Clovelly House Residential Home Limited

Clovelly House Residential Home LTD

Inspection report

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Ratings

Overall rating for this service	Inadequate
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

This inspection took place on 12 February and 4 March 2015 and was unannounced which meant that nobody at the home knew about the visit in advance.

Clovelly House Residential Home LTD is registered to provide accommodation and personal care for up to 48 people. Many of the people at the home are living with dementia. The home has a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People using the service, and relatives were positive about the service. However we found that some risks to people's safety were not identified and managed effectively. Medicines were not always administered safely, and we found some examples of people's dignity not being protected . There were also shortfalls in the

Summary of findings

provision of activities and stimulation for people in the home, care planning and care provision, systems in place to obtain people's consent, and the quality assurance procedures for the home.

The home was clean and well maintained, and staff received supervision and training in their role at the home. An appropriate complaints procedure was in place, however people did not always feel able to speak about their concerns, so these could be addressed.

People's health and nutritional needs were met, however during the inspection visit there were not always sufficient staff available to meet people's individual social and emotional needs.

At this inspection there were five breaches of regulations relating to care and welfare, medicines, consent, respect and involvement, and quality assurance. We have also made one recommendation relating to staffing deployment in the home. 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?

Inadequate

The service was not always safe. Some risks to people who use the service were not identified and managed appropriately.

Systems in place to manage people's medicines administration were not sufficiently rigorous to protect people from harm.

Staff knew how to identify abuse and the correct procedures to follow if they suspected that abuse had occurred. Recruitment procedures were in place to determine the fitness of staff to work in the home. We have recommended that the number and deployment of staff within the home be reviewed to ensure that people's individual needs are met appropriately.

Is the service effective?

Inadequate

The service was not always effective. The service did not always protect people's rights to make choices about their care and have decisions made in their best interests if they were unable to do so. Staff support to meet people's nutritional needs did not always protect their dignity.

Staff received training to provide them with the skills and knowledge to care for people effectively.

People's health care needs were monitored. People were referred to the GP and other health care professionals as required.

Is the service caring?

Requires improvement

The service was not always caring. The majority of interactions we saw were positive, however we saw some interactions that did not protect people's dignity.

People were not always consulted about the care provided to them.

Is the service responsive?

Requires improvement

The service was not always responsive. Care plans were not always accurate in outlining people's care and support needs, and were not always being followed appropriately. People did not always receive sufficient stimulation within the home.

People using the service and their relatives were aware of how to use the home's complaints system.

Is the service well-led?

Requires improvement

The service was not always well-led. There were gaps in the systems in place to monitor the quality of the service people received.

The home's culture was not always open and transparent and people were not always encouraged to provide feedback.

Clovelly House Residential Home LTD

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.

The last inspection of the home took place in August 2013 at which the home was found to be compliant with the five outcomes inspected. This inspection took place on 12 February 2015 and 4 March 2015 and was unannounced on both days. The first day of the inspection was carried out by three inspectors and a professional advisor who was a nurse with knowledge of older people's needs and dementia.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service.

There were 47 people living at the home during our inspection. We spoke with twelve people who lived at the home, six relatives, and a health care professional who visited the home. We also spoke with five care staff, the head of care and the registered manager and we spent time observing care and support in communal areas.

Some people could not let us know what they thought about the home because they could not always communicate with us verbally. Because of this we spent time observing interactions between people and the staff who were supporting them. We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We wanted to check that the way staff spoke and interacted with people had a positive effect on their well-being.

We inspected the home premises including 26 bedrooms and all bathrooms within the home. We also looked at a sample of twelve care records of people who lived at the home, seven staff records, and records related to the management of the service.

Following the inspection we spoke with three relatives of people living at the home and two health and social care professionals by telephone.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe in the home. However our observations during the inspection indicated that some risks were not addressed. Relatives of people living at the home were positive about the safety of the service. One relative noted "Staff are polite but they are overworked."

We were concerned to find no action recorded to report or seek medical advice for significant unexplained bruising for one person living at the home during September to November 2014. The bruising was recorded on four dates during this time period, however no incident form was completed and medical advice was not sought. No investigation was undertaken nor was a safeguarding referral considered as this could have been the result of abuse or poor moving and handling practices. The person saw their GP once during this time period for a general check up, but with no mention of the bruising.

