Buckland Care Limited

Blackwater Mill Residential Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 23 and 27 January 2015 and was unannounced. The home is a large building based on three floors. It provides accommodation and personal care for up to 50 people, including people who were mostly independent and people who were living with dementia. There were 49 people living at the home when we visited.

At our last inspection, on 8 and 14 April 2014, we found people on the middle and upper floors of the home were isolated and their call bells were not responded to quickly. We set a compliance action and the provider wrote to us telling us how they would become compliant with the regulations.

Summary of findings

At this inspection, on 23 and 27 January 2015, we found improvements had been made, but the home was not meeting the requirements of all regulations.

People's safety was compromised in some areas. There were not always enough staff to meet people's needs. Staff responded more quickly but they often had to wait more than 10 minutes for support. Many people on one floor of the home had high levels of dependency and staff felt they were "run ragged" trying to meet people's needs.

Medicines were not stored at safe temperatures. Those that needed to be taken before food were often not given until after people had eaten. There was a lack of information about when "as required" medicines should be given. Medicines were not always recorded correctly when given. Staff did not have access to information to help them identify when people were in pain and assess what pain relief was needed.

Whilst most care plans were up to date, some did not reflect people's current needs. Information about supporting people who displayed behaviours that challenged was not always adequate to allow staff to support the person appropriately and consistently. A wide range of activities was provided for people, but there was little provision at weekends or for people who spent their time in their rooms.

Most risks were managed safely. However, a person who was at risk of choking was not having their drinks thickened as required, which put them at risk of harm. Changes were not always made following the analysis of incidents. For example, there were seven occasions over the past year when people had left the home unaccompanied and were put at risk. Action taken to address this had not been effective.

The provider had a system in place to regularly assess and monitor the quality of service people received. However, this had not identified all of the above concerns. The provider did not tell us about incidents of abuse when they needed to, although they did inform the local safeguarding authority and take appropriate action.

Most people felt safe at the home. Staff had received training in safeguarding adults and knew how to identify and prevent abuse. The process used to recruit staff was safe and ensured staff were suitable for their role. Risks of people falling or developing pressure injuries were managed safely. Equipment, such as hoists and pressure relieving devices were used safely and in accordance with people's risk assessments.

People were offered a choice of nutritious meals and drinks. They were encouraged to eat and drink well and staff provided one to one support where needed. People were referred to GPs, community nurses and other specialists when changes in their health were identified.

Staff followed legislation to ensure people's rights were protected when decisions about their care were taken. Any restrictions placed on them were done in their best interest using appropriate safeguards.

Staff understood the needs of older people, including those living with dementia and knew how to care for them effectively. Most staff were supported appropriately in their role and received one-to-one sessions of supervision. However, few had received appraisals to assess their performance.

People were cared for with kindness and compassion and staff showed concern when they were not always able to meet people's needs. In most cases they responded appropriately when people needed support but were focussed on tasks and were unable to spend time with people.

People (and their families) were continually involved in assessing and planning the care and support they received. Support was provided in accordance with people's wishes and their privacy was protected. Daily care records relating to re-positioning, eating, drinking and continence were up to date and confirmed people had received care in a personalised way.

The home had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. The registered manager sought feedback from people and made changes as a result. There was a complaints procedure in place which was followed.

Summary of findings

There was a clear management structure in place for care staff. However, some care staff expressed concerns about the guidance they received from senior carer staff and at times they were not well organised. Most people felt the home was well-led.

We have made a recommendation about creating suitable environments that support people living with dementia.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have taken at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Staffing levels had improved but were still not adequate to meet people's needs in a timely way.

Medicines were not stored at safe temperatures and were not always administered in accordance with relevant guidance. There was insufficient information about when "as required" medicines should be given.

A person was not protected appropriately from the risk of choking, although risks to other people were managed safely.

Staff knew how to protect people from abuse. Recruitment procedures were safe. There were plans in place to deal with foreseeable emergencies.

