St Dominic's Limited

St Dominic's Nursing Home

Inspection report

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Ratings

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

Overall summary

We inspected St Dominic's Nursing Home on the 25 and 29 November 2014. St Dominic's Nursing Home is registered to provide care to people with nursing needs, such as Parkinson's, diabetes, and heart failure, many of whom were also living with dementia. The home was divided in to five units over three floors, Fern, Crocus, Dahlia, Aster and Bluebell. The top floor, Elderflower unit was closed for refurbishment. Fern unit was on the lower ground floor and was home to people with complex dementia needs. The home can provide care and support for up to 91 people. There were 57 people living at the home on the days of our inspections.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider.

At the last inspection in September 2014, we took enforcement action against the provider and issued a warning notice in relation to the care and welfare of the people at St Dominic's. We also asked the provider to make improvements in respecting and involving people, consent to care and treatment, care and welfare and quality assurance. An action plan was received which

Summary of findings

stated they would meet the legal requirements by 31 October 2014. Whilst we found improvements had been made in some areas there were still areas of significant concern and some actions were not yet embedded in practice. We were still concerned about the care and welfare of people living at St Dominic's and how the service was managed. This is reflected in the enforcement actions we have taken which can be seen at the back of this report.

People spoke positively of the home and commented they felt safe. Our own observations and the records we looked at did not always reflect the positive comments some people had made. People's safety was being compromised in a number of areas. Care plans did not reflect people's assessed level of care needs and care delivery was not person specific or holistic.

The delivery of care suited staff routine rather than individual choice. Care plans lacked sufficient information on people's likes, dislikes, what time they wanted to get up in the morning or go to bed. Information was not readily available on people's preferences.

Not everyone we spoke with was happy with the food provided. We found lunchtime to be chaotic with some people not receiving their lunch until 1:40pm. The dining experience was not a social and enjoyable experience for some people. People were not always supported to eat and drink enough to meet their needs.

People's medicines were stored safely and in line with legal regulations. People received their medicines on time and from a registered nurse.

People we spoke with were very complimentary about the caring nature of the staff. People told us care staff were kind and compassionate. However we also saw that many people were supported with little verbal interaction and many people spent time isolated in their room.

Feedback had been sought from people, relatives and staff. 'Residents' and staff meetings were held on a regular basis which provided a forum for people to raise concerns and discuss ideas. Incidents and accidents were recorded, but not consistently investigated.

Staff told us the home was well managed and there were good communication systems in place between all levels of staff. These included handover sessions between each shift, regular supervision and appraisals, staff meetings, and plenty of opportunity to request advice, support, or express views or concerns. Their comments included "Much better– we are now working as a team. We support each other.

We found a number of breaches including continuing breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

St Dominic's Nursing Home was not safe. Risk assessments were devised and reviewed monthly. However, management of people's continence care needs and skin integrity was poor and placed people at risk.

People were placed at risk from pressure relieving equipment not set correctly for their needs and poor moving and handling techniques.

People told us they were happy living in the home and they felt safe. Staff had received training in how to safeguard people from abuse and were clear about how to respond to allegations of abuse. However, we found this was not embedded into everyday practice. Staff recruitment practices were safe.

Is the service effective?

Inadequate

St Dominic's Nursing Home was not consistently effective. Meal times were observed to be a solitary and inefficient service with food being served to people who were asleep or left with their meal untouched in front of them. Nurses had no oversight of people ate and drank. No guidance was available on how much people should be eating and drinking to remain healthy, specifically diabetics.

People spoke positively of care staff, but expressed some concern about lack of communication between staff and people who lived in the home.

Staff received on-going professional development through regular supervisions, and training that was specific to the needs of people was available but not always put in to practice. Safe moving and handling was a particular concern.

Is the service caring?

Requires Improvement

St Dominic's Nursing Home was not consistently caring. People were positive about the care they received, but this was not supported by some of our observations.

Care mainly focused on getting the job done and did not take account of people's individual preferences and did not always respect their dignity. People who remained in their bedroom received very little attention.

Staff were not always seen to interact positively with people throughout our inspection. We saw staff undertake tasks and care without any interaction.

Is the service responsive?

