Mr M S and Ms A A Berry

Hillbro Nursing Home LLP

Inspection report

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Date of inspection visit: 27 and 28 May 2015
Date of publication: 22/07/2015

Ratings

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

Overall summary

Hillbro Nursing Home provides accommodation and nursing care for up to 42 older people at any one time in accommodation spread over 3 floors. On the dates of the inspection, 27 and 28 May 2015, 41 people were living in the service. The inspection was unannounced. At the last inspection in May 2014 the home was compliant with all the standards we looked at.

People and their relatives told us they felt safe in the home and comfortable in the company of staff. Staff we spoke with had a good understanding of safeguarding and how to identify and act on any concerns. They said the manager would take concerns seriously and fully investigate. Safeguarding procedures were in place and we saw evidence these were followed to help keep people safe.

The premises was appropriately managed with a range of communal space available and a sensory garden where people could spend time. Some areas of the building required updating, the provider told us they had a plan in place to refurbish remaining areas.

Summary of findings

Medicines were not consistently well managed. Although we found people received their prescribed medicines, some people were not receiving their medicines at the time they needed them. Record keeping in regards to the application of topical medicines was not consistently completed. Appropriate arrangements were in place to record and check stocks of medicines.

People and their relatives and staff told us they thought staffing levels were sufficient. Although we found staffing levels were safe during the morning and early afternoon, staffing was much reduced during the evening and overnight and we concluded it was not sufficient to enable consistently safe care. We saw there was a trend for increased falls in the evening and some overnight care tasks were not always completed as frequently as required which indicated insufficient staff at these times.

Appropriate recruitment procedures were in place and we saw evidence these were followed to ensure staff were suitable for the role.

People and their relatives told us staff displayed a high level of skill and knowledge. Staff were provided with regular training and development. Staff demonstrated a good level of knowledge about the topics we asked them about which indicated training arrangements were effective. Training updates were overdue in some subjects such as fire which the registered manager agreed to address as a matter of priority.

We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and the service was acting within the requirements of the Mental Capacity Act (MCA).

People and their relatives told us the quality of care provided by the home was excellent and staff we spoke with demonstrated a good knowledge of people's care needs and how to meet them. People's needs were assessed on admission and covered a range of areas to ensure staff delivered appropriate care. However we found that following changes in people's needs amendments to plans of care were not consistently taking place.

A varied range of activities was provided by the activities co-ordinator which included trips out into the community. People and their relatives praised the activities co-ordinator and said they were friendly and dedicated to the role.

An effective complaints system was in place. Feedback from people and their relatives showed a high level of satisfaction with the service.

People and their relatives praised the management of the home and said they provided a high quality service.

A range of audits were undertaken. However these were not always sufficiently robust to fully assess and monitor the quality of the service. Checks and audits should have identified and resolved the issues we identified with regards to medication, training and care records.

We identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back 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?

Requires improvement

The service was not always safe. Although we found people received their prescribed medications this was not always at a time which met their individual needs and records of topical medication application were not robustly kept. Appropriate arrangements were in place to record and check stocks of medicines.

Staffing levels were not always sufficient. Although we found there were enough staff during the day, we concluded that staffing levels during the evening and overnight period were not sufficient to ensure people's needs were consistently met.

People told us they felt safe in the home and systems were in place to protect people from harm to protect people from abuse. We found safeguarding incidents were thoroughly investigated to help keep people safe.

Is the service effective?

Good

The service was effective. People and their relatives told us staff displayed a good level of skills and knowledge. We found training plans were in place and staff were being constantly developed to continuously improve their practice.

We found the location to be meeting the requirements of the Deprivation of

Liberty Safeguards (DoLS) and the service was acting within the requirements of the Mental Capacity Act (MCA).

People and their relatives told us the home provided effective care. Healthcare needs were assessed and appropriate plans of care plan in place. People had access to external health professionals and their advice was recorded to assist staff deliver appropriate care.

Is the service caring?

Good

The service was caring. People and their relatives told us that staff treated them well with dignity and respect. Our observations of care practices confirmed this was the case and we saw the home was a friendly and pleasant atmosphere with staff providing companionship to people as well as completing required care tasks.

Care plans contained personalised information which showed the service had taken the time to understand people's likes, dislikes and life histories in order to plan appropriate care.

