Bupa Care Homes (AKW) Limited

Broomcroft House Nursing and Residential Home

Inspection report

Ecclesall Road South
Sheffield
S119PY

Tel: 0114 2352352
Website: www.bupa.co.uk

Date of inspection visit: 30 March and 2 April 2015
Date of publication: 24/07/2015

Ratings

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

Overall summary

This inspection took place on 30 March and 2 April 2015 and was unannounced. An unannounced inspection is where we attend the service without informing anyone beforehand. We last inspected this service in May 2014 and found that the service was not meeting the requirements of two of the regulations we inspected at that time. This was because the Mental Capacity Act 2005 was not always being adhered to in order to ensure people were not being deprived of their liberty inappropriately. Accurate records and documentation were not always maintained for people who used the service. An action plan was subsequently received setting out how the service intended to address these issues by November 2014.

Broomcroft House is registered to provide accommodation for up to 87 older people who require

Summary of findings

nursing and/or personal care. The first floor of the home meets the needs of people who are living with dementia. There were 61 people living at Broomcroft House at the time of our inspection.

There was a registered manager in place at the service. 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 understood Deprivation of Liberty Safeguards (DoLS) and applied for authorisations as needed, which we saw evidence of. However, we found that the arrangements in place for obtaining consent for decisions did not always consistently follow the principles of the Mental Capacity Act 2005 (MCA).

Medicines were not managed in a safe way. We saw that temperatures for the storage of medicines were not being regularly checked to ensure they were within a safe range. Medication records were not suitably checked to identify gaps and omissions.

Although staff were visible most times, there were some busy periods where there was a lack of staff to respond to people's needs. Staff told us they sometimes struggled if they were short staffed and some care staff felt nursing staff could have more input in direct care provision.

People's care records were reviewed regularly and contained information about people's individual support requirements and preferences and how these were to be met. Individual risk assessments were in place in order to minimise and manage risks to people. However, we saw instances where care was not provided in accordance with people's care plans.

Staff demonstrated knowledge of people's preferences. They provided explanations to people and offered choice when providing support. People told us they were encouraged to be independent and were given choice. All people spoke positively about staff and we observed positive interactions between staff and people at the service. Relatives were equally complimentary about staff and positive about the care their family members received.

People at the service were supported to access healthcare and received assistance and treatment for their health needs. People's nutritional preferences were accommodated.

An effective recruitment process was in place so that people were assessed as being suitable to work at the service. Staff undertook an induction on commencing employment at the home. Staff spoke positively about this and said it gave them a good grounding for their role.

The service employed two activities co-ordinators. We saw, and were told about, some activities that took place. However, there were periods of time where there was a lack of stimulation available for people.

Incidents that occurred were overseen by the manager and monitored for trends and themes to prevent reoccurrence.

We found four breaches 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.

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

Some areas of the service were not safe. Checks of medicines were not robust enough to ensure they were managed and administered safely.

We saw periods of time where there was a lack of staff to respond to people's needs and ensure appropropriate supervison of people.

Individual risk assessments were in place in order to minimise and manage risks to people. Staff knew how to identify and report abuse and unsafe practice. An effective recruitment process was in place so that people were assessed as being suitable to work at the service.

Is the service effective?

Requires Improvement

Some areas of the service were not effective. The registered manager had made, and was in the process of making, Deprivation of Liberty applications where required. We found that some decsions were made in line with the principles of the Mental Capacity Act 2005 where it was stated people did not have capacity. However, this was not always consistent.

Staff did not receive regular supervision and appraisals to ensure development and support needs were identified and acted upon. Training was provided to ensure staff had relevant skills and knowledge to support people they cared for.

Peoples' nutritional preferences were accommodated and people were supported to access healthcare professionals and maintain good health.

Is the service caring?

Good

The service was caring. Observations and comments from people and their relatives showed that staff were kind, caring and patient in their interactions with people.

Staff offered choice and explanations to people whilst providing support. Care records contained information about people outside of their care needs such as their backgrounds, favourite things and family histories. This helped staff to form positive relationships and engage with people.

People were treated with dignity and respect. There was information in place for people's end of life care needs.

Is the service responsive?

Requires Improvement

Some areas of the service were not responsive. Although people's care records were reviewed regularly, we saw occasions where people were not cared for in accordance with their personalised needs.

