Laudcare Limited

Blackwell Vale Care Home

Inspection report

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Date of inspection visit: 7 and 8 December 2014
Date of publication: 09/03/2015

Ratings

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

Overall summary

This unannounced inspection took place on 7 and 8 December 2014. This visit was to check if compliance actions from the last inspection had been met and because of concerns about staffing and standards of care that had been raised with us.

We last inspected Blackwell Vale Care Home on 26 March 2014 and at that inspection we had found that the registered provider had not always obtained appropriate information with regard to consent in relation to care and treatment. The registered provider wrote to us and gave us an action plan saying how and by what date they intended to make changes to their systems.

We found that the registered provider had made the improvements needed from the previous visits. However at this inspection we found that there were others breaches of regulations that had an impact on people living in the home.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to making sure there were sufficient staff, with the right skills to meet the needs of people who used the service. We also found that people were not being protected against the risk of unsafe care because the registered provider

Summary of findings

had not made sure that all aspects of service provision were being regularly monitored for effectiveness. You can see what action we told the provider to take at the back of the full version of this report.

Blackwell Vale Care Home provides nursing and personal care to 60 older people. The home has two floors, the upper floor accommodates people with dementia illnesses and the ground floor is designated to general nursing and residential care. Both floors have separate dining and communal areas and all of the bedrooms in the home are for single occupancy.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

We found that there were not always staff available on the units to provide support to people to meet all their needs promptly. We also found that training and staff support was not being well monitored so people could be sure all staff had the right skills and experience to support them. Most training was via e-learning and there was a reliance on staff to monitor their own training rather than this be ensured by the registered provider.

The systems used to assess the quality of the service had not identified all the issues that we found during the inspection. Whilst we found that some aspects of the quality monitoring processes were being done well others were less well monitored.

We found that people living at Blackwell Vale Care Home were able to see their friends and families as they wanted.

There were no restrictions on when people could visit them. We could see that people were able to follow their own faiths. People living there and visiting relatives told us that staff were "good" and "kind".

There were areas of the premises and equipment that were in need of improvement and upgrading to meet the needs of the people living there. There was evidence that this had been assessed and action was underway to make improvements to the environment and premises. The work was underway and plans indicated that the improvements would make the environment more supportive of the needs of people with dementia.

People's needs had been assessed and care plans developed. Although medicines were being stored appropriately they were not always being administered in line with good practice and the home's policies and procedures.There were suitable hoists and moving aids in use in the home to assist with the different mobility needs of people living there.

There was information in care plans that showed the staff had discussed with people if they wished to be resuscitated should their health conditions change. The service had policies in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, staff and management did not demonstrate a clear understanding of the procedures in regard to a situation regarding a possible deprivation of a person's liberty that we found during the inspection.

The home had safe systems when new staff were recruited and all staff had appropriate security checks before starting work. The staff employed at Blackwell Vale Care Home were aware of their responsibility to protect people from harm or abuse. They knew the action to take if they were concerned about the safety or welfare of an individual.

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

This service was not safe. People who lived in the home were placed at risk because there were not always enough experienced and suitably skilled staff available to provide the support people needed when they needed it. It was not safe because medicines were not always well managed and recorded.

The premises were in need of repair and refurbishment and the registered provider had plans in place to carry out the necessary work to make the environment safer, more accessible and a more pleasant place to live.

Staff were being recruited safely and knew how to recognise and report abuse.

Is the service effective?

Inadequate

The service was not effective. Some information in the care plans lacked information or detailed management plans. This was needed to provide staff with sufficient and up to date information to be sure of always providing the most effective support to people.

Information was not available to staff on people's hydration needs and this and the poor assessment, recording and monitoring of fluid intake could put people at risk of dehydration.

We found a lack of clarity from nursing staff and management around their understanding and application of Deprivation of Liberty safeguards.

Systems to provide staff training were in place but were not well supervised to ensure staff always had the right training and support for their roles.

Is the service caring?

Good

This service was caring. People's privacy was protected and promoted and we saw that where staff engaged with people it was friendly and polite.

People were able to see personal and professional visitors in private. Family members spoken with confirmed they could visit whenever they wished.We could see that people had been supported to attend religious services and take communion as they wanted.

Is the service responsive?

Inadequate

The service was not responsive to people's individual needs as their assessed needs were not always planned for, evaluated or delivered consistently. In some cases, this meant that people were also not having their individual preferences met.