Requires Improvement

St Dominic's Nursing Home was not consistently responsive to people's needs. Care plans did not always show the most up-to-date information on people's needs, preferences and risks to their care.

Summary of findings

Some people told us that they were able to make everyday choices, but we did not see this happening during our visit.

There were not enough meaningful activities for people to participate in as groups or individually to meet their social and welfare needs; so some people living at the home were isolated. This was confirmed by discussions with people.

Is the service well-led?

St Dominic's Nursing Home was not well led. People were put at risk because systems for monitoring quality were not effective.

The home had a vision and values statement, however staff were not clear on the home's direction. Staff however told us that they felt supported by the management and worked as a team.

People had an awareness of who the manager was but not everyone could tell us they had met the manager and were aware of them.

Requires Improvement

St Dominic's Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

The inspection took place on the 25 and 29 November 2014 and was unannounced. The inspection team consisted of four inspectors and an Expert by Experience, who had experience of older people's care services and dementia care. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the Quality Monitoring Team- (social services placement team) and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also contacted the local authority to obtain their views about the care provided in the home.

During the inspection, we spoke with 18 people who lived at the home, eight relatives, the manager, regional manager, four registered nurses, seven care staff and the maintenance person. We looked at all areas of the building, including people's bedrooms, the kitchen, bathrooms, the lounge and the conservatory.

We contacted healthcare professionals who visit the service. This included the community dieticians, speech and language therapists and tissue viability nurses. We spoke with two healthcare professionals from a local GP surgery, a GP and community matron. We also had feedback from the Quality Monitoring Team.

Some people had complex ways of communicating and several had limited verbal communication. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed records which included quality assurance audits, staff training schedules and policies and procedures. We looked at ten care plans and the risk assessments included within the care plans, along with other relevant documentation to support our findings.

We also reviewed the care pathways of people living at St Dominic's Nursing Home. We looked at the care delivery on the day of inspection and obtained the person's views of the care. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Inadequate

Is the service safe?

Our findings

People told us they felt safe. Comments included, "I feel very safe here." "I definitely feel safe here." Relatives told us they felt confident leaving their loved one at St Dominic's. One relative told us, "I feel they are in safe hands." Although people told us they felt safe, we found examples of care practice which were not safe.

At the last inspection in September 2014, we found the provider was in breach of Regulation 9 of the Health and Social Care Act 2008. This was because risk assessments were not accurate and lacked sufficient guidance. During this inspection, whilst we found some improvements had been made we also found shortfalls that had not ensured peoples safety.

Individual risk assessments were in place, which covered areas such as mobility, continence care, falls, nutrition, pressure damage and overall dependency. They looked at the identified risk and included a plan of action. However, some risk assessments did not always include sufficient guidance for care staff to provide safe care and others were not being followed. For example, one person had had 15 falls since admission in August 2014. The falls risk assessment stated this person was at high risk of falls due to mental condition and stroke. The actions stated "can stand up and walk around with a zimmer frame (walking frame) but balance is poor so sensor matt in place". However, there was no sensor mat in the person's bedroom to alert staff this person was up and at risk from falls.

Before our inspection we had received concerns about the poor management of people's skin integrity and pressure ulcers. We were informed by the manager that wound and pressure sore audits had been undertaken regularly since our last inspection in September 2014 and that an identified nurse had become the home's lead in wound care. We looked at ten people's care plans in depth. There was no mention of how staff were to recognise and report on first signs of skin damage. Staff were not monitoring condition of people's skin to prevent pressure sores. One person had pressure area that was painful and the skin was broken which had not been monitored.

In addition a person had been assessed as at very high risk of skin damage. There was reference on 17 September 2014 to swollen legs that were leaking water. The GP suggested dry bandages and to keep dry. There were no further references recorded to this identified problem. For another person we saw that records for skin damage did not identify the wounds until they were established. A further person had had a dressing applied on the 18 October 2014 and there was no further information as to if this dressing had been changed or the condition of the skin underneath.

There was guidance for people in bed to receive two hourly position changes and the use of a pressure mattress to reduce the risk of pressure sores. However for people sitting in chairs or wheelchairs there was no change of position or toilet breaks in their care directives for staff to follow. During the inspection, we observed people sitting in the communal lounges. Throughout the inspection, we saw that eight people had not been assisted to access the toilet or offered a change position in over six hours. This increased the risk of skin breakdown.