Sensitive and dignified end of life plans were in place to help ensure people received personalised care and support at the end of their lives.

Summary of findings

Is the service responsive?

Requires improvement

The service was not always responsive. People's needs were fully assessed on admission to help staff deliver appropriate care. We saw care delivered in line with people's care plans which demonstrated staff were aware of care plans and routinely followed them. However we found that following changes in people's needs, risk assessments and care plans had not always been updated.

A varied programme of activities was provided by a dedicated activities co-ordinator. People and their relatives praised the provision of activities in the home.

An appropriate system was in place to manage complaints.

Is the service well-led?

Requires improvement

The service was not always well led. People spoke positively about the way the service was run and the overall quality of the home. Feedback from people, their relatives and a recent survey completed by the home showed a high level of satisfaction with the service.

Although some systems were in place to monitor the quality of the service, these were not consistently applied . For example the medicine management audit was not sufficiently robust to identify some of the issues we identified and deficiencies in care plans had not been identified.

Hillbro Nursing Home LLP

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 27 and 28 May 2015 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used a number of different methods to help us understand the experiences of people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we spoke with six people who used the service, eight relatives, the operations manager, registered manager, a registered nurse, five care workers, the chef, and the activities co-ordinator. We reviewed four people's care records in detail and elements of a further 24 people's care plans relating to specific areas of care and support.

We did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection, we reviewed all the information held about the provider. As part of the inspection we also spoke with a health care professional who visited the service.

Requires improvement

Is the service safe?

Our findings

We spoke with the registered manager about the method for calculating staffing requirements and were told this was influenced by the assessed dependency of each person receiving care. We looked at a random sample of 15 people's dependency ratings and in particular took note of people receiving care from two or more members of staff or requiring higher levels of observation. The manager told us eight care staff were available each morning, seven during the afternoon, five during the evening and two to three overnight. In addition a registered nurse was on duty at all times. There were other staff that supported the service which included housekeeping, catering and administrative support. The team were led by the manager who worked in a supernumerary capacity which allowed them to assist when required.

From our assessment of the dependency of people, our observations of care delivery, and a discussion with the manager we found there to be sufficient staff available to safely care for people from early morning until late afternoon. Our observations over the two days of our inspection during this period did not witness anyone having to wait for assistance from staff for their personal care. Although we did find some staff took smoking breaks together which reduced visibility of staff at times.

Staff, people and their relatives generally said there were enough staff in the home to safely care for people, although one relative did tell us that effective supervision in communal areas was not always possible. We saw the home was unable to consistently attain its required staffing levels in the evening and overnight. The manager told us that there were currently vacancies being advertised to enable staffing levels during these times to be more consistent. From 5pm each day the registered manager told us five care staff were required. The staff rota often showed only four which we concluded was not sufficient particularly as it was only half the staffing provision in the morning. We noted a new member of staff had been recruited and was currently undergoing shadowing work prior to taking up a permanent post. This would ensure that at least five carers were present during the afternoon. We noted some trends in minor fall incidents which indicated staffing was insufficient in the evening time. For example, during the period 1 March to 26 May 2015 within the lounge and dining room, 9 falls took place in the 9 hour period between 8am and 5pm but 16 falls took place in the 5 hours 15 minutes between 5pm to 10.15pm. This showed a greater rate of communal area falls in the evening suggesting that the lower staff numbers were a factor, as with only four staff to manage the numerous communal areas, effective supervision could not be provided, particularly as some staff were helping people to bed and with toileting and undressing. Total falls per hour throughout the whole home were also greater in the evening period.

We found staffing levels at night were not sufficient. The manager told us the ideal staffing deployment per shift should be three care staff yet our observations from the duty rotas showed only two care staff. People's care needs during the night indicated a large number of people required help with toileting with many people needing regular turning to prevent tissue damage. These requirements indicated two staff were needed to safely carry out the task. We found whilst tissue damage was not a feature of the service, people were not always being given pressure relief as often as described in their care plan thus indicating insufficient staff to meet people's needs. We looked at four people who were on turn charts to reduce the risk of pressure areas. Care records showed these people required regularly pressure relief between two and four hourly. This was regularly not happening, for example one person's care plan stated they should be turned three hourly throughout the night. On examining records we saw this was not regularly happening and was on occasions six hourly. We also took the view that the given the lay-out of the building over three floors, people could not be sufficiently observed by two care staff plus a registered nurse. We saw call bells were responded to promptly during the day. However two people eluded to longer waiting times at night when they rang the call bell.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at people's medicine administration record (MAR) and reviewed records for the receipt, administration and disposal of medicines and conducted a sample audit of medicines to account for them. We found records were complete and people had received the medication they had been prescribed. We found people's medicines were available at the home to administer when they needed them. Staff maintained records for medication which was not taken and the reasons why, for example, if the person