Summary of findings

The service employed two activities co-ordinators. We saw and were told about activities that took place. However, there were periods of time where there was a lack of stimulation available for people.

Feedback was sought by the registered manager by way of relatives' and resident's meetings. We saw that complaints were investigated and responded to appropriately.

Is the service well-led?

Requires Improvement 

Some areas of the service were not well led. We found audit processes were not sufficiently robust to identify areas for improvement. Most staff felt supported, however, there was a lack of formal assessment of their development needs.

Some relatives believed issues and information they discussed about improving the service was not always was acted upon.

Incidents that occurred were overseen by the manager and monitored for trends and themes to prevent reoccurrence. The registered manager made notifications to the commission and referrals to other agencies as required.

Broomcroft House Nursing and 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 30 March and 02 April 2015 and was unannounced. An unannounced inspection is where we attend the service without informing anyone beforehand. The inspection team on the first day consisted of two adult social care inspectors, a specialist advisor who was a registered mental health nurse and an expert by experience. An expert by experience is a person who has experience of using, or caring for someone using, this type of service. The second day of the inspection was undertaken by an adult social care inspector only.

Before the inspection, the provider completed 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. Prior to our inspection visit we reviewed the information included in the PIR, together with information we held about the home. This included information that the service is required to notify us of and includes, for example, details of any serious incidents and deaths at the service.

We contacted commissioners of the service and Healthwatch to ascertain whether they held any information about the service. We contacted four other stakeholders for any relevant information they held and received feedback from one of these.

During our inspection we used different methods to help us understand the experiences of people living at the service. These methods included both formal and informal observation throughout our inspection. 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. Our observations enabled us to see how staff interacted with people and see how care was provided.

We spoke with ten people, and three relatives of people, who lived at the home. We spoke with the registered manager, the head of care, a registered nurse, a specialist nurse delivering training, five care workers, a cook, a domestic worker and the maintenance man. We reviewed the care records of seven people and a range of other documents, including medication records, staff recruitment and training records and records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

All people we spoke with told us that they felt safe at the service. One person told us, "It's a lovely place to be when you're in this situation." The 'situation' they referred to was a reference to their dementia. Other comments from people included, "I couldn't say exactly what it is that makes me feel safe, it's just a feeling that I have" and "We have a very homely situation here." We asked people who they would talk to if they felt worried or had any concerns. The most common answer was "The staff" and people said they would be able to speak to any member of staff at any time. One person told us, "I would feel very comfortable talking to staff about anything." Relatives told us that they felt their family members were safe in the home. One said "I don't have any worries when I leave here, I know my [family member] is being looked after."

People we spoke with told us they felt the home was clean. One person said about the domestic staff, "They are always in here [my room] with the hoover. They do keep it clean to my standards." Another person told us "I have been in a few homes and some of them have had a smell. This one never does." We observed that the home was clean and we saw domestic staff working around the home.

We spoke with the service's maintenance man who showed us records of and told us about the various checks he undertook. These included safety checks of equipment, premises and fire checks, which were completed on a regular basis. Staff received fire safety training and we saw policies and guidance in place about how people were to be supported in the event of an emergency.

There was a safeguarding policy in place which set out the process to follow for reporting abuse. A training matrix showed that all staff had completed safeguarding training. The registered manager told us this was updated annually and we saw where it had been identified where refresher training was due for staff. Staff we spoke with told us they understood how to identify and report suspected or actual abuse. They told us any concerns would be reported immediately to a manager. We saw the registered manager had reported safeguarding concerns to the local authority safeguarding team where required as well as notifying the commission.

There were risk assessments in place for people using the service in relation to their support and care provision. They were reviewed periodically and in response to changes. The assessments covered risks in a number of areas such as skin integrity, falls and any other identified risks specific to each person. Care plans provided instructions as to how the risks were to be managed to ensure the safety of the person.

We looked at the personnel files of three members of staff and confirmed that each had relevant documentation in place. We saw that previous employment references and a satisfactory DBS (Disclosure and Barring Service) check had been obtained prior to the staff member commencing employment. The Disclosure and Barring Service helps employers make safer recruitment decisions. This demonstrated that processes were in place to ensure that staff were assessed as being suitable to work at the service.

The registered manager told us they did not use a formal tool to determine staffing levels. She told us if people's needs increased, for example, if a person needed more one one support, she would discuss this with head office to look at amending staffing numbers. There were vacancies for night nurses at the time of our inspection, which were being covered by the use of agency staff.