Is the service effective?

Requires Improvement

The service was effective although improvements were needed. People told us the food they received was acceptable, but not always warm by the time it got to their rooms. There was a choice of suitably nutritious meals and drinks. People received support to eat but this was not always appropriate.

Staff were following the principles of the Mental Capacity Act 2005 and were making decisions in the best interests of people. Where restrictions were placed on people, legal safeguards were put in place.

Staff were skilled and knew how to care for people effectively. They received one to one sessions of supervision. The environment was in a good state of repair although it was not dementia-friendly.

Is the service caring?

Requires Improvement

Aspects of the service were not always caring. People were cared for with kindness and compassion. However, staff were focussed on tasks and did not always have time to spend with people.

Most staff responded appropriately to people's needs, although they did not identify or respond to one person who became anxious.

Staff spoke respectfully of the people they cared for and positive interactions were observed between staff and people. People were involved in planning their care and their privacy was protected.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive. Staff did not have information to help them identify and assess when people needed pain relief.

Summary of findings

Most care plans were up to date, but some did not reflect people's current needs. Information recorded in people's 'behaviour records' did not help staff identify the triggers that led to the behaviour, or the interventions that were effective.

A wide range of activities was provided, although there was limited provision at weekends or for people who spent their days in their rooms.

Most people praised the quality of care and felt their needs were met. The registered manager sought feedback from people and made changes as a result.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led. Appropriate changes were not always made following the analysis of incidents. The provider had a system in place to assess and monitor the quality of service but it was not always effective.

The provider did not notify us about incidents of abuse as required, although they did take other appropriate action to deal with the incidents.

There was a clear management structure in place for care staff. However, some care staff expressed concerns about the level of support they received from senior carers. The home had an open culture where staff strived to meet people's needs.

Staff described the registered manager as "approachable" and "supportive". Regular meetings were held with staff teams. The registered manager was aware of key strengths and areas for improvement; there was a development plan in place.

Blackwater Mill Residential 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 23 and 27 January 2015 and was unannounced. The inspection team consisted of two inspectors and an expert by experience in dementia. 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 the inspection we reviewed information we held about the service including notifications. A notification is information about important events which the service is required to send us by law. We also reviewed the action plan that the provider sent us following our last inspection, describing how they would meet the requirements of the regulations.

We spoke with 20 people living at the home and five family members. We also spoke with a senior representative of the provider, the registered manager, the deputy manager, five senior care staff, 14 care staff, three catering staff and two housekeepers. We looked at care plans and associated records for eight people, staff duty records, three recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records. We observed care and support being delivered in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. Following the inspection we received feedback about the home from a community nurse.

Inadequate

Is the service safe?

Our findings

At our previous inspection on 8 and 14 April 2014, we found people's needs were not always met as their call bells were not always responded to quickly. At this inspection staffing levels had improved but were still not adequate. One person said, "They come a bit quicker now than they used to. Sometimes you can wait [for the toilet] and sometimes you can't". A third person said, "Standards drop when [staff] go off sick". A family member told us it frequently took staff 10 minutes to respond to a call bell. One relative said, "Yesterday it was 20 minutes due to a misunderstanding between floors". Another relative told us "Staff are stretched five days out of seven".

Analysis of call bell response times showed people received help promptly at night. However, records showed there were frequent delays in responding to people's bells during the day. On one particular shift, delays varied between eight and 26 minutes over a two and a half hour period. Delays in responding to call bells put people at risk if they tried to mobilise themselves, for example to use the toilet, and fell.

The staffing levels were rarely sufficient during the day time. Many people had high levels of dependency and needed two staff to help them re-position regularly and to transfer between chairs. Some people also needed full support to eat. Staff shortages meant people had to wait for care and support to be delivered and did not receive a prompt response when they called for assistance. Comments and feedback from staff confirmed this. For example one staff member told us, "People pick up on staff shortages; it makes them reluctant to ask for help when they can see we're busy". Other staff said they were "run ragged" and "rushed off our feet".