had refused to take it, or had dropped it on the floor. We looked at medication charts and reviewed records for the receipt, administration and disposal of medicines. We conducted a sample audit of medicines to check their quantity. We found that records were complete and people had received the medication they were prescribed. We found people's medicines were available at the home to administer when they needed them

We asked a registered nurse about the safe handling of medicines to ensure people received the correct medication at the correct time. Answers given demonstrated they had a good understanding of their responsibilities yet this was not consistently being translated into safe practice. We observed on six occasions people were not administered their medicines as directed by the prescriber. Some medicines are required to be given either before or after food. On five occasions we witnessed medicines to be given 30 to 60 minutes before food being administered whilst the person ate their breakfast. On a further occasion we saw medicines to be administered with food given two hours after food. On the second day of our inspection we found the manager had taken immediate action and medicines were being administered as prescribed.

We saw that a number of people were prescribed topical creams. However, records of their administration indicated they were not given as frequently as per their plan of care. For example in five records we looked at, topical medicines were supposed to be applied twice a day but records showed this was not always happening. Staff we spoke with were aware they were supposed to be applied twice a day but thought that this was not always robustly documented. We asked two relatives who told us they thought creams were put on as prescribed. However, without consistent records in place we were unable to confirm this.

Medicines may only be administered to people in care homes without their knowledge (covertly) within current legal and good practice frameworks designed to protect the person who is receiving the medicine and staff involved in the administration. The home had in place a medicines policy but this did not include guidance on covert medication. During our inspection of medicines we were informed one person with dementia received their medicines covertly. Our subsequent scrutiny of the person's care records showed evidence that mental capacity assessments had taken place. We saw best interest meetings had been conducted with the registered manager, the person's family and a GP. However neither we, nor the manager could find any involvement of a pharmacist in determining a safe and effective method of disguising the medicines in food. During our observation of the medicine round we saw the person receiving their medicines covertly. The decision to administer medicines covertly had been taken in 2011 with no review since. Furthermore the manager was not aware of the National Institute for Health and Care Excellence (NICE) document 'Managing medicines in care homes guideline (March 2014) which defines good practice. The manager assured us a review of the person's need to continue with covert medication would be conducted as soon as practically possible.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Arrangements for the administration of PRN (when needed) medicines protected people from the unnecessary use of medicines. We saw records which demonstrated under what circumstances PRN medicines should be given. The registered nurse demonstrated a good understanding of the protocol. We saw people were offered their PRN medicines by nursing staff by asking if they required pain relief.

Some prescription medicines contain drugs that are controlled under the misuse of drugs legislation. These medicines are called controlled medicines. We inspected the controlled medicines register and found all medicines were accurately recorded. We noted the date of opening was recorded on all liquids, creams and eye drops that were being used and found the dates were within permitted timescales.

We saw the drug refrigerator and controlled drugs cupboard provided appropriate storage for the amount and type of items in use. Drug refrigerator temperatures were checked and recorded daily to ensure these medicines were being stored at the required temperatures.

People told us they thought risks were appropriate managed by the home. Each person had a range of risk assessments in place. For example covering, bed rails, risk of developing pressure areas and maintaining a safe environment. Where risks were identified detailed plans of care were put in place to help manage the risks. Access was restricted to hazardous areas such as staircases by key

Is the service safe?

coded doors. The provider had enabled a balance of freedom and safety, some people had been given the access door codes that were not deemed at risk and also managed their own room keys. A concerning incident occurred in February whereby a person accessed a staircase and fell down. Although there was a locked door in place, of concern was that the homes investigation was unable to conclude how the person gained access to the hazardous area. We saw as a precaution, a new lock had been put on the door to reduce the risk of a re-occurrence.

