staff described the culture in the home as 'friendly' and 'open'.

Staff said the registered manager was approachable and always had time for them. They said they felt listened to and could contribute ideas or raise concerns if they had any. They said they were encouraged to put forward their opinions and felt they were valued team members. We saw staff meetings were held on a regular basis which gave opportunities for staff to contribute to the running of the home. We noted that the latest staff meeting took place over two separate days to give staff opportunity to attend and cause the least disruption to service delivery in the home.

People who used the service and their relatives were asked for their views about the care and support the service offered. The care provider sent out annual questionnaires for people who used the service and their relatives. These were collected and analysed to make sure people were satisfied with the service. The only results available at the time of our visit were from a survey undertaken in Autumn 2013. We were told that an independent company had recently carried out telephone surveys with relatives of people who used the service and analysis of this information was expected.

People who used the service said they had regular meetings. We looked at the minutes of the most recent meetings and saw people who used the service and their relatives were asked for their comments and given information on aspects of the service. We saw this included feedback after CQC visits, menus, activities, staffing information and any concerns people may have. The registered manager said they were hoping to have them more frequently in the future as they had only happened annually for the last year.

The registered manager had informed CQC about a number of significant events that had occurred but they had failed to inform CQC about all reportable events. Due to the managers lack of awareness of the authorisation to deprive someone of their liberty no notification of the approval had been made to the CQC. The regulation requires any request to the supervisory body made pursuant of Part 4 of Schedule A1 of the 2005 MCA by the registered person for a standard authorisation to be made known to the CQC without delay. Before our inspection was complete a notification had been made.

Systems of quality assurance were in place to monitor whether the service was providing high quality care. These included audits on care plans, medication, health and safety and infection control. We saw documentary evidence that these took place at regular intervals and any actions identified were addressed through action plans. The registered manager had a system in place to sign off action plans when issues were addressed. We saw at times that the action plans were not clearly linked to the audits in that they were not held with them and were often difficult to

Requires Improvement

Is the service well-led?

navigate around as they were loose pieces of paper. There was a risk that the action plans could be lost or mixed up. The frequency of audit was not scheduled and appeared to take place randomly or in response to concerns, for example, the infection control audit documentation stated it should be carried out every three months but this was not being adhered to.

We were told there was a short daily meeting known as the '10@10' meeting where any issues or risks affecting the home were reviewed by all heads of department. Records showed these were not taking place daily as planned. The registered manager was aware they needed to try and improve this.

Senior managers visited the home regularly to check standards and the quality of care being provided. The registered manager and staff said they spoke with people who used the service, staff and the manager during these visits. We looked at the records of visits for the last four months. We saw that frequently the same issues were identified each month and it was unclear if effective action had been taken to address them. For example; the need for staff to fully complete supplementary charts such as fluid balance and food diaries was frequently raised at each visit for the last four months.

We therefore concluded from the above evidence that this demonstrated a breach of Regulation10 (Assessing and monitoring the quality of service provision); of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw evidence that the registered manager analysed accidents, incidents, near misses and falls on a monthly basis and checked the actions were completed and effective. Records showed that the manager reviewed falls of people who used the service on a monthly basis to see what action could be taken to prevent re-occurrence.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Before people received any care or treatment they were not asked for their consent and where people did not have the capacity to consent, the provider did not act in accordance with legal requirements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not have effective systems in place to monitor the quality of the service delivery.