At our last inspection in September 2014 we found people's pressure mattresses were incorrect for their weight and we found this had not improved. One person's was set at twice its correct setting. The daily audit had been signed to indicate that settings were correct. For another, the mattress was set on hard despite the person being asleep and therefore the person was at an increased risk of pressure damage due to the incorrect setting.

We observed three instances where people were being supported to move from a wheelchair to armchair with the support of hoisting equipment). On two occasions we saw the person suspended and swaying, and not supported safely by the two staff members. There was little verbal support or reassurance from staff to the person being moved. This was not a safe or pleasant experience for them. We also saw one person moved with skill and expertise. The staff spoke to the person throughout and reassured them.

People were not protected from avoidable harm due to inappropriate moving and handling techniques. We saw two examples of poor moving and handling techniques during our inspection. All of the above issues demonstrate that people were not protected against the risks of receiving care or treatment that is inappropriate or unsafe. These issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider had appropriate arrangements in place for the safe management of medicines. There were records of

Inadequate

Is the service safe?

medicines received, disposed of, and administered. We observed the administration of the morning and lunchtime medicines and saw that staff administered medicines safely. Nurses who administered medicines carried out the necessary checks before giving them and ensured that the person took the medicines before signing the medication administration record (MAR) chart. The nurse ensured medication was swallowed before signing the MAR chart and ensured the trolley was locked when left.

Training schedules confirmed all staff had received safeguarding training and staff we spoke with confirmed this. Staff had a clear understanding of abuse and felt confident that any allegations made would be fully investigated to ensure people were protected. Safeguarding policies and procedures were in place and were up to date and appropriate. Staff had received training in safeguarding adults at risk and were able to tell us of the signs of abuse, we found safeguarding referrals were made to the local authority when required.

We talked to staff about their training and experience and confirmed that new staff were placed with experienced staff. This ensured that staff were supported in delivering care until they gained essential experience and knowledge of the people they cared for. We looked at the skill mix, staff experience and allocation of staff across the units. on the first floor (Bluebell and Aster units) and on the second floor (Crocus and Dahlia units) the teams consisted of five care staff and one registered nurse for each floor. The staffing complement on Fern was separate and was one nurse and five care staff, which staff said was sufficient to meet people's needs. Whilst staff told us that staffing levels were sufficient for providing care and support, we observed that staffing levels did not take in to consideration peoples social and welfare needs. This was because we observed that some people were left in their rooms for long periods of time with little or no verbal interaction or company.

People were protected, as far as possible, by a safe recruitment system. Staff told us they had an interview and before they started work, that the provider obtained references and carried out a criminal records check. We checked three staff records and saw that these were in place. Each file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by St Dominic's Nursing Home and bank nurses all had registration with the nursing midwifery council (NMC) which was up to date.

Inadequate

Is the service effective?

Our findings

People spoke positively about the home. Comments included, “I’m looked after.” “The carers are very good.” However, we found St Dominic’s Home did not consistently provide care that was effective.

People’s care plans included risk assessments for skin damage, incontinence, falls, personal safety and mobility and nutrition. Records showed that people had regular access to healthcare professionals, such as GPs, chiropodists, opticians and dentists and had attended regular appointments about their health needs. However the care plans lacked details of how to manage and provide specific care for peoples individual needs. For example one person with diabetes was on a sugar free diet. This person was given a bowl of sweets and crisps that were not sugar free. It was recorded in the care plan that they liked sweets however there was no plan to manage their preferences or the involvement of a dietician. None of the care plans for people with diabetes contained information of how staff could identify or support people with high and low blood sugars which out people at risk of poor health.

People’s continence needs were not always managed effectively. Care plans identified when a person was incontinent, but there was no guidance for staff in promoting continence such as taking to the toilet on waking or prompting to use the bathroom throughout the day. Mobility care plans lacked guidance for staff in maintaining what mobility people had and encouraging retaining their mobility. For example, a mid-morning and afternoon stroll or just standing to relieve pressure.

Feedback from people, staff and visitors about the food was varied and ranged from ‘tasty and okay' to 'awful and disgusting.' We observed the midday and evening meal service on three units. On Fern unit 12 people were served lunch in the lounge/dining area, five people sat at the dining tables and seven sat in the lounge area where they had been sitting during the morning. They were not asked if they would like to sit at a table or have a change of position or a different view.