We saw that the provider had in place effective staff recruitment and selection systems. There was a clear process which ensured appropriate checks were carried out before staff began work to make sure that job applicants were suitable to work with vulnerable people. These included checks on identity, entitlement to work in the United Kingdom, references and DBS (Disclosure and Baring Service) check. The provider had a robust system to ensure all registered nurses had a current Pin number issued by the Nursing and Midwifery Council (NMC) to signify they were entitled to work.

People and their relatives told us they felt safe and they had not seen anything that concerned them. They all told us that staff were kind and caring and treated them well. For example, one person told us "I've never seen any clients upset by staff, I have never seen anything untoward. This home is quite good; The staff care and are kind." A relative told us, "I've seen them with others as well as when they come to [relatives name] and they are very nice and very caring." Another person said "I can't say that I have ever seen anything to concern me, they are all very good." One person mentioned an altercation that had occurred with another resident. We informed the manager who was unaware and said they would investigate immediately.

Arrangements were in place to ensure people's property was kept safe. Property lists were in place to help reduce the risk of items being unaccounted for. People did not report any concerns with their possessions and said for example that laundry was always returned to them.

Safeguarding procedures were in place and we saw these had been followed. A number of safeguarding concerns were received from the provider early in 2015, however we found these had been thoroughly investigated with all staff interviewed and reports compiled and action taken to address with staff. This included preventative measures. In one case we saw a recent supervision had not been carried out concerning one of the staff members which the manager agreed to immediately address. Staff reported no concerns about other staff practice; said residents were safe and demonstrated a good understanding of how to act on allegations of abuse to help keep people safe.

We looked around the premises. Generally the home seemed clean, warm and comfortable and thought had been put to dedicating areas for leisure use, for example the movie room. Bedrooms were homely and nice decorated. There was evidence ongoing improvements to the building were being made and a plan of refurbishment was underway. For example, a sensory roof garden had been created with plant beds and a sheltered seating area and a garden room. Some of the other corridor areas had also been decorated. The second floor was in need of redecoration as the décor was tired and the floor was damaged in a number of areas and the ground floor outside areas was in need of a tidy. Although we found the premises were overall suitable for use, the dining room was rather small with only three or four tables and a number of narrow corridors and rooms and made supervising all communal areas difficult . The operations manager told us there were plans in place to open up some of this area which would allow more supervision and a more open and suitable atmosphere.

Periodic checks on gas, electrical items, water systems, fire and lifting equipment was undertaken to help keep people safe. We noted the provider's fire policy stated a full evacuation would take place every 6 months, however records showed this was not taking place. Although we concluded this was impracticable given the needs and mobility of people, the policy was not reflective of current practice.

We saw safe handling techniques were used. We observed the hoist used on several occasions and the two staff used it correctly and they talked and reassured people throughout the lift. One relative told us that although they had previously had some concerns about handling they thought staff were now better trained.

Good

Is the service effective?

Our findings

People and their relatives spoke very positively about the quality of care delivered by the home. For example, one person told us, "This place has saved my life. They look after me too, they give me meals. The staff have been really good and I have no complaints." One relative told us, "Can't speak highly enough, of this place, on top of dementia care." Another relative told us, "She is very settled, they know her care needs."

People reported the food in the home was good and they had a sufficient choice. For example one relative told us, "The food is absolutely marvellous, the chef is lovely; he loves everyone. Nothing is too much trouble. They made a special birthday meal recently for everyone. They made fancy cakes; all sorts of sandwiches and cakes." Another person said, "The food is very good and if it's someone's birthday, we get something special." We saw people were given a choice at breakfast, staff clearly explained what was available to people which gave them chance to make an informed decision. Menus were on display to inform people of the lunchtime meal options.

We observed the lunchtime meal and saw people received appropriate support delivered patiently by staff. Appropriate cutlery was available to ensure food could be consumed easily. Staff were patient and people were not rushed to eat their meals.

Systems were in place to ensure people received food that met their individual needs. We spoke with the cook who demonstrated a good understanding of people's individual dietary requirements such as who required specific diets due to allergies or being diabetic. We saw people received their meals in line with their requirements set out in their care plans. For example, staff appropriately supported people who needed assistance to cut up their food, or needed pureed food. We observed the addition of food supplements and fortification to people's meals in line with the requirements described in their care plans.