People were supported to maintain relationships with friends and relatives.

There was a system in place to receive and handle complaints or concerns.

Summary of findings

Is the service well-led?

The service was not well-led. Although there were systems to assess the quality of the service provided in the home we found that not all aspects of care had been effectively monitored.

Staff training needs had not been effectively monitored to make sure that all staff had received training appropriate to their role. Complaints were not well monitored to help ensure lessons were learned and that the situation did not arise again.

Requires Improvement

Blackwell Vale Care 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 was 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 7 and 8 December 2014 and was unannounced. The inspection was carried out by two adult social care inspectors, a pharmacist inspector and a specialist advisor in dementia care.

Over the two days of the inspection we spoke with 12 people who lived in the home, seven relatives/visitors, five nursing staff, six care staff, three ancillary staff, the registered manager and deputy manager, the service's dementia care project manager and their regional director. We observed care and support in communal areas and spoke to people in private and communal areas. We also spent time looking at records, which included looking at 13 people's risk assessments and care plans to help us track how their care was being planned and delivered.

We also looked at staff rotas, staff training and supervision, records relating to the management of the service and records regarding how quality was being monitored.

The pharmacy inspector carried out a detailed inspection of medicine management, storage, administration and disposal. As part of the inspection we also looked at records, medicines and care plans relating to the use of medicines.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. It is a tool to help us assess the quality of interactions between people who use a service and the staff who support them. This was done over the lunch time period on both the ground and first floor units.

Before our inspection we reviewed the information we held about the service. We also contacted the local authority and social workers who came into contact with the home to get their views of the home. We looked at the information we held about notifications sent to us about incidents affecting the service and people living there. We looked at the information we held on safeguarding referrals, concerns raised with us and applications the manager had made under deprivation of liberty safeguards.

Inadequate

Is the service safe?

Our findings

We observed evidence that demonstrated to us a breach of Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked people living there about the staff and the availability of staff. One person told us, "There seems to be some discontent at the moment with staff staying off and ringing in so there isn't enough". We spoke with one person living in the home at 10.15 am who had just finished their breakfast. They told us, "There are not many staff so it's always well after nine when I get breakfast".

On both days of the inspection we found that there was only one person on the ground floor that was up and having their breakfast at 09.10. We heard other people calling out for their breakfast during the morning and spoke with three of these people. At 09.30 one person told us they wanted to have their breakfast and said "I'm starving". We asked staff to assist this person to sit up in bed and get their breakfast for them.

We asked relatives about the availability of the staff on duty. One relative told us, "The staff are very good but there isn't enough on duty as my relative sometimes has to wait some time for a carer to take her to the toilet". Another relative told us they had moved their loved one from another home and that, "It is heaps better here and I should know as I come in twice each day in the afternoon and in the evening. The staff are very good here, although they could do with some more, as there never seems enough".

The registered provider had a tool for assessing the 'indicative staffing level' required to support people's needs. This was based upon assessed needs for both people with continuing care nursing and residential care needs and assessed levels of dependency. It did not take into account the layout of the premises, the skill mix required for complex individual needs or differentiate between staff providing specific nursing care interventions and high dependency personal care interventions.

Staff we spoke with told us that there were times when staff levels were low so there were not enough staff on duty to make sure people were supervised, supported and that their needs were promptly met. Staff we spoke with said they could be moved around, change shifts and come in at short notice to try to maintain staff numbers.

The first floor had 26 people living there on two separate units with 16 on one and 10 on the other. On the first floor staff told us that "Sometimes there are two carers, sometimes three" on each of the two units. We saw there were two care support assistants on each of the two units and one 'runner' working between the two units. We looked at the rotas for both floors for the previous five weeks and could see that staff numbers had fluctuated below the service's 'indicative staffing levels' on day and night shifts due to staff absences. Alterations to the rotas made it difficult to see exactly how, and by whom, shifts had been covered.

Care records for people on the first floor unit showed one person was in need of one to one support and that would mean one staff member attending to this need so taking them out of staff numbers. At one point the two available care assistants were helping a person shower and the nurse was with the doctor. There were no staff available to supervise or assist someone should they need it.

The nurse on the first floor had to split their time between the two units, where people with dementia lived. We asked how they managed care for people whilst not on a unit. We were told that usually they delegated tasks to a senior carer but rotas for the last five weeks showed the only senior care assistant on the rota had been off. Therefore the nurse would have to delegate to care staff that may not have had the appropriate skills.