Although a sign on the wall next to the serving hatch highlighted the need to use red (or brightly coloured) crockery for people living with dementia, meals were served on red or white plates without any plan or rationale. Staff said the red crockery was to help people focus on their food but did not know who was to have a red plate or why. One staff member said it was advice from the community mental health team. There was no clear rationale for the use of the different colours for specific people and so the advice

People had a varied meal time experience. Staff used clothes protectors for people and explained what they were doing before fastening these. The television was turned off during the lunch period and there was a quiet relaxed atmosphere. The food was not presented in an attractive way and it was difficult to distinguish what some of the food items were. With one exception, people who needed help to eat received this. Staff sat at an appropriate height to offer help, which was offered at an unhurried pace. However, there was no attempt to explain to people what the food was or to maintain eye contact and chat. One person however did not receive any help to eat. Staff placed a meal and a fork in front of the person but the person was asleep and staff did not awaken them to eat.

People’s meal time experience on other units were also varied and was not always a pleasant experience for some people. The midday meal on Crocus and Dahlia unit was served at 12:30 pm. There were initially two members of staff in the room and eight people in the lounge. Five remained in lounge chairs and three sat at dining tables. One person was sat on their own, not eating and no one supported them until an inspector identified that this person hadn’t eaten and the food had sat there for 20 minutes uncovered and was now cold. The person didn’t eat any of the main meal and was not asked if they wanted anything else. They were only offered the pudding as an alternative. At 1.10 pm one person still had no food to eat. Their food arrived at 1.15 pm, 45 minutes after the meal service started and people had finished. A clothes protector was put on without asking or explanation. Another person ate their meal independently from an arm chair with no interaction from any staff unless staff removed their empty plates. High backed arm chairs were in front of this person so they couldn’t see other people or staff. We asked this person if they wanted to eat at the table, they responded, “Didn’t know I could.” Food was placed in front of one person with a lid on it for over 10 minutes before someone came back to support them to eat. This person didn’t eat any of their meal and was then given pudding which they also didn’t eat. This person was supported by three different members of staff who all kept getting up to

support other people, this did not promote consistency in the support received. The television was on through the first half of lunch then it was turned off and radio put on. No one was consulted or asked their preference.

On Bluebell and Aster unit staff brought people over to the tables for 12:30 pm but didn't ask people if they wanted to they just moved them without consultation. Staff served the food without telling people what it was in order to help aid peoples orientation and motivation. Pureed food was not attractively presented and one person refused the food as "It looks horrible.". Some people had plate guards and the large majority of people had beakers although they all didn't need beakers, this was not seen as individualised care. One person had a preference for a red beaker which was written in their care plan, but this was not offered throughout the inspection.

We observed supper being served at 5:30pm and noted that not everybody received an evening meal they enjoyed. Overall choice was limited and the presentation of food was not attractive in order to help promote people's appetites. One person had a meal in front of them which had salt all over it put on by a member of staff. The amount of salt on meal had made it inedible. The meal was returned to a nurse who was unsure what to do. Soup was offered to the person some time later but not eaten. We looked at food and drink charts and found that people had not received food or drink after 5:30pm until 7am the following day. This identifies over 12 hours without food or fluids. Staff told us how they monitored people's food and drink. One care staff told us, "We fill in people's food and fluid charts every day." On the day of our inspection we found some people's fluid and food had not been completed at all.

The meal service on two units was disorganised and solitary. It was not seen to be a good experience for people. We could not be assured that people received food and fluids that maintained their health and well-being. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At the last inspection in September 2014, we found the provider was in breach of Regulation 18 of the Health and Social Care Act 2008. This was because mental capacity assessments were not completed in line with legal requirements. Deprivation of liberty safeguards (DoLS) had not been requested for those that required them. Staff had also not received training on the Mental Capacity Act (MCA) 2005. At this inspection improvements had been made. Senior staff had received MCA and DoLS training and were cascading training to all staff. DoLS referrals had been submitted and two referrals were being submitted on a weekly basis as directed by the Local Authority DoLS team. An assessment form was completed to determine each person's capacity to make decisions and this was reviewed when decisions were made. The form explained how staff should support people to make these decisions, for example by making sure the person's past and present wishes, feelings, beliefs and values had been taken into account and were understood. Care plans reflected decisions made with a rationale recorded. Staff were able to discuss the principles underpinning the MCA act and talked through how they sought consent from the people they cared for. However this was not embedded in everyday decisions as we found during our inspection. For example meal time decisions.