People and their relatives spoke positively about the skills of staff. For example, one relative told us, "Impressed by staff training, they put real effort into dementia awareness and staff manner reflects this." A training and staff development plan was in place which included first aid, manual handling, medication, the application of the Mental Capacity Act 2005 (MCA), safeguarding people from harm, use of restraint and supporting people living with dementia. Whilst the training matrix was comprehensive it demonstrated some staff were overdue updates in subjects such as fire and safeguarding. The manager agreed to ensure these were updated as a matter or priority. We saw the provider was putting considerable effort into enhancing the skills and knowledge of staff in dementia care with most staff enrolled on a four month training programme. We saw seven staff had achieved NVQ level 3 in health and social care with a further six staff achieving level 2. Staff we spoke with told us they had received a range of high quality training. Staff demonstrated a high level of competency about the subjects we asked them about indicating training was effective.

Systems were in place to ensure staff received structural supervision, appraisal and development. This looked at their strengths and weaknesses, motivations and set targets. Records showed a number of staff were overdue supervision, the manager agreed to prioritise this.

We spoke with the manager about the use of restraint which included the use of bed-rails. Our discussion demonstrated bed-rail assessments were used to ensure people who may roll out of bed or had an anxiety about doing so would be protected from harm. The manager demonstrated a good understanding of how inappropriate use of bed-rails may constitute unlawful restraint which provided us with assurance they were acting appropriately.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Manager and senior staff had a good understanding of DoLS demonstrating they were aware of how to act within the correct legal frameworks. We were told that two people using the service were subject to authorised deprivation of liberty and a further 11 applications had recently been made. During our visit we observed some practices and security measures which may indicate more people may be being subject to deprivation of liberties. Our discussions with the manager proved our assumptions to be correct. The manager told us of a further 23 people who were in the process of being assessed and in all probability would need applications to be made to the relevant supervisory body. Our observations throughout our visit and discussions with the management team demonstrated a service working within the required legal frameworks. We saw one of the two people subject to

Good

Is the service effective?

DoLS had six conditions attached to the authorisation. Discussions with the manager and our observations of annotations in the care plan showed the conditions were being met.

People and their relatives told us they had access to health professionals and that the staff were on the ball. People said the service was good at ensuring their healthcare needs were met. For example, one person told us, "I get checked every Monday. Yes, blood sugars are checked here." A relative told us, "They rang me when Mum had chest pain and they inform me if they bring the doctor out." Another relative told us the health of their relative had improved since admission indicating the service was meeting their healthcare needs. We saw when specific health issues were identified, managing these needs was done through appropriate plans of care.

We saw people had access to a range including doctors, dentists and input from tissue viability. For example, one person with diabetes needed to attend for regular retinal screening appointments at the local hospital. Each attendance was recorded along with the next appointment date.

Where pressure ulcers had developed we saw that clear preventative plans were put in place such as applying creams and ensuring pressure reliving equipment was in place. We saw episodes of pressure ulcers were low in the home which indicated that current prevention mechanisms were adequate. We saw staff ensured people were sat on the correct pressure reliving equipment during the course of the inspection. However, we did note that people were not always turned at the required frequency as set out in their care plan during the night.

Good

Is the service caring?

Our findings

People and their relatives all praised the attitude of staff and said they were kind and compassionate and provided personalised care and support. They also told us that staff comforted them when they became upset. One person told us, “Staff are lovely, they are all nice.” Another person told us, “They talk to you when you need help.” A relative told us, “The staff all know our names. The staff interact with us all (the family) and they remember things that have gone on.” Another relative told us, “I can’t fault this place; the carers are wonderful; this place is marvellous.”

People reported that although staff were busy they took their time to engage people in conversation and provide companionship. People and their relatives remarked how staff went out of their way to help them. For example, one person was especially pleased about how the service had assisted them to make their room homely with their own furniture.

We observed care in the communal areas of the home. People appeared comfortable, well dressed and clean which demonstrated staff had taken the time to assist them with their personal care needs. A relative remarked that staff were good at responding to dignity issues such as the spilling of food onto clothes, ensuring any spills were promptly cleaned. We observed staff were patient with people, for example, one person was supported with their mobility calmly and patiently by the registered manager. We observed staff prioritised ensuring people were treated with dignity and respect, for example adjusting clothing during hoist transfers and knocking on people’s doors before entering. Relatives confirmed this for example one relative said, “They are friendly with my wife, they treat her with dignity; she seems really happy here.”