The above information was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments in people's care records enabled other risks to be managed effectively, and these were reviewed at least monthly. Staff told us that they had training and demonstrated an understanding of action to take in some emergencies such as choking or stopping breathing.

We found that medicines were not always administered safely. At 8.50am, on the morning of the first day of the inspection, we observed medicines in the form of three tablets left in front of one person sitting unattended at a table in one of the lounges. This person used a spoon to move them around but was not able to pick them up. There were no staff in the room at this time, and somebody else could have picked up the tablets. At 9am a staff member came in and gave this person cornflakes and prompted them to take their tablets.

Medicines to be given as required (known as PRN) were given to several people who exhibited challenging behaviour, as prescribed. However we were concerned to find that the instructions for administration for one person prescribed such medicines indicated that they should be given if the person did not 'cooperate' which left these medicines open to misuse. Staff were unable to explain clear guidelines as to when these medicines should be administered.

The above was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the Medicines Administration Records and stocks of medicines for ten people living at the home. People had their allergy status recorded to reduce the risk of inappropriate prescribing. Medicines were stored in locked cabinets. We did not find any gaps in the records or inconsistencies between the stocks and records.

Staff told us that medicines were only administered by senior staff, who had undertaken the appropriate training. People living at the home told us that they were given their medicines on time, however four people said that staff did not always explain what the medicines were for. We checked records of controlled medicines and found that these were stored and recorded appropriately.

Relatives and health professionals that we spoke with did not have any concerns over the safety of people living at the home from abuse. People living at the home and relatives told us that they could talk to staff if they were worried about anything. However we did find that one person living at the home and one staff member were anxious to ensure that the manager would not know what they had said to us about the service.

Staff members we spoke with told us that they had received safeguarding training and we saw certificates to confirm this. Staff were able to describe the signs and symptoms of abuse. They were aware of the procedure for reporting concerns and the home's whistleblowing procedure. All staff spoken with told us that they did not use any physical restraint within the home, and if somebody was exhibiting behaviour that challenged they would provide verbal reassurance, and provide them with time to calm down if needed. We found records to show that bruises were recorded in people's daily records as they were found, although at the time of the inspection these were not recorded on body map charts. The manager

Inadequate

Is the service safe?

advised that body maps were being introduced by the time of the second inspection visit. People's monies were not kept for safekeeping by the home, instead people were invoiced for expenses.

People living at the home and their relatives were satisfied with the support staff provided them with, although they noted that there had been a lot of changes within the staff team resulting in a lack of continuity of care. Three people said that staff were always very busy, and two people told us that the staff did not always understand them. One person said "The staff change and they don't know my routines."

Most staff told us that there were enough staff available to ensure people were well cared for. Two staff members said that they needed more staff in certain lounges to be able to provide activities and stimulation for people living at the home, support at mealtimes and ensure care plans were kept up to date. One staff member said "There is not enough time to give people proper personal care because of too many residents to get up."

Our observations on the first day of the inspection indicated that there were not sufficient staff members to provide person centred care in one lounge, with staff having time to undertake care tasks only, and no stimulation provided. Two care plans noted "Staff to be vigilant and never leave the lounge unattended," but we observed that staff did leave this lounge unattended as two staff were needed to help some people with personal care and mobilising. The manager indicated that the circumstances on this day were influenced by the presence of the inspection team and their time demands on the staff team, and two staff being off sick on this day. We did not see this lounge being left unattended on the second day of the inspection.

We looked at the staffing rota for the previous month and the week of the inspection. These indicated that there were at least nine staff on during the morning (including the head of care), six staff on in the afternoon and four staff on duty at night. Agency staff were used in the home occasionally when other cover was not available, and extra staff were booked to escort people to hospital appointments. Staff said that sickness and absences were covered effectively. We were told that the home was fully staffed with no vacancies. The care team included a head of care, seven senior care assistants and eight care assistants. We were told that the night staff provided morning care for seven people at the end of their shift.

We did note that people getting up in the morning waited for their breakfast, which was served at 9am after staff had supported other people with personal care. We observed a long wait for lunch whilst staff supported people who required additional support in this area. This indicated that the number and deployment of staff within the home was in need of review to ensure that people's individual needs are met appropriately.