External health care professionals had visited the service, such as GP's, speech and language therapists, chiropodists, opticians and the district nurse. The staff recorded health professional visits in individual care plans. People we spoke with were happy with the health care support they received. One person told us, "We have a chiropodist and optician, I think they come and visit every so often. The dentist and GP visit as well."

Staff received on-going support and professional development. Supervision schedules and staff confirmed they received regular supervision (every two months) and appreciated the opportunity to discuss their concerns. Nursing staff also confirmed they had received clinical training and support. The manager produced a supervision programme which confirmed that supervision sessions had been introduced and planned.

We looked at the induction and training schedule for staff. Staff had received essential training, such as fire safety and first aid awareness. All staff members had received training that was specific to the needs of people living at St Dominic's Nursing Home. The staff confirmed that they had received good training. We saw from individual staff records that training had been given on topics such as infection control, dementia awareness, health and safety and prevention of falls. However due to the concerns we had about the delivery of the care particularly safe moving and handing we were not assured that the training was being followed or put in to practice.

Requires Improvement

Is the service caring?

Our findings

There was inconsistency in how people were cared for, supported and listened to and this had an effect on people's individual needs and wellbeing. As staff did not always focus on people's comfort, there was a risk of people receiving inappropriate care, treatment or support. We observed people who found it difficult to initiate contact were given very little time and attention throughout the day. People spoke positively of care staff, but two visitors expressed some concern about lack of communication between staff and the people who lived at St Dominic's Nursing Home. Comments included, "I see staff smile but they say very little to my mum," and "I think that staff are kind, but I do wish they would chat to the residents, I visit my mum but spend time chatting to other people as staff don't."

Staff were task focused and did not always treat everyone with respect, kindness and compassion or maintain their dignity. One person was complaining of pain in their stomach and was visibly seen to be unsettled. Staff occasionally came to this person and asked if they were "ok" but did not then offer any reassuring or assistance. Another person became distressed whilst in a corridor they called out for some time disorientated and lost. Two staff members heard but did not assist this person until an inspector asked them to help. We saw one person needed personal support in their room. One person was supported from a bathroom back to the lounge. The member of staff had a plastic bag in their hand, the content of which was visible. There were other people, visitors and staff around who could clearly see this. This person's privacy and dignity after using the toilet was neither maintained nor respected. We noted in wet rooms that instead of a shower chair people were sat on a commode without the seat cover, as if sitting on a toilet rather than a chair. When we asked staff we were told that it was normal practice as it saved the person from being moved twice. This was seen as time saving practice rather than a person's choice or supporting people's dignity.

People's dignity was not always promoted in the communal lounge when they were helped to move, as people's underclothing was displayed as they swayed whilst being supported in a moving and handling hoist . No attempt was made to offer privacy during the procedure. Some people's hair and personal hygiene had not been attended to and they appeared unkempt. People were not offered a choice of a cup and saucer and were instead given a plastic beaker. We asked one person if this was their preference and were told, "No I just get this, would be nice to drink out of a china cup, tea tastes better out of china."

People's preferences for personal care were recorded but not always followed. We looked at a sample of daily notes, which included documentation on when people received oral hygiene, bath or a shower. Documentation showed us that often people would not receive a bath or a shower in 14 days but instead an assisted wash. The care plan did not state that as a preference. One person had only received one shower in 10 days. We saw that people could go eight days without receiving oral hygiene. The clinical lead informed us if that if a person refused personal care it would be recorded in the daily notes. However we could not find records of this within the daily notes. We could therefore not tell if people received regular support to bath or shower or if they received oral hygiene as identified they wished in their care plan. These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During lunchtime we observed some good interactions between staff and people they were assisting with their meals on Fern, but this was missing on the other units. On Fern unit staff chatted with people, held their hand and did not rush the meal. Staff read the body language well when the person was ready to take some food or have a drink. However, on other units staff members did not talk to the person while helping them eat and there was no eye contact. They occasionally referred to the person by name and put food or drink in their mouth or in front of them without describing or explaining what it was. One person was referred to by the wrong name during the meal service. People were sat on their own who required support with food or drink and staff did not recognise people needed support until prompted by inspectors.