When we spoke with people, most referred to staff as "busy" or "always on the go." One person said, "There are only two and a nurse at night [on the floor] and I worry for them. It must be hard to keep up with everything. I'm very impressed. If they are busy when I press my buzzer they come straight away but might tell me they will come back in a few minutes to help me. They always apologise." We asked relatives about staffing levels. One told us, "I have raised this issue at a number of meetings, but nothing seems to have happened. Occasionally they have had an extra person and this transforms the place." On the morning of our first visit we saw a relative come into a lounge to locate a staff member to assist their family member. We heard the relative say to staff, "There's nobody about. Can someone get [my family member up] so she can go to have her hair done please. We've been waiting."

We asked staff whether they were able to meet people's needs. Two staff members told us about the expected staffing levels and said, "It does fall below this often" and "It can be less if people call in sick, we have to try to get cover." They said at night times it was sometimes "difficult to keep an eye on people" with the staff complement in place. They said they were able to meet people's needs but were not able to "spend time with people." Another staff member

Requires Improvement

Is the service safe?

told us the period after lunch time was a busy period but staffing levels declined due to staff lunch breaks. They also had concerns that qualified nursing staff rarely intervened or engaged in direct personal care for people. They told us, "Not as much hands on support from qualified staff as we need." On one occasion during the inspection we overheard a member of staff saying, "We've got extra staff on today but everybody is just wondering about doing nothing."

We spent some time in the lounge on the first floor during and after lunch time. We observed for a period of 90 minutes. During the lunch period no staff were present in the lounge for the majority of time. We saw that one person sat on their own became restless and pushed over a table. As no staff were present we had to intervene to pick the table up and reassure the person until a staff member came. After lunch we saw that one person who was not mobile was shouting out for over 15 minutes that they needed the toilet. Care staff were engaged with assisting other people elsewhere and no other staff were in the lounge. We went to find a staff member and alerted a nurse who was in an office outside of the lounge.

We undertook another period of observation for 30 minutes in a communal lounge on the ground floor where four people were seated. A member of staff was not in the lounge. We found a nurse was in a separate room behind the lounge completing paperwork.

We found that at times, staff were not deployed in a way to meet the requirements of the people who used the service. This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked the treatment room on the ground floor and looked at the arrangements in place for the storage and management of medicines and controlled drugs (CDs). We found the storage of these to be suitable and in accordance with required practice. We looked at medication administration records (MARs) for people on both floors. We saw some gaps in records where it appeared medicines had not been administered as no explanation had been provided for the omission. One person who had experienced weight loss had been prescribed with a nutritional supplement, which their care plan said they were to take twice a day. We looked at their medication administration records for March 2014 and saw only four days where it was documented the person had received their supplement and once, not twice as identified in their care plan. There was nothing else recorded on the remaining days. We asked the nurse whose responsibility it was to provide the supplement and they told us it was the role of the hostess who would then tell the nurse who should record it in the MAR chart. The nurse was unable to account for the gaps or why the issue had not been previously identified. This meant there had been a failure in the system, which led to the person being at increased risk of losing weight.

We found that fridge and room temperatures were not being taken daily. For example, records showed that the fridge temperature in the treatment room on the ground floor had been taken only three times in March 2015 and the room temperature only once within the same month. Fridge temperature records for February 2015 showed that the fridge temperature often exceeded the maximum temperature for safe storage. We saw no temperature checks in place for the treatment room on the first floor. If medicines are not stored within the required range for safe storage there is a risk these medicines may be ineffective.

Medication audits consisted of checks of one person's medicine chosen at random each month. This system was not effective as it was not comprehensive enough to identify and rectify any service wide issues. The ''audit' did not incorporate suitable checks to ensure all people had received their medicines appropriately, as required and in a safe way.

We asked the registered manager whether staff who administered medicines had annual competency assessments to assess their competency to administer medicines. The registered manage told us this did not take place which further increased the risk of medicines not being managed in a safe way.

We found that people were not suitably protected people against the risks associated with unsafe management of medicines. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

People were positive about the staff's abilities. Comments included, "Everybody here helps me along with my dementia", "They can make people forget how ill they are" and "The staff communicate well. They pass on information about us during their handover, so they always know what's going on." A relative told us, "They have super staff here. They understand people's conditions and respect their dignity." Another relative said, "Most people [staff] here give 100%", however, they went on to say that "a few staff let the others down" as they felt they didn't provide the same level of care.