Safe recruitment procedures were in place to ensure that staff were suitable to work with people. Inspection of staff files, including those for newly recruited staff, showed evidence of people being checked for fitness to work. We saw records of disclosure and barring checks, written references, identity checks, copies of employment histories and qualifications, application forms and national insurance numbers. There were records of induction training, including observations of care provided, for new staff, however some of these were not dated, so it was not possible to verify if this had been provided promptly on employment. The manager advised that only staff with a national vocational care qualification and experience of working with people with dementia were recruited to provide care within the home.

Two people told us that they did not always have hot water available in their bedrooms, although we found this to be hot during our visit. We checked the heating and hot water in eight rooms across the home, and found this to be working. In the top floor flat the radiator was not working but an alternative heater had been provided. The manager was aware of some recent issues with the boiler but advised that this had been addressed.

People spoke highly of the cleanliness of the home. They told us "It is very clean here," and "The home always smells nice." The building was clean and in a good state or repair and decoration throughout. Where repairs were required we saw evidence that these were addressed swiftly, and appropriate health and safety certificates were available for the home. Kitchen inspection checklists were available to ensure that food hygiene procedures were followed, and at the most recent environmental health inspection of the kitchen in June 2014, a five star rating (excellent) was awarded.

Inadequate

Is the service effective?

Our findings

People spoke positively about the support provided by staff. People told us, "They look after me very well here," "I get what I want to eat," and "The staff are good." However we found that people's consent to care was not recorded, and it was not clear whether people's choices were always respected.

Care records included a section on mental capacity, however they did not make it clear as to whether people had capacity to make specific decisions about their care and treatment, or detail best interest decisions made for those who were unable to do so. Staff had received training on the Mental Capacity Act 2005 (MCA). They could explain the process to be followed if they believed that people were not able to consent and make decisions about their care and treatment. Two people had a Deprivation of Liberty Safeguard (DoLS) in place. The manager was aware of the duty to ensure that further DoLS applications were made in the light of the most recent Supreme Court Judgement, however this had not yet been undertaken.

During our visits we observed the placement of furniture in the room which may have had the effect of restricting some people's movements. We also saw clear physical (although gentle) and verbal restriction of people's movements, when they attempted to wander out of one of the lounges. In two cases this appeared to be causing the people concerned distress as their attempts to get up and walk around were repeatedly stopped. We asked staff why they were not allowed to walk around, and staff advised that this was for their wellbeing, however it was not clear that all other avenues for protecting them had been explored.

Bedrooms had a basic summary care plan displayed so all staff knew the person's preferred getting up time, likes/dislikes, and important care needs. Only one plan seen said the person wanted to get up before 7.30am, and two said "8 am onwards." On our arrival in the home at 8.30am the great majority of people were up and waiting for breakfast in the lounges. Indicating that getting up times were not always according to people's preferences. One person told us that they would prefer to get up later, but that they did not have a choice noting "They are very strict." Another person said that they would probably prefer to have a lie in, "but I don't think that would be allowed." Another person said that they had been supported to get up at 6 am but this was not their choice. This lack of choice, or feeling that they did not have a choice, impacted on other aspects of life in the home, such as meal times and activities. One person told us "I don't know if I could go out with staff, I would have to have permission."

The above was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Forms were completed in some people's files to "allow a natural death." We noted that these were not recorded on the approved paperwork for medical professionals not to attempt resuscitation. The manager advised that she was addressing this issue by the second day of the inspection.

Most people told us that they were satisfied with the food served in the home. People told us "The food is very nice," and "There's what there is and if you don't like that you can have something else." Two people were less positive about the food and choices available. A relative said "They put themselves out, they make sure [my relative] drinks and eats."

People's nutritional needs were assessed and when they had particular preferences regarding their diet these were recorded in their care plan. Drinks and snacks were available at set times throughout the day. However we were concerned that not all people living at the home had a choice of food at mealtimes and the home's practices in this area did not always protect people's dignity. In some lounges there were not enough spaces at the dining tables for all people in the room, and many ate at side tables in their armchairs, meaning they stayed in the same seat throughout the day. People waited for their breakfast to be served at 9 am despite many of them having been assisted to get up earlier. At breakfast time, we observed that plates were pre-prepared, with toast already buttered, cold and covered with cling film, and sugar already on the cereal. We did not see people being given a choice at the time that breakfast was served. Throughout the day tea was served preprepared with milk, rather than to the taste of each individual person. There were no choices of biscuits with tea, and each person was given the same. Other drinks were provided including coffee, juice and water at other times.