Requires Improvement

Is the service responsive?

Our findings

Whilst some people told us they were happy with the standard of care provided and that it met their individual needs, our observations identified that staff were not always responsive to individual needs.

We had mixed feedback from visiting healthcare professionals about the responsiveness of the provider. We were told by a nurse specialist that communication with staff was not always positive and the staff were not always prompt in requesting specialist advice, for example on wound care.

We asked people and their relatives if they had been involved in the assessment of their needs. Some told us that they could not remember, whilst two visitors told us they had been. The care plans gave information about the person's family history, their preferences, relationships, family and key medical information. The information however was not always easy to locate. Staff told us they felt the care plans were detailed enough so that they could provide good quality care and know the person as an individual. However when we reviewed the care files we noted that not all contained specific details to provide person specific care. For example, what time people preferred to get up or go to bed. The directives we saw in care plans had not been updated to reflect their changes to their health. One person who was on continuous bed rest still had their preference recorded for getting up at 7am and going to bed at 10pm.

Communication and social well-being was an area that we identified as a concern as there were some people isolated in their bedrooms and in the lounge areas with little interaction. Twelve people were in bed in a darkened room with no television on or radio all day, there was no rationale given or any evidence this was their choice. The only opportunity of respite from lying in their bed was meal times when they were sat up and assisted with their meal. Staff performed the tasks but did not use this one to one time to chat or offer reassurance. One person could communicate and was articulate when we spoke with them. We returned to this person throughout our inspection and saw that for eight hours they received no other social interaction from staff. We observed staff waking this person for dinner by nudging them awake with very little verbal interaction. The staff member fed the person over the bedrail from a standing position and there was no eye contact or verbal interaction made throughout this procedure. It was a sad and solitary experience for the person, who told us they missed company and were 'pretty bored and lonely.'

Care was not personalised to the individual. For example, people did not always get up when they wished. Care staff told us it was not uncommon for people not to receive personal care just before lunchtime. During the inspection we monitored how long it took for people to receive personal care. We found that some people were still receiving assistance with washing and dressing at 11.30 am. People we spoke with confirmed they often had to wait for assistance in the morning. One person told us," I think I am usually got up at just after 10 am, but I have nowhere to be so it doesn't really matter." Another person told us, "I have to wait and remember it's not just me waiting." A third person told us, "Yes I wait, but as long as I'm dressed for lunch it doesn't worry me." This was not what people wanted as one person said, "It's a very short day because we get ready for bed at fiveish and that's it."

We observed one person in a wheelchair moved without being asked into a position facing high windows and a ramp. Their back was to the television which according to their care plan was their main enjoyment. There was no explanation given, and they remained there for three hours with no interaction.

Care plans reflected some people's specific need for social interaction, but these were not being met. There were times when we saw that people were isolated and staff interaction was minimal due to other tasks being undertaken.

When social events did take place not everyone had the opportunity to join in. A singer visited on the first afternoon of our inspection. He played in the lounge on Crocus and Dahlia. staff did not bring people from other units or ask people in their rooms if they would like to listen to the music. One person said "It would have been nice to join in but I didn't know it was on." The relative said, "We didn't know it was on, which is a real shame, they don't ask or tell people what's on." We asked the manager why people didn't know about the entertainer. The manager said it was displayed on notice boards, but we only saw it displayed on the Aster/Bluebell corridor.

Activities promoted were not people's individual interests and hobbies. One person told us that scrabble would be

Requires Improvement

Is the service responsive?

good, 'get my mind working' whilst another would have liked to play bridge. The records showed us that the activity co-ordinator spent time on one-to-ones sometimes but this was not regular. This also meant if the activity co-ordinator was visiting people in their room, the people in the communal areas were left watching television with no other meaningful activity.

Whilst we saw that visitors were welcomed during the day and there were some activities on offer, people's social and welfare needs were not being met. This was a breach of Regulation 9 of the Health and Social Care Act 2008.