On the ground floor units, there was one registered nurse and three care assistants during the morning. Staff told us there should have been four care assistants but one called in sick. We observed the lunch time meals and saw that the staffing levels at meal times did not allow for a member of staff to check that people who were eating in their rooms were getting the support they needed to eat their food. We saw that there were not sufficient staff to provide people with the support they needed at the time they needed it and to make the mealtimes a meaningful and interactive experience. We saw two people on a first floor unit trying to eat a roast dinner with their fingers as there were no staff available to help them.

Our observations, the records we looked at, the responses to the questions we asked staff and the comments of people living there and their relatives indicated that there

were not always sufficient experienced and suitably skilled staff available at all times to meet people's individual personal and support needs. This was having an impact on people's experiences of living in the home.

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

We looked at medicines records, supplies and care plans relating to the use of medicines. We saw that consideration was given to the times that medicines were administered in order that any special label instructions such as 'before food' were followed. However, the actual times that paracetamol medicines were given was not recorded to evidence that enough time was left between each dose. Where new medicines were prescribed these were promptly started. However, nurses were not consistently following the home's policy for confirming people's medicines on first admission to the home, increasing the risk of mistakes.

The medicines administration records showed the treatment people had received. However, contrary to the home's medicines policy clear records were not always made to evidence the application of prescribed creams.

Written individual information was in place about the use of 'when required' medicines. However, clear records of the effectiveness of this intervention were not consistently made. For example for a person who was prescribed a 'when required' medicine to help reduce anxiety or agitation.

Stocks of medication were maintained to help enable continuity of treatment but on the day of the inspection one person had only one strength of a prescribed medicine available, increasing the number of tablets they had to take. A second person had only a one day supply of a medicine left when an order was placed, increasing the risk that new supplies would not be delivered on time to continue their medication as prescribed.

We checked all parts of the building and noted there was work to be done to bring the environment up to a good, safe standard and provide adequate storage facilities. For example the ground floor bathroom had a hole in the ceiling from a previous leak. The room could not be used as a bathroom, was being used for storage and smelt of damp.

We saw that other bathrooms and shower rooms were being used for storage. This meant that their proper use was compromised affecting people's access to bathing facilities.

We found that a corridor leading to a fire door was cluttered with items of furniture and equipment that could impede wheelchair access to the fire exit. An under stairs area off the corridor was used for storing incontinence pads for people. The packets of pads were open and contents spread over the floor with no appropriate storage off the ground to keep items separate and free from contamination.

We saw in parts of the home that wood work was chipped and there were exposed wooden surfaces that were not easily cleanable to help prevent cross infection. On Chadwick unit there was an unlocked room containing various items of furniture, also mattresses, light fittings, boxes, wheelchairs and also emollient creams and some people's incontinence pads. The doors to the room were not locked so anyone could go in. This could pose a hazard to people living there especially those with cognitive disorders. Staff told us that this room was going to be turned into a lounge for people when refurbishments were carried out.

The registered manager had carried out an environmental review and was able to show us the costing and quotations for the work to be done and permissions from the registered provider for the required level of capital expenditure. This included repairs and up grading some bathrooms and bathing aids, the new lounge area, new front door, more external storage areas, new signs, external painting and maintenance and the construction of a secure garden area incorporating a sensory garden. Work had begun on the garden areas. We will continue to monitor the progress of this improvement work.

There were procedures in place regarding the protection of vulnerable adults and the process for reporting it to the appropriate agencies. We spoke with nursing, care and ancillary staff who all told us that they would challenge poor practice and would report any safety concerns to the manager. The staff we spoke with told us that they had completed e- learning courses in recognising and reporting possible abuse.

The recruitment records we looked at indicated that systems were used to help ensure nursing and care staff

Inadequate

Is the service safe?

were only employed if they were suitable and safe to work in a care environment. Since our last inspection there had been 19 new staff employed. We saw that the checks and information required by law had been obtained before new staff had been offered employment in the home.

Inadequate

Is the service effective?

Our findings

At the last inspection of this service we identified concerns with arrangements in place for obtaining and acting in accordance with the consent of people living there in relation to care and treatment provided for them.

At this inspection we found that action had been taken to improve the systems in place to obtain valid consent from people and information on where someone held power of attorney for someone living there. We looked at records around end of life decisions including 'do not attempt cardio-pulmonary resuscitation' (DNACPR).