At lunchtime, people identified as not eating well, were supported to eat first in each lounge. One person became

Is the service effective?

anxious asking when they were going to eat, as they had waited for 38 minutes, while the first serving of lunch was undertaken. We observed that most people were told what was for lunch, with a small number asked what they would like. We were told that people were asked earlier in the day for their choices for lunch.

We asked staff about preparing meals for people with special dietary requirements and people's likes and dislikes. Staff were aware of people who had particular dietary needs, and we saw an alternative menu book recording alternatives provided to them from the main menu. There were also dietitian instructions available in the kitchen for particular people.

Staff provided frequent food and drink and were clearly trying to ensure that people ate and drank enough, however the support did not always protect their dignity. On three occasions we observed one staff member putting a cup or spoon to someone's mouth without asking or telling them what they were doing.

The above four paragraphs contributed to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who had the necessary training to meet their needs. Staff who had recently started to work at the home had completed induction training. Training records showed that most staff had completed all areas of mandatory training in line with the provider's policy, and those who had not had been identified and were due to complete this training. Staff also had specific training on dementia, and managing behaviour that challenged. Care staff had attained a national vocational qualification in care, with many staff trained to a higher qualification. A training matrix chart was used to identify when staff needed training, however this did not include the dates on which training was completed to ensure that updates were provided promptly.

Staff told us that they received regular supervision in their work with people. Staff records showed that staff had received supervision sessions approximately two-monthly and annual appraisals in line with the provider's policy. Records showed that some supervision sessions were themed, to cover a relevant area of training. Observations of staff members' work with people took place as part of their supervision.

People were supported to access the health care they needed. They told us that they were able to see their GP and other health professionals when they wanted. Relatives said that they were kept up to date with their relative's medical situation. Care records showed that the service consulted relevant health professionals including district nurses, community psychiatric nurses, dentists, opticians and chiropodists about people's needs. Two health professionals told us that they were happy with the support provided by the home in meeting people's health and social care needs.

Risk assessments were in place describing preventative measures to protect people from identified health risks such as developing pressure sores. At the time of the inspection no one living in the home had a pressure sore. People's weights were monitored regularly with appropriate support plans put in place to address people who were losing weight. Staff described action they would take to support someone whose weight was of concern including consulting with their relatives, providing supplements and fortification (on the advice of a dietitian or GP), GP monitoring, and referral to a speech and language therapist or dietitian if needed.

We found that the building was difficult to navigate for people with dementia or cognitive impairment. For example there were no names or distinguishing features on people's doors, and the layout of three attached houses could be confusing. The manager pointed out some signs that could be used to navigate, however these were quite subtle and not easy for someone with cognitive difficulty to follow.

Requires improvement

Is the service caring?

Our findings

People told us that they or their relatives were treated with kindness and respect and staff responded to their views regarding how they wished their needs to be met. They said, "I'm very happy with the care," "I'm very well cared for," "I'm not unhappy," "Very pleasant staff," and "Nothing is too much trouble." Relatives were also very positive, and told us "We feel very lucky and grateful," "We're delighted," "They allow [my relative] to be as independent as possible, "[My relative] is very happy here," "They are wonderful - always attentive," "I can't praise the staff enough always very helpful," and "It feels like a home from home."

However, although we observed some good interactions between staff and people living at the home, we found that people's dignity and choices were not always respected. We observed one staff member supporting people with eating, drinking and other tasks without speaking to them, and a lack of choice for some people of when to get up, have meals, or where they spent their day.

One person asked nine times to be helped to leave the table before staff responded, even though they were in the room throughout.

In one person's care plan, it was recorded "Staff to be very firm in their approach to X. The reasons for exercise must be explained very clearly without entering into discussion." This did not reflect a person centred and respectful approach. This person's observed care also demonstrated a lack of respect for their choice of how and where they wished to spend their time, as they were repeatedly prompted to return to their seat in one of the lounges.

In one lounge approximately six people had to watch four people eating for 40 minutes before their lunch was served, as people who needed more support were served first. On one occasion we observed a staff member telling somebody to sit down in a reprimanding tone. We observed different reactions from staff to a person who was crying. One staff member tried to joke with this person and cheer them up, and this worked well as the person was distracted. On two other occasions when this person cried staff ignored them. We were told that it was best not to give this person attention as this "oxygenates" the distress. However this person's care plan, indicated that staff should try to reassure or distract them, give one to one attention and encourage them to take part in activities.