Staff said they received an induction on commencement of their employment. One staff member told us, "I felt a lot more confident [for the role] after my induction. It gave me a good grounding." We saw a training matrix, which showed the majority of staff were up to date with their mandatory training. It had been identified where an individual staff member's training was due so that this could be updated as required. Training covered a number of core subjects such as fire safety and moving and handling. Training was also provided in other relevant areas, which included nutrition and hydration, behaviour that challenges and care of a person with dementia. Staff told us they found the training useful and said it equipped them for their role. On the first day of our inspection, a number of staff attended training delivered by a specialist nurse who worked for the provider, delivering training to homes. The nurse told us that staff were keen to develop their skills and understanding of dementia care and training was being delivered to facilitate this.

We asked the registered manager about supervision and appraisals, a two way process between a manager and employee to identify any development needs and set performance objectives. The registered manager told us she aimed for a frequency of six supervisions a year for staff. She acknowledged that they had not taken place this often and also that appraisals had not been completed with staff. We saw a supervision matrix for 2014, which showed that six out of the 29 staff listed on the matrix had last received supervision in March 2014. Fourteen of the staff were documented as never having received supervision at all in that year with the remainder having a last supervision date prior to March 2014. We saw another matrix from 2015, which listed separate staff who worked on another floor in the home. Supervisions were similarly infrequent with a number of staff with no supervisions recorded.

Although staff told us managers were supportive, their comments confirmed the lack of formal supervision. One staff member had been employed at the home since October 2014 but had received no supervision. They said, "[senior staff member] pulls me aside to see how things are", but told us they had not met with a manager to discuss their progress formally. Two other staff confirmed they had received no formal supervisions and were unable to say what frequency they believed these should take place. No staff we spoke with had received an appraisal.

A staff member outside of the care team told us, "I feel very undervalued and frustrated with what seems very unfair differences." The registered manager told us only clinical and care staff currently received any supervisions. The lack of suitable, frequent supervisions and appraisals for all staff meant there were limited opportunities to discuss staff performance and identify development needs.

This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA 2005) is legislation designed to protect people who are unable to make decisions for themselves, and to ensure that any decisions are made in people's best interests. The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS), which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. Discussions with the registered manager and head of care demonstrated an understanding of when DoLS authorisations were required. We saw that applications had been made where these were needed and more were in progress.

Staff we spoke with demonstrated an understanding of the MCA and DoLS and said they had received training in this.

Requires Improvement

Is the service effective?

The training matrix showed that all staff had received training in the MCA and DoLS. We saw that a number of staff had last completed this in 2010 and 2011 and so may have been unaware of the latest changes in legislation.

We did see evidence of where the MCA was followed, for example where someone required a flu inoculation, the MCA had been followed with evidence of a best interests decision. However this was not always consistent. In one person's care records we saw it documented that they could have medicine administered covertly. We saw a form titled 'record of decision to administer medication covertly' dated 17.02.2015, which stated the person's GP had assessed the person as not having capacity. Included was a letter from the GP saying the person's medicines could be given covertly if necessary. It was not clear from the information as to how the person or their family/advocates had been involved in this decision and what alternatives had been considered. Our findings showed that the Act was not always being applied consistently in decision making. The registered manager acknowledged this and told us that this was an area they were working to address and improve.

We spoke with the cook and saw they had information about people's nutritional needs such as whether they required a specialised diet, likes and dislikes and any allergies the person had. We saw people were weighed at regular intervals and food charts were in place for people who required these. Care plans were in place for people's nutritional needs which provided information about their nutritional preferences and requirements.

Everyone we spoke with referred to the meals at the home as "lovely" or "very good." One person told us, "They come round the night before and ask what you would like, there are always options." Another commented, "There is always a salad option every day, and there is fruit that you can help yourself to. What there is varies depending on what's available." A relative told us about one time when their family member wasn't eating properly, " [Staff] offered her some of her favourites to try and tempt her to eat." Another relative told us, "I eat here with my [family member] five days a week and the food is as good as mine. Always very nice." One relative said their family member was diabetic and staff accommodated their needs" and "They made a list when my [family member] first came in, I think they always get it right."