Analysis by the registered manager showed the workload, based on people's levels of dependency, had increased in recent months. The registered manager had responded to this by increasing staffing levels to a minimum of eight care staff during the morning and, more recently, eight care staff during the afternoon shifts. Staff felt this was not sufficient and that 10 care staff were needed. The registered manager had also made a decision not to admit new people with high levels of dependency. On the days of our inspection 10 care staff were on duty in the mornings and we observed this was sufficient to meet people's needs.

The above issues were a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicines were not stored at safe temperatures. The temperatures in the storage rooms and the fridge used to store medicines that needed to be kept at cooler temperatures frequently exceeded safe limits. Staff were not aware of this as they did not know how to operate the electronic thermometers. As a result, there was a risk some medicines would not have been effective.

Some medicines were not given as recommended. Medicines which should be given half an hour before food, were often given with or after food. They would not have been as effective taken at these times. There was insufficient information available to staff about medicines that were given on an "as required" basis. For people who were prescribed sedatives for "agitation" there was no information about other support the person should be given before staff resorted to medicine. Where there was an option to give a variable dose of the medicine, there was no guidance about how much was appropriate. Consequently, people may not have received these medicines in an appropriate and consistent way.

Guidance issued by the National Institute for Health and Care Excellence (NICE) recommends that staff record the administration of medicines immediately after giving them to people. We observed part of a medicines round and one staff member did not do this. They gave medicines to several people then signed a group of medication administration records (MAR) afterwards. This posed a risk that mistakes could be made and MAR charts may not be accurate. Medicines were left insecure on top of the medicines trolley, which was left unattended in a corridor for short time. This posed a risk they could be accessed by people not prescribed them.

Medicines that were controlled by law (CDs) were stored securely. However, "as required" CDs given to a person for three days had been recorded as given in the CD register but not on the person's MAR chart. The reason for the administration was also not recorded. This was contrary to NICE guidance and put the person at risk of receiving additional doses of the medicine.

Appropriate arrangements were in place for obtaining medicines, although some medicines were not in stock due

to errors by the home's supplier. The registered manager dealt with these concerns as a matter of urgency. Appropriate arrangements were in place for disposing of prescribed medicines.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A person who had been assessed as at risk of choking needed to have their drinks thickened to reduce the risk and a member nearby to respond if they started to choke. They told us, and staff confirmed, this did not always happen. We observed they were given a cup of tea without any thickening agent in it; when we asked the staff member about this they did not know thickener was required. This put the person at risk of harm.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Most people told us they felt safe at the home. One person said, "nobody bothers me". However, one person told us they did not feel safe because "there are too many people here and they hit each other". We observed a physical altercation in the dining room where two people hit each other with their arms. Neither person was injured. At the time, there were 16 people in the dining room eating breakfast and no staff member was present to intervene. One person who saw the incident appeared upset by it.

Staff had received training in safeguarding adults and knew how to identify, prevent and report abuse, and how to contact external organisations for support if needed. They had no hesitation in reporting abuse and were confident the registered manager would act on their concerns. One staff member described how the registered manager had attended the home out of hours to support them with a concern they had raised. The provider had suitable policies in place to protect people; they followed local safeguarding processes and responded appropriately to any allegation of abuse.

Records showed the process used to recruit staff was safe and ensured staff were suitable for their role. The provider carried out the relevant checks to make sure staff were of good character with the relevant skills and experience needed to support people appropriately. Staff confirmed this process was followed before they started working at the home. A risk assessment was put in place for a staff member whose checks had not been fully completed to ensure they did not work unsupervised. Where staff did not meet necessary standards, appropriate action was taken.

All care plans included risk assessments which were relevant to the person and specified actions required to reduce the risk. These included the risk of people falling or being harmed by bed rails and risks posed by the environment. Records showed the necessary actions were followed by staff. A community nurse had worked with staff to reduce the risk of people developing pressure injuries. People were supported to change position in bed regularly, according to their level of risk. Where people had fallen, they were monitored appropriately to ensure the extent of their injuries was assessed fully. A comprehensive assessment of one person had been conducted following a number of falls. This looked at all contributory factors and was an example of good practice.