The information in the above three paragraphs further contributed to a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In other cases we saw staff providing positive care and support to people in the home. For example one staff member provided unhurried, sensitive support for someone with their hearing aid. They spoke to people with compassion and kindness. The relationships appeared warm and people spoke positively about care workers. Overall the majority of staff interactions were positive.

The majority of bedrooms were personalised and homely. Throughout the day we observed staff knocking on bedroom doors prior to entering to ensure people had privacy. One staff member told us that dementia training had been very helpful in their role, and that they always read people's care plans and personal histories "so we know what care people want from us."

People were encouraged to feedback about their experience of care in the home at resident meetings held on a regular basis.

One relative told us that they were impressed at how sensitively the home had discussed the issue of their relative's end of life care with them. Health and social care professionals told us that staff were very friendly and helpful. Staff showed an understanding of people's needs with regards to their disabilities, race, sexual orientation and gender. Care records showed that staff supported people to practice their religion, attend places of worship or have religious services within the home.

Requires improvement

Is the service responsive?

Our findings

Most people were satisfied with the responsiveness of staff in the home. People told us, “Staff are good,” “If you need them for anything they are here,” and “If I press the red button call bell they are here in a second.” Three people told us, “Staff don’t always understand what you say,” “Staff don’t really understand me,” and “Staff change and don’t know my routines.” Although people did not complain about activities provided, we observed a lack of sufficient stimulation for most people living in the home.

In the morning on our arrival at 8.30am, the majority of people were up and sitting in the lounges, either sleeping or sitting unoccupied waiting for breakfast at 9 am. In one lounge the TV was on but nobody was watching t. Another lounge did not have the television on or any other stimulation until 3.15pm when some music was played. Prior to this there was nothing for people to do, no objects to touch, or books or magazines to look at or read. Two people who were repeatedly told to sit in their chairs, had no other stimulation, apart from one of them being taken for a short walk along the corridor. The manager advised that this situation may have been influenced by the presence of the inspection team on this day. We have taken this into account in forming a judgement about the service.

One person was seen reading a newspaper. In the afternoon an instrumentalist performer provided a session for a group of people. Other activities recorded for people included art therapy, mobility sessions, bingo, cards, reminiscence, knitting, church services, and singing and two people attended a day centre. We were told that at least one person went out every day, with group trips out arranged twice weekly. However people’s daily records and activity records of the last two months prior to this inspection did not reflect this. However we did note an increase in trips out recorded between the first and second day of the inspection including five trips to the park, and walks in the garden.

The layout of care records for people living in the home included life and medical histories, likes and dislikes, personal care, plans to maintain health and mobility, medicines, significant social contacts, thoughts about being retired, emotional needs, risk assessments and behavioural charts.

However we were concerned to note some shortfalls and inaccuracies in care records inspected. The risk assessment and care plan for one person who had fallen from their bed, had not been updated to clarify the support in place to protect them from repeat injury. Care plan agreements for people had not always been completed by them or a representative if they were unable to do so to confirm their involvement in the planning, and those spoken with were not aware of the contents of these plans. The provider advised that efforts were made to gain written confirmation of people's consultation but this was not always possible.One person’s care plan indicated that they needed one staff member to support them with mobility, however it was clear from observing staff supporting them, that two staff members were required for every transfer, and this was being provided. The care plan was being reviewed monthly however it was not accurate.

A care plan for one person indicated that they spent their day in one of the lounges. Our observations indicated that this was not this person’s choice, as they clearly expressed a repeated wish to go to their room throughout the day. This person’s care plan indicated that they should be encouraged to maintain regular walks throughout the day. However our observations indicated that this person was actively discouraged from taking walks on the first day of the inspection. An assessment suggested positive ideas for activities for this person, but none were included in their care plan. In fact, although the care plan indicated that they enjoyed being busy and active, our observations were that they were not offered any stimulation on that day and became increasingly distressed as the day went on.

Another person’s care plan indicated that staff should ensure that they participated in constant activity, and that they needed conversation and stimulation. Our observations did not show any evidence that this was carried out by staff.

The information in the above five paragraphs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Family members spoke very positively about the support provided to their relatives in the home. They told us “[My relative] is always washed and dressed,” and “is as happy

Requires improvement

Is the service responsive?

as [my relative] can be." They said that they were always informed of any changes in their relatives' conditions, including prescribed medicines, and the outcome of any health appointments.