We asked about the availability of drinks and snacks. One person told us, "You get a drink with your meals, and they come round with drinks in the morning and afternoon and at supper time. I've never felt that I needed any more." Another said, "You get something with the morning and afternoon drinks, and something for supper if you want it." We observed hostesses around the home offering and providing people with drinks, snacks and meals throughout each day we were there.

We observed the lunch service in the dining rooms on each floor at the home. Where people required support to eat, staff provided this assistance in a patient respectful way. A variety of drinks were available with meals which included teas, coffees, juice and wine. We observed staff encouraging people to eat and drink sufficient amounts.

Relatives told us that staff kept them updated with any changes to their family member's health. People had access to healthcare professionals to help promote good health and maintain their wellbeing. Care records showed that people had access to, and involvement with, various health professionals. These included, speech and language therapists, GP, dentists, opticians, falls prevention team, psychologists and linguistic services.

Every week on each floor at the home a 'clinical review meeting' took place to discuss and identify any health and clinical issues for follow up. This included information about people that needed further action to ensure that this did not get missed. Details were kept in the nurses office so that all clinical staff had access to the information.

Good

Is the service caring?

Our findings

We asked people what they thought about the staff who supported them and everyone was very complimentary. One person said, "The staff look after us well. They do everything to make it happy here for us." Others said, "There is always plenty of laughter when they are around. The fun helps" and "I absolutely love it here. We laugh such a lot" and "Sometimes someone's illness might make them a bit more vocal or angry. The staff use persuasion and kindness to calm them."

Relatives were equally happy. One said "The staff are very caring, I can't fault them." Others told us, "They have got to know my [family member] and all of us. They look after everyone very well" , "I'm quite happy with the care my mother gets here" and "I fly the flag for this home. Can't speak highly enough. The staff are all great with my [family member]."

Care plans contained person centred information about people. Life story detail was provided in a document titled 'Who Am I' which provided background information about the person outside of their care needs. Staff demonstrated awareness and knowledge of people's backgrounds and family. Relationships between people and staff appeared open and friendly. Information was included about people's preferences for end of life, so that care could be delivered in accordance with their wishes at that time.

We talked to people about what choice they had about what they wanted to do each day. Some examples people told us about were that they were able to have baths and showers on request and were free to get up and go to bed whenever they wished. One person told us about choosing for themselves when they took a shower. They said, "I can use it by myself, but the staff might give me a gentle nudge if I had forgotten to do it for a while. They always do it nicely." Another person said "I need help to do most things, but when they come they always ask first. If I am watching something on television when they come to put me into bed they will ask if I want them to come back later." People told us about ways in which they were helped to maintain their independence in the home. One person told us, "They always ask before helping me, I insist on keeping my independence and they respect that."

Our observations showed that people were encouraged to do things for themselves where they were able to and at their own pace. Staff asked people if they would like help before providing support and encouragement. During the lunch service we observed a staff member assisting a person to their seat. The person appeared anxious and the staff member asked what was wrong. The person told the staff member that they thought they might need to go to the toilet. The staff member asked if the person would prefer to go before or after their meal. When the person asked for the staff member's advice she replied "Only you can tell me that, (name) but shall we go now to make sure?" This showed that people had choice but were encouraged by staff where appropriate.

Staff we spoke with were able to describe how they maintained people's dignity and respect and gave examples of how they would implement this. This included practice such as ensuring personal care was provided discreetly and maintaining confidentiality. Staff said that these areas were covered throughout all of their training, which highlighted the importance of this.

We saw that the majority of the time, people were offered explanations when support was provided. For example, one person was being supported by two staff members to be transferred into their wheelchair by use of a hoist. The staff explained each stage of the the procedure to the person and checked often whether they were ok. At one stage, the person looked notably anxious and a staff member told them, "Don't worry, you're safe, do you want to hold my hand?" This had the result of reassuring the person and allowing the transfer to take place successfully. However, at another time during a busy period after lunch, we saw one care worker move someone in a wheelchair from one area of the lounge to another. They did not ask the person if they wanted to move or explain to them what was happening or why. The care worker asked another staff member "Where shall I put him?" This showed that at times staff did not always ensure people were afforded dignity and offered choice.

People told us that staff were respectful and the interactions which we observed supported this. One person came into the communal lounge and it was apparent they needed assistance with personal care. A staff member quickly attended to the person and discreetly supported them back to their room to get washed and

Good

Is the service caring?

changed. Another person described the way in which care was provided for them. The person told us that they were living with mild dementia and said, “I am never made to feel stupid, no matter what I ask or how often I forget.”