A complaints procedure was in place and displayed in the reception area of the home. However, this was not displayed elsewhere in the home or provided to people in an accessible format. Most people told us they felt confident in raising any concerns or making a complaint.

One person told us, "I'm happy to complain if I need to. I know who the manager is, I sometimes see her." However, some people did not feel confident that their complaint or concern would be resolved. One person told us, "If I had concerns I couldn't raise them, it's just a waste of time, they ignore me." There had been one complaint since September 2014 which was still on-going, documentation confirmed complaints were investigated and feedback was given to the complainant.

The manager had sent out satisfaction surveys in October 2014, and was in the process of collating them. One visitor said, "I have been asked to complete a survey, which I will be doing, but I do tell staff if I have a problem or want information about my husband and staff always respond immediately."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in September 2014, the provider was in breach of Regulation 9, 10 and 18 of the Health and Social Care Act 2008. This was because we were concerned about lack of agreement and consent to care and treatment, care delivery and the provider's framework of monitoring the quality of care provided. We found that whilst some improvements had been made, there were still areas of concern.

There still not effective systems in place to regularly assess and monitor the quality. This was a continuing breach of Regulation 10. The home received regular quality monitoring visits from the management team. These audits looked at the home's medication practices, documentation and health and safety. We looked at the October 2014 audit. The audit identified concerns but we found that improvements had not been made following the audit. We looked at a sample of care plans. Within the care plans, we found inaccuracies. Information had been wrongly calculated and therefore people's levels of needs were wrongly assessed. For example, one person had been assessed as having a low need in mobility but needed two staff for moving as we observed during the inspection. There was a lack of guidance for managing diabetes and the promotion of maintaining skin integrity. For example regular position changing. The audit of care plans had not picked up the errors we identified. This was a continuing breach of Regulation 10 of the Health and Social Care Act 2008.

The culture and values of the home were not embedded into every day care practice. The registered manager told us, "The vision of the home is to put the person at the centre. This is their home. When I first started working here, the culture was not good here, but I've been working on that and improving that." Staff were unclear when we discussed values and cultures with them. They felt values and cultures were just for staff relationships rather than including the people they supported. People were not put at the centre of the care delivery. There was an element of task orientated care being delivered rather than individualised person specific care. Staff we spoke with did not have a strong understanding of the vision of the home and from observing staff interactions with people; it was clear there was some elements of a negative culture within the home as care was task based rather than person centred. Staff however spoke positively of team work culture and how they all worked together as a team; this was said by all staff we spoke with. They said they supported each other and helped out on other units if they were busy. The staff talked about staff support but not about how to improve the lives of the people they supported and cared for.

Communication and leadership needed to be improved within the home. People had an awareness of who the manager was but not everyone could tell us they had met the manager and were aware of them. We were informed that staff deployment on each unit was organised daily by the registered nurse and senior carer on duty. Whilst observing the meal services, it was found to be chaotic with staff not receiving adequate support and supervision. Therefore people did not get the support required. The manager acknowledged it was chaotic during this period, but we did not observe senior staff providing leadership or overseeing the situation.

Systems had been introduced to seek the views of people, relatives and staff. Staff meetings had been held and we looked at a sample of minutes which confirmed this. These provided staff with a forum to air their views and provided opportunities for staff to contribute to the running of the home. Staff commented that they found these meetings useful and could raise concerns. One staff member told us, "The staff meetings are very informative and give us a chance to see everyone."

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered person did not have suitable arrangements in place for ensuring service users were protected against the risks of inadequate nutrition and hydration. **Regulation 14 (1) (a) (c**

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered provider had not taken steps to ensure that each service user was protected against the risks of receiving care that was inappropriate or unsafe by means of carrying out of an assessment of needs of each service user and the planning and delivery of individual needs.** Regulation 9 (1) (b) (i) (ii) (iii) (iv)

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person did not have effective systems in place to identify, assess and manage risks to the health, safety and welfare of service users and others.** Regulation 10 (1) (a) (c) (i) (d) (i) (e)

The enforcement action we took:
Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **The registered person had not ensured the dignity and privacy of the service users.** Regulation 17 (1) (a) (2) (a) (c) (g)

The enforcement action we took:
Warning notice