Discussions with staff revealed they understood people’s individual care needs and preferences and they demonstrated a good knowledge of the people they were caring for. This indicated that staff had built up good relationships with people. We saw care records were individualised containing a good detail of personal information to assist staff to deliver personalised care. Information on people’s life histories had been obtained during the care planning process, to aid staff better understand the people they were caring for. Care plans recorded what each person could do independently and identified areas where the person required support to ensure they could remain as independent as possible.

The home was working towards Gold Standards Framework (GSF) for end of life care. Although they had not yet achieved accreditation, the manager showed us how they were working to the standards and end of life pathways were in place. Care plans recorded whether someone had made an advanced decision on receiving care and treatment. The care files held ‘Do not attempt 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.

People and their relatives said they felt listened to by staff and able to approach the manager on an informal basis to discuss any issues or problems.

Requires improvement

Is the service responsive?

Our findings

People's needs were assessed prior to admission by the registered manager to ensure that the home was suitable and could meet their needs. On admission, a comprehensive assessment of needs was undertaken to allow staff to plan and deliver appropriate care. Care planning was largely computer based with minimal reliance on paper documents. We observed staff accessing the electronic care plans in the remote computer station adjacent to the lounge. The staff appeared to use the system with ease. In conversation staff said, "It's no problem when you get used to it and easier than ploughing through paper."

We saw each person had a range of care plans in place which included personal hygiene, elimination, night care, skin integrity, nutrition, and mobility. We saw care plans were kept under regular review. Each element of care also contributed towards a dependency rating which ensured a decline or an improvement in a person's health or care needs could be monitored over time. Care plans were personalised and contained clear instructions to enable staff to deliver effective care for example the details of any pressure relief required, and how to support appropriately at mealtimes. We saw examples of care delivered in line with care plans for example appropriate nutritional support given and people sat on the correct pressure relieving equipment. People and their relatives reported staff were responsive to any changing needs. For example, one relative said that following falls, the home had encouraged their relative to change their daily routine and this had helped reduce the incidents of falls.

Daily activity records were complete and adequately recorded care delivered. The system benefitted from recording the time the activity was logged and by whom to increase accountability.

We did note some areas of concern where care was not consistently responsive. Although most people were weighed regularly and appropriate plans were put in place, on looking at one person's care plan, weight records showed they had lost 9.8% of their body weight in the month following admission to the home. Our investigations revealed the explanation for this was likely as they had been unwell immediately after admission but had since recovered. However, once they had been weighed, there was no documented evidence of any action taken to identify this loss and investigate the cause and possible interventions. Their nutritional risk assessment and care plan had not been updated following this weight loss. This showed that on this occasion the provider had not responded appropriately to weight loss. In another two people's files we saw that although they had fallen numerous times, risk assessments had not been appropriately updated following these incidents and stated they were at low risk of falls. This demonstrated the service was not consistently responsive to identifying and mitigating potential risks to people's health, safety and welfare.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although people and their relatives said the manager had an open door policy, people reported that they had not had a formal care plan review with two relatives stating they thought this would be beneficial. Records we saw showed a lack of recent formal reviews of people's care which would allow the complete care package to be reviewed in a structured manner.

We saw arrangements were in place to meet people's spiritual needs for example in accessing religious services. People and their relatives told us there was a wide range of activities available at the home. On the day of the inspection entertainers visited which people appeared to enjoy. People and relatives confirmed this was a regular occurrence. A dedicated activities co-ordinator was available six days a week which people praised highly. We spoke with them, they demonstrated a dedication to providing high quality and varied activities with a clear passion and enthusiasm for the role. A range of trips were undertaken such as walks around the village, and periodic trips out in the dedicated minibus. Activities in the home included mental exercises, sensory experiences, films, celebrations and animal therapy.

An appropriate system was in place to manage complaints which was on display to bring it to the attention of people who used the service. People we spoke with told us they had no complaints but felt confident they could take matters to the manager and they were be appropriately addressed For example, one person told us, "I've never had to complain, I've got nothing to complain about." One relative told us they had a minor complaint but this was

Requires improvement

Is the service responsive?

dealt with appropriately by the service. We looked at the complaints records, we saw action plans had been put in place following complaints to reduce the risk of a re-occurrence.

Requires improvement

Is the service well-led?