There were plans in place to deal with foreseeable emergencies. Staff were aware of the action to take in the event of a fire and fire safety equipment was maintained appropriately. People had personal evacuation plans, which included details of the support they would need if they had to be evacuated. The provider had alternative arrangements in place to care for people if they had to be evacuated to a different location.

Requires Improvement

Is the service effective?

Our findings

People told us the food they received was acceptable. One person said, "The food is marvellous" and another person told us "The food is very plain but fresh and nutritious; but very basic". Two people, whose rooms were a long way from the kitchen said food was "always cold by the time it arrives". One of them also felt the quality of food was "not as good as it was".

People were offered a choice of nutritious meals and drinks. Vegetables were presented in serving dishes so people could eat as much or as little as they wished. A range of desserts was offered to people from a trolley which they could choose from. Kitchen staff were aware of people who needed their meals prepared in a certain way and presented these in an appetising way. Drinks were available to people, together with a variety of cups and beakers to suit people's needs.

People who took their meals in their rooms were served by kitchen staff, unless they needed support to eat, in which case they were served by care staff. However, kitchen staff were unsure which people required a diabetic diet and relied on care staff checking that people received such a diet. There was a risk this could be missed as care staff did not see all meals served to people by kitchen staff.

Staff provided one to one support where needed. One person in the dining room was supported by a member of staff who was stood up, did not interact with them and was distracted by other events in the dining room. This could discourage the person from eating well. Another person who struggled to cut a large piece of fish was not offered help and the fish ended up on the table.

Staff closely monitored the food intakes of people at risk of malnutrition and took appropriate action when people started to lose weight. The amount people drank was also monitored. However, there was no information about the amount each person should be encouraged to drink. Therefore, staff may not have been able to identify people who were not drinking enough.

Staff were following the principles of the Mental Capacity Act, 2005 (MCA) and latest guidance. The MCA provides a legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant. Care records showed such decisions had been made in respect of the use of bed rails, administration of medicines and delivery of personal care.

Where people were able to make decisions, they were supported to do so and had signed relevant consent forms in their care plans. A best interest decision had been made for one person to receive their essential medicines covertly, hidden in their food, following consultation with family members, the GP and the pharmacist. Staff had not had to do this yet as they had always found ways to support the person to receive their medicines openly. This demonstrated good practice in line with the MCA.

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The provider had appropriate policies in place in relation to DoLS. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. DoLS had been authorised for three people and the registered manager had made applications for two other people. Staff knew how to support people subject to DoLS and ensured relevant conditions were complied with.

People were able to access healthcare services and were involved in the regular monitoring of their health. People saw a doctor when needed and were admitted to hospital promptly if investigations or treatment were required. Care records showed people were referred to appropriate health care professionals when changes in their health were identified. This included if they started to lose weight or showed signs of developing pressure injuries. A community nurse praised the support they received from care staff during their visits and said they had a good working relationship with the registered manager.

Staff were skilled and knowledgeable about the needs of older people including those living with dementia and knew how to care for them effectively. New staff followed the Skills for Care common induction standards. These are the standards people working in adult social care need to meet before they can safely work unsupervised. Records showed staff were up to date with the provider's essential training or this was planned. All training was refreshed regularly to ensure staff knowledge was up to date. Most

Requires Improvement

Is the service effective?

staff had obtained vocational qualifications relevant to their role or were working towards these. People were cared for by staff who had the skills and knowledge to work to a high standard

All but one staff member felt they were supported appropriately in their role. They received one-to-one sessions of supervision which provided opportunities for them to discuss their development and training needs. One staff member had changed teams as a result of this process, to perform work they were more suited to. Staff could seek advice, when needed, from the registered manager, who most staff described as "approachable" and "supportive". However, records showed that not all staff had received an annual appraisal in the past year where their performance could be discussed and objectives set for the coming year.