People told us that they were able to have visitors whenever they wished and spoke positively about how the staff made other people feel welcome. One person said, “Everyone is welcome, and they look after visitors, giving them drinks and biscuits.” A visiting relative told us, “They know us as a family, the staff are very good with all family members.” All vistors we spoke with told us they were made to feel welcome whenever they visited.

People we spoke with had support from family and friends and did not use any formal advocates. Although we saw that there was an advocacy policy in place at the service, we did not see any details of advocacy information around the home that people could access and find information about if they required.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us they were kept updated about their family member's care and had opportunities to be involved in care plans. One relative told us "I come to care planning meetings." Care plans we looked at showed evidence of regular updates. Information was detailed and covered a number of areas covering a wide range of people's care. However, we noted that some care plans did not provide clear information about how a person was to be supported. One person's 'safety' care plan said the person should be checked regularly as they were 'unable to use a call bell'. The same care plan later provided instruction to 'leave call bell in hand.' The registered manager and head of care said the person could 'sometimes' use the call bell. We visited this person in their room and saw the call bell was on the wall and not in the person's hand. This contradictory information meant there was a risk the person was not supported in a way suitable to their needs.

Another care plan contained information about a person's medical conditions and how these were to be managed. The care plan for one of their conditions stated that the person should have their blood pressure taken monthly and a chart was in place to document this. We saw that nothing was recorded since 5 November 2014. The same person had a care plan in place for pressure care, which stated they needed regular repositioning at night. We asked the nurse to show us the positioning charts for the person which we were told were kept within the nurse's office. There was no documentation in place for the person. The nurse told us, "It must have been stopped and he doesn't need it now" but was unable to show us where this decision had been made. The care plan did not contain any information to this effect and staff we spoke with were unfamiliar as to what was required for this person in terms of pressure care needs. We fed this back to the registered manager so they could ensure the person's health could be checked accordingly.

Our findings showed that care was not always person centred and delivered in accordance with people's needs. This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds with Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service employed two activities co-ordinators. During our visits we saw one co-ordinator undertaking some gardening duties and supporting a person on a trip out of the home. We saw another co-ordinator asking people on the ground floor if they wanted to assist with making a flower display upstairs. The hairdresser was present on the first day of our inspection and a number of people chose to have their hair cut or styled.

We asked people what they liked to do and how they spent their time. Many people told us that they spent time in their rooms. One person told us, "There are things going on in the lounge sometimes but I find some of the residents can make sounds and noises all the time. It's not their fault but I tend not to join in. I have a lot of visitors to help me pass the time." Another person said, "I think that there are things I can join in with, but I can't tell you what they might be. I like to knit." We saw a lot of people spent time in an upstairs lounge but other than the television being on we saw no activities on the afternoon of the visits for people to engage in. Some people sat for significant periods of time without having anything to stimulate them.

We looked at the latest complaints and and saw these had been investigated and responded to in writing to each complainant. We asked people and relatives about any complaints they had made. One relative referred to a previous situation and said although they were happy with the way the registered manager responded, they said, "The people above (the manager) were very slow to respond." No-one else that we spoke with could recall any complaint that they had made. Everyone said they felt they could approach the manager if they did have any issues to raise. We saw a compliments file which contained a number of positive compliments from people about the service.

'Residents meetings' took place quarterly. We saw in the latest minutes that three items had been discussed: menus, the residents fund and activities. One person told us ,"I have been to the meetings and I take part. I don't have any concerns to raise but I go." The minutes also stated that people had said that they would like to go out more, both in the garden and on outings into the wider community. On the day of the inspection no person could tell us about how they were able to spend time outside. We saw that one person liked to sit outside for a cigarette, but had to be supervised by a staff member.

A poster was displayed on a notice board advertising dates of quarterly relatives meetings for the year. Relatives we

Requires Improvement

Is the service responsive?

spoke with told us that they attended meetings at the home. One relative said of the meetings, "I think they are constructive but not well attended. You don't necessarily see things being changed." When we asked why they thought this was they said, "Often things need input from higher up, but no-one from BUPA attends the meetings." Minutes of the last meeting were displayed on the noticeboard so any relatives that had not attended were able to be kept up to date.