Our findings

People and their relatives spoke positively about the registered manager, leadership and overall quality of the home. For example one person told us, "Ann is the manager, I could go to her, she is approachable. [staff name] is the senior nurse; he is a really good bloke; the way he has dealt with things. I can't speak highly enough of the staff and the management." Another relative said, "Ann is a very good manager, very person centred, she will prioritise any serious issues". A second relative told us how nursing staff were competent and the standard of care had also been raised under the current management. We saw the registered manager interacted well with people, understood their needs and was regularly involved in care for example assisting at mealtimes . This helped ensure they were aware of the issues that affected people and staff.

Staff reported that they had a good relationship with the registered manager, felt well supported by the service and indicated that morale was high within the staff team . For example, one member of staff told us, "The manager is fantastic, if I have a query of a problem she will deal with it right away." Another staff member said, "I feel I can go to Ann with problems." Periodic staff meetings took place. We looked at minutes from a recent meeting and saw that these were an opportunity to support and develop staff. Information was provided to staff on topics such as end of life care, new care practice, training and development.

An appropriate management structure was in place which included operations manager, registered manager, team leaders and senior workers. We found these staff had appropriate expertise and knowledge to undertake their roles.

Some systems were in place to assess and monitor the quality of service although these were not consistently robust. Audits included environmental checks, mattress audits and infection control audits. We saw evidence action had been taken to address identified risks. Hand hygiene audits with staff were carried out which were linked to the appraisal system. Reflection on the end of life experiences of people was in place as part of working towards the Gold Standards Framework which helped the provider to continuously improve the end of life experience for people.

We found inconsistencies in the quality of the service which should have been identified and rectified by a robust system to monitor and evaluate the effectiveness of the home. Some staff training was out of date for, example fire training. This should have been identified and addressed before it became out of date through a robust system of monitoring compliance with mandatory training. Some staff supervisions and appraisals were also overdue, for example we were concerned that a staff member who had been involved in a safeguarding incident had not received a recent supervision to ensure their working practices were reviewed. The provider should have identified and addressed the shortfalls in supervisions and appraisals through a robust system of monitoring. Although medicines management audits were undertaken, they were not robust enough to identify and assess all risks to the health, safety and welfare of people. As such they did not identify the issues we found, namely that some medicines were not given at the correct times and the recording of topical medicines was inconsistent. The registered manager agreed to refine the audit process to make this more robust. Issues we found with care records such as two inaccurate falls risk assessments should have been identified through a system to monitor the quality of care records.

Incidents were recorded, we saw there was a culture to report minor incidents as well as more serious incidents which helped the provider to monitor for any emerging trends. However we found that the preventative actions section of incident forms was rarely completed which made it hard to establish what lessons had been learnt to prevent a re-occurrence of incidents. In one incident record plan we saw they had been an incident of aggression towards a member of staff. Although the information showed the member of staff had been informed of a better care strategy, the was no evidence this had been shared with other staff and the persons behavioural care plan had not been updated following this incident with key information for all staff to be aware of.

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

A quarterly safety incident report was undertaken to analyse any trends in accidents and incidents. This looked at the type of incident for example falls, pressure areas, and hospitalisation. Although an analysis of the number of incidents took place, we found more could have been done

Requires improvement

Is the service well-led?

to analyse when and where falls were occurred, particularly as we identified some trends which had not been identified by the home such as an increase in falls in the lounge areas during the evening time.

An annual satisfaction survey was taken to seek the views of the people who used the service and their relatives. We looked at the results from the most recent survey in December 2014 where there were 19 surveys returned. 26% rated the overall quality as excellent, 69% very good and 5% good, indicating a high level of satisfaction with the service. People and their relatives reported they felt involved in how the home was managed and said they could provide feedback to the registered manager at any time.

Documentation relating to care of people who used the service and documentation relating to the management of the service was well ordered and easily accessible. This helped the service to quickly assess the information they needed. Information was kept secure to maintain the confidentiality of people who used the service.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users as the risks to people's health and safety were not appropriate assessed and mitigated. There was a lack of proper and safe management of medicines as medicines were not always given at the correct times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not sufficient numbers of suitably qualified staff deployed at all times.

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 Effective systems were not in place to assess, monitor and improve the quality and safety of the service and to assess, monitor and mitigate the risks to the health, safety and welfare of service users.