Monitoring records were in place for people who were at risk of pressure sores, or weight or fluid loss. There were also behavioural monitoring records for people who had behaviour that challenged.

Health and social care professionals had no concerns about the staff support within the home other than the changes to the staff team which had an impact on the continuity of care.

People living at the home and relatives we spoke with said that they knew how to make a complaint. They were confident that if they made a complaint this would be listen to. However we did find that some people did not feel happy to express verbal concerns during our inspection.

Copies of the complaints procedure were available in the service. Staff told us that if anyone wished to make a complaint they would advise them to speak with the manager and inform the manager about this, so the situation could be addressed promptly. Records showed that when issues had been raised these had been investigated and feedback was given to the people concerned. Complaints were used as part of on-going learning by the service so that improvements could be made to the care people received. People were also encouraged to discuss their views about the home at residents meetings.

Requires improvement

Is the service well-led?

Our findings

People and their relatives spoke positively about the management of the home. Relatives told us, "This is one of the good homes," and said that the management were "very accommodating," "very friendly," and "very helpful." However our findings during the inspection indicated that there were some shortfalls in the management of the service.

Relatives told us that the service had been affected by a lot of changes within the staff team, or as one relative described it, "a constant manoeuvre of staff." The manager confirmed that the home had recently lost a number of staff to posts in the NHS.

We were concerned to find that the management were not aware of the breaches that we found during the inspection, indicating that their auditing procedures were not effective. We asked about quality assurance measures in place, however although the manager said that audits were undertaken we did not see evidence of any recent quality assurance audits in the home. We were told that staff and resident surveys were conducted every year.

We found that the manager had not taken action to ensure that some accidents or incidents were recorded and addressed appropriately. This included significant unexplained bruising to one person, and a suspected fall for one person (found on the floor) both of which were recorded in people's daily records without an accident/ incident form being completed. In both cases it was not evident that appropriate action had been taken to protect these people from a reoccurrence, and their care plans and risk assessments had not been updated.

We saw many compliments from people's relatives about the service. However it was not evident that there was an open culture in which people were encouraged to speak up about their concerns on a daily basis. We observed that two people were reluctant to express their concerns during the inspection visit. One person was given custard with their dessert and told us "I don't like it, but I don't want to complain." Another person was worried about being 'told off' if they talked to us about issues of concern to them.

The information in the above three paragraphs was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that the management were open to suggestions they made, and ensured they were meeting people's needs. They told us, "They are there for you," and "We work as a team." Staff were clear about their roles and responsibilities and attended monthly team meetings to discuss the way the home was operating. The most recent staff survey conducted in 2014 showed that staff were generally satisfied with working conditions but felt that they were not always sufficiently consulted about changes in the home.

Staff advised that they reported any items which needed to be repaired to the manager, and these were addressed swiftly. We saw records of regular fire drills and records confirmed that there were also regular fire bell checks and servicing of alarms and fire-fighting equipment as appropriate. A fire risk assessment and evacuation plan were in place, and appropriate safety certificates were available for the building.

Health and social care professionals we spoke with told us they did not have concerns about this home and its management. They said that the home was working well with other agencies to make sure people received their care in a joined up way.

The home was accredited with the Gold Standards Framework for end of life care, and participating in a research study on pain relief in dementia.

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 People were not protected against the risks associated with receiving care that was inappropriate or unsafe because of insufficiently rigorous care planning and care provision and steps taken to address incidents within the home. Regulation 9(1)(a)(b)(i)(ii) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 9(1)(a)(b)(c)(3)(a)(b)(c)(d)(f)(g)(Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People were not protected against the risks of inappropriate care due to an insufficiently effective system for assessing and monitoring the quality of the services provided. Regulation 10(1)(a)(b)(c)(i) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 17(1)(2)(a)(b)(Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected against the risks associated with the unsafe administration of medicines. Regulation

This section is primarily information for the provider

Action we have told the provider to take

13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 12(2)(g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People's dignity was not always protected and support did not always have due regard to their preferences. Regulation 17(1)(a)(b)(2)(a)(b)(c)(ii) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 10(1)(2)(b)Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Arrangements were not in place to ensure that people's consent was always sought where possible, and best interest decisions were made for people who were unable to consent to their care. Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, this corresponds to Regulation 11(1)(3)Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.