The environment was safe and maintained in a good state of repair. The provider had recently installed a new kitchen which met food safety standards. Adaptations had been made to make the environment suitable for older people, such as passenger lifts and level access to an outside area with raised flower beds. However, signage was limited and there was a lack of colour contrast in corridors and communal areas. This did not support people living with dementia to navigate their way around the home. The call bell in the dining room was not prominent and not all people knew it was there. The access along one corridor was restricted by an overhanging flight of stairs. These presented a hazard, which was not prominently signed and which staff told us they sometimes hit their heads on.

We recommend that the provider considers guidance issued by national bodies about creating suitable environments that support people living with dementia.

Requires Improvement

Is the service caring?

Our findings

People were cared for with kindness and compassion. People described staff as "nice", "very kind" and "caring". One person said, "The restaurant staff are always friendly and make you feel welcome". Another person told us "Staff treat you like your own family, it's just unfortunate that they are short staffed sometimes". A community nurse said, "On the whole all of the carer team are caring and supportive".

Care staff showed concern when they were not always able to meet people's needs. They said their workload meant they had little time to spend with people and were focussed on tasks, such as delivering personal care and supporting people who remained in bed. One staff member felt they could not always "give the care when it is needed or have time to chat". Another told us "We can't always stop what we're doing when the call bells ring, but we may have to cut what we're doing short, which isn't satisfactory for the person". A further member of staff said, "Old people are really awkward. They think when they get to a certain age they don't have to do things". This comment did not demonstrate an understanding of the needs of older people.

We observed one person becoming anxious and frustrated as they were not able to communicate effectively with other people sat at their table. Staff did not recognise the person's anxiety as they were engaged in lengthy discussions about when to take their tea breaks. As a consequence, the person did not receive the support they needed.

In other cases, we observed positive interactions between staff and people, where they were treated with consideration. For example, when another person became anxious, staff talked with them calmly and took time to reassure them. When a person spilt food on their clothes, staff encouraged and supported them to change before taking part in a group activity. Another person was having difficulty adjusting the volume of their hearing aid and a staff member skilfully adjusted it for them until it was at a suitable level.

Staff spoke respectfully of the people they cared for when discussing them, for example during shift handover meetings. Where it was difficult to understand what people were saying, staff used facial expressions, body language and touch to reassure people and make them feel listened to. Non-care staff also interacted well with people by smiling, taking time to listen and calling care staff for them when needed.

Care records showed that people (and their families where appropriate) were continually involved in assessing and planning the care and support they received. People's preferences, likes and dislikes were known, support was provided in accordance with people's wishes and staff used people's preferred names. Information was included about how people liked to take their medicines and staff checked this before giving medicines to people. Records showed people and their families had been involved in decision about resuscitation.

Staff ensured people's privacy was protected by staff speaking quietly to people about sensitive matters. All bedrooms had en-suite facilities where personal care could be delivered and staff ensured doors were closed when they attended to people. People had been asked whether they had a preference for male or female care staff; their preferences were recorded, known to staff and respected. Confidential information, such as care records, was kept securely and only accessed by staff authorised to view it.

Requires Improvement

Is the service responsive?

Our findings

People had been prescribed medicines for pain relief as and when needed. Many people were living with dementia and were unable to communicate their pain verbally. Staff were able to describe the body language and behaviours of people which may indicate they were in pain. However, these were not recorded in people's individual care plans. This meant staff did not have access to information to help them identify when people needed pain relief. One person's care plan identified that pain sometimes caused the person to display behaviours that challenged. However, there was no information about how staff could identify and assess the person's level of pain or when pain relief should be given. The care plan for another person detailed two forms of pain relief that could be used but did not specify when and how each should be used. Consequently, they may not have received appropriate pain relief in a consistent way.