Requires Improvement

Is the service well-led?

Our findings

Most people told us they knew the registered manager and found her to be approachable. One person said, "I know her very well. She is very nice, she knows what's going on." Another person said they did not know the registered manager but said of the home,"It all runs smoothly and very well indeed."

Most staff we spoke with said they felt supported by the manager and senior staff. They told us, "[The manager] and [head of care] are both approachable" and "We can go to them with any concerns." Most staff said they were happy working at the home and enjoyed their role. One staff member said, "I really enjoy it. It's like a family."

There were quality assurance systems in place although it was not evident these were effective. We were told that provider review meetings took place monthly where an area manager and quality manager would assess all areas of the service and produce an action plan for any issues that needed to be followed up. We asked for the latest report and saw this was from January 2015 with no visits since this time. The registered manager told us she was due another visit but did not know when this would take place.

We identified that the current audit systems were not robust enough to effectively assess, identify and act upon, risk and improvements at the service.Medication audits were not comprehensive enough to identify risks within the service, which was acknowledged by the registered manager and head of care who told us they hoped to revert back to another more detailed audit which had been used in the past.

We found that audits of care plans took place but again, this consisted of random checks which did not always identify key discrepancies. For example, a care plan that had been audited in January 2015 had not identified that a person had not received treatment in line with their care plan as we discovered at our inspection.

The registered manager told us she had three formal meetings a year with her manager and also was asked about any issues during monitoring visits. She told us she felt supported and would feel comfortable in accessing support at any time if she needed to. From our discussions with the manager, she had a good knowledge of people's needs within the home. She told us she had an open door policy and staff, residents and relatives were able to access her at any time and we saw this throughout our inspection.

We identified that staff had either not been provided with supervisions at all or had not received regular supervisions and did not have appraisals. The supervision matrixes we saw showed that there were significant gaps in supervisions. The register manager acknowledged this and was aware of this shortfall. There was no plan in place as to how this ongoing issue was to be addressed in order to improve the service being delivered.

Some care staff we spoke with could not recall being present at team meetings. We saw meeting minutes from the last meeting in January 2014, which named 16 staff as being present. The registered manager said it was difficult to arrange meetings to incoporate and suit all people. They told us that the head of care would occasionally start work early in the morning so they could catch up with night staff and monitor how the service ran at night. There was no evidence to see how other staff groups within the home were kept updated about any changes and information they may be required to know.

The registered manager told us that quality assurance surveys had been sent to stakeholders in October 2014 but she had still not yet had the results of these. We found that although processes were in place to obtain feedback by way of residents and relatives meetings, information was not always followed up and acted upon. For example, in the minutes from the last meeting dated 27.01.2015 we noted one section contained the following; 'Staff will be writing books either at 11.30 or in afternoon. Encouraged to write in lounge with residents.' Our observations of a staff member writing in a room next to an unsupervised lounge had shown that this did not always take place, which meant feedback was not always taken on board and implemented. Another relative had told us about staffing being a recurrent theme which they felt was not acted upon.

We noted in the care records that some hand written information and entries were illegible which meant it was difficult, if not impossible, to read what the entries said. Some care records contained loose documentation that was not secured, which posed a risk of important information getting lost or misplaced. These were issues that had also been identified at our last inspection. The

Requires Improvement

Is the service well-led?

action plan that had been provided stated these issues would be addressed however it was evident that they had not been fully rectified. This showed that the plan in place to improve to the service had not been effective in this area.

Our findings showed assessment and quality assurance processes did not always identify areas of concern so that risks could be minimised and improvements made to the service. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a process in place to ensure the registered manager had oversight of all incidents at the service. These were monitored on a regular basis to identify any themes and trends and to look for ways to reduce potential risks. We saw evidence of incidents that were recorded and saw that these were documented and followed up with referrals made where necessary. Statutory notifications in line with the criteria set out in the Health and Social Care Act 2008 had been made accordingly.

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	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: The care and treatment of service users was not always appropriate and did not always meet their needs and reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not provided in a safe way for service users as medicines were not being managed in a proper and safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems were not effective to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: People employed by the service provider did not receive such appropriate support, training, professional development, supervision and appraisal as is necessary

This section is primarily information for the provider

Action we have told the provider to take

to enable them to carry out the duties they were employed to perform. Staff were not deployed in a way to meet the requirements of the people who used the service.