Most care plans reflected people's current needs and were reviewed regularly. For example, records showed continence needs were monitored and frequently re-assessed. However, some care plans did not provide up to date information about how people's needs should be met and current information was not always easy for staff to find. For example, information about which topical creams a person needed to treat an area of soreness was not up to date. For another person, the information about equipment they needed to mobilise had been updated, but did not explain how the new equipment should be used. A third person had broken their arm and their support needs had not been updated. Therefore, there was a risk people would not receive appropriate and consistent care.

Information about how staff should support people who displayed behaviours that challenged was not always adequate to allow staff to support the person appropriately. For example, one person's care plan stated they "can get restless around certain residents" but did not identify which 'residents' or what the risks were. Behaviour records did not identify the triggers that led to the behaviour, or the interventions and support offered by staff. Consequently, the provider could not analyse staff responses to identify which supported the person most effectively. However, some staff demonstrated an insight into people's behaviours. One staff member said, "If [a person] is agitated there is usually a reason for it. We try to identify why their behaviour is occurring and address it".

A wide range of activities was provided in the home by an activity coordinator, who people praised, and external entertainers. These included music, exercise, ball games, reminiscence and quizzes. We observed people were singing along to songs, and later listening to classical music which they appeared to enjoy. The activities coordinator frequently changed and refined the activities according to feedback they received from people. Some people were able to make their own entertainment, for example playing board games, reading papers and doing crosswords. One person enjoyed folding the napkins. The service had links with a range of faith organisations and voluntary groups. A minister of religion visited people weekly and volunteers were used to run a mobile shop which was taken to people's rooms. However, there was little activity provision for people who spent the day in their room. Staff did not have time to spend with people on a one to one basis. Care staff had not been trained to run activities, so in the absence of the activity coordinator, for example at weekends, no activities took place. The shortage of staff meant the provider was not able to offer any activities outside the home, such as trips to local attractions.

The above issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Most people praised the quality of care and told us their needs were met. One person said, "I get what help I need". A family member told us their relative was "well looked after, better than he was at home" and was now "one of the most mentally alert residents". However, another family member said they "have had to make sure things are done" for their relative as they felt they could not rely on staff to provide appropriate support.

Care plans provided information about how people wished to receive care and support. For example, they gave detailed instructions about how people liked to receive personal care, how they liked to dress and how they liked to spend their day. Initial assessments had been completed using information from a range of sources, including the person, their family and other health or care professionals.

Requires Improvement

Is the service responsive?

Daily care records and monitoring charts relating to re-positioning, eating, drinking and continence were up to date and confirmed people had received care in a personalised way according to their individual needs.

The registered manager sought feedback from people by talking to them on a daily basis and holding 'residents' meetings'. Minutes from recent meetings showed people were involved in decisions about the menu and activities and changes had been made as a result. A person who used a handheld computer was supported to move to a bedroom where the broadband signal was stronger. People had also been consulted about plans to extend the building. The provider conducted surveys of people and their relatives four times a year and used the information to assess how satisfied people were with the service. However, there was no evidence to show how these had been used to improve the service.

The provider had a complaints procedure in place. People knew how to use it and observed one person making a complaint about their medicines. This was investigated and resolved quickly, in conjunction with the medicines supplier. Records showed other complaints had also been dealt with in accordance with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

Appropriate changes were not always made following the analysis of incidents. Incident records showed there were seven occasions over the past year when people had left the home unaccompanied and were put at risk. These included one person, who was subject to DoLS, who left the building four times. Most of the people had left the home when visitors had entered or left the building. They had put signs up to alert visitors to this possibility and had monitored one person more closely in the evenings when they were at risk of leaving. However, these measures had not proved effective and visitors still had unrestricted access to the home. A family member had attended the home to collect property from a relative's room while their relative was in hospital. They had entered using the keypad, taken the property and left the building without seeing a member of staff. This compromised security as staff were not always aware who was entering or leaving the building.

The provider had a system in place to regularly assess and monitor the quality of service people received. This included audits of key aspects of the service such as medicines, infection control, the environment, people's care plans and staff training. Checks were conducted by the registered manager and a senior representative of the provider on a regular basis. Where changes were needed, action plans were developed and changes made. Action plans were monitored to ensure they were completed promptly. In addition the registered manager and the deputy manager spent time working with staff and observing care being delivered to ensure staff were working effectively. The registered manager was aware that some care plans needed additional information or updating and was working with senior care staff to achieve this. However, the auditing system had not identified the concerns we found relating to the management of medicines; the lack of information in 'behaviour records'; or the continuing concerns about people leaving the building.

The above issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider did not notify us about all incidents as required. A notification is information about important events which the service is required to send us by law. The provider had sent us notifications relating to most incidents, including serious injuries, deaths and events that disrupted the service. However, they did not tell us about five incidents where one person had physically abused other people. The local safeguarding authority had been informed and thorough investigations had been conducted. Appropriate action had also been taken by the registered manager to reduce the likelihood of recurrence. The registered manager was not aware that such incidents needed to be notified but would ensure this happened in future.

Most people told us the home was well-led, open and welcoming. One person said, "Management is good, but they rely on the staff, who can let them down sometimes". Another person described the home as "well managed". However, one person was less complimentary about the management and told us their impression was that there were "more staff in the office than outside".

Handover meetings were held at the start of each shift where staff were allocated responsibilities for the day and updated on the health and welfare of people they would be caring for. There was a clear management structure in place for care staff. However, some care staff expressed concerns about the level of communication and guidance they received from senior carer staff. They said they rarely saw "the seniors" and the information they were given was inconsistent. Care staff were not always well organised or directed by senior staff. For example, at breakfast there was no member of staff in the dining room; during lunch all care staff suddenly left the dining room together, leaving no one to attend to people who were eating; and in the afternoon we heard staff trying to sort out tea breaks between themselves. At these times, no senior member of staff was present to take control. When meals were delivered to people's rooms, there was a lack of coordination between kitchen staff and care staff. People were not always ready to receive their meal, which resulted in some meals starting to go cold.

The home had a caring culture where staff strived to meet people's needs to the best of their abilities. Staff expressed pride in looking after people well. A community nurse told us "There has been an open and supportive culture to improve service for the residents". Most staff described the registered manager as "approachable" and "supportive" and enjoyed working at the service. However, most staff

Requires Improvement

Is the service well-led?

also expressed a strong sense of being understaffed, over-worked and often exhausted through working extra hours or long shifts. One staff member said "I regularly get phone calls up to twice a day asking me to work".

Regular meetings were held with a range of staff teams. These provided opportunities for staff to discuss the way the home operated and to make suggestions for improvements. These included arranging training for staff from a tissue viability nurse, and improving infection control systems.

The provider operated a number of other homes and supported the registered manager by sharing good practice. For example, infection control arrangements had been improved and new systems implemented across the provider's services. The registered manager also belonged to a range of professional organisations and forums that provided advice and guidance on new developments within the sector to help them keep up to date.

The registered manager was aware of key strengths and areas for improvement and there was a development plan in place, which included recruiting more staff, delivering more training, and increasing the size of the home. The provider was also planning to re-register the home as a new company.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person had not taken proper steps to ensure service users were protected against the risks of receiving care and treatment that is inappropriate or unsafe by means of the planning and delivery of care to meet service users' individual needs. Regulation 9(1)(a), 9(1)(b)(i), 9(1)(b)(ii) and 9(1)(b)(iii).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person had not protected service users against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to regularly assess and monitor the quality of services provided or made changes following the analysis of incidents that had the potential to result in harm. Regulation 10(1)(a), 10(2)(b)(iii) and 10(2)(c)(i).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person had not made appropriate arrangements to protect service users against the risks associated with the unsafe use and management of medicines. Regulation 13.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person had not taken suitable steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. Regulation 22.