We could see where GP's had included people's views, their family and others involved in there care in the decision making process and mental capacity assessments. They had documented mental capacity assessments where there was doubt about a person ability to make a decision on this. We saw where one person had been assessed by the GP as having capacity to make this decision and the person had made their wishes clear and had been supported by family members.

We found from evidence there was of a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered provider had not ensured that people living in the home were being protected against the risks of inadequate hydration.

We spoke to a person who was having breakfast in the dining room on the ground floor. They told us that this was the best meal of the day as "The other meals are dreadful". They said they were "not really bothered" as they were moving to another care home. There were conflicting views on the food provided as other people we spoke with told us that they enjoyed their meals. We were told that they were "always nice" and another that "I've had enough to eat thank you, it was very nice".

We spoke with a person shouting out for their breakfast and we asked staff to bring this. Staff took their dishes away without asking the person if they had sufficient or would like more. The person told us they would like some more and that, "I could eat some more porridge if there is some". We asked care staff to get some more, which the person ate. This person told us that the previous day, "It was eleven o'clock before I got my breakfast, that's ridiculous". We asked staff if other people were still waiting to have their breakfasts and they were not sure who still wanted breakfast.

We looked at people's assessed nutritional needs and saw some of the people we spoke with had been assessed as needing support with meals and were at risk of weight loss. One person we spoke with had been awake early and fluid records indicated they had been given 80 mls of water at that time. It was over three hours since that and no hot drinks or food had been offered and they said they wanted their breakfast and a hot drink.

We saw that people were not always supported to drink enough to meet their nutrition and hydration needs. Charts were in place for recording what people had had to drink and how much liquid they should have. These were not always dated and none of the charts we saw stated what the required fluid intake was in line with individual's assessed needs. We could see on the charts that some people were receiving inadequate amounts of fluid. For example, according to one chart a person had received only 470 mls of fluid in a 24 hour period; another had 300mls in a 12 hour period and another 580mls in14 hour period. This could put these people at risk of dehydration. Care records showed that these people had recurrent urinary tract infections and so a high level of hydration was required.

We found evidence to indicate a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person had not ensured that all staff had received training and development appropriate to their roles.

We found that staff had not always received the training they needed to carry out their roles effectively. A system was in place to provide staff with training however it required improvement to ensure staff always had the required skills and knowledge to carry out their role. We asked staff about the training, development and supervision they had received. We were told that they did their training 'on line' by e-learning. We saw the records of the e-learning staff had completed and could see that all training was provided using this method, including basic life support training for the nursing staff, fire training, and conflict resolution for dealing with behaviours that

challenge and moving and handling. We were told by staff and the registered manager that there was a moving and handling trainer on staff for the practical aspects of this training.

The manager showed us the records of the e-learning staff had done and told us if they had not completed it all a letter was sent to them telling them to do so. However, we discussed this approach to monitoring training with the manager. We discussed that the responsibility for making sure all staff had the right skills and training before they worked on the units with the people living there, was the registered managers and the registered providers. Before any nurse or care assistant provided care the registered manager and provider needed to be certain that they had received all the training they needed. This was so people living there could be sure that their health and welfare needs were being met by competent staff. All training required for the roles should have been done and staff competence assessed not just a reminder letter sent to the staff member if it had not.

We spoke with some care staff who told us that they had not completed any training since starting and one who had not completed their moving and handling training. This meant that that staff member could not use mobility equipment to assist people and so limited some aspects of personal care they could provide. This lack of essential skills in effect reduced the provision of safe support available to people living there during the busy morning period. It also increased the work load of the remaining care assistants.

However some staff we spoke with told us that they had received an induction and had spent time shadowing more experienced staff when they had started work. This indicated that there may be a lack of consistency in the training staff had received.

We saw procedures were in place for the use of a syringe driver (a pump that delivers a measured dose of a medication) for the provision of palliative care. The procedures stated that all staff using this must be personally competent in their use and a log kept of staff that were trained and competent to use such devices through the training course 'The Management of Infusion System'. We asked for the record of the training provided on this. There were no records available of this or any other training on the use of that piece of equipment to make sure staff using it were competent to do so.

We spoke with a new member of the nursing staff who was in their first nursing post since registration. They were in charge of the unit during their shift. There were no records of a preceptor programme in place during their six months working there. Preceptor programmes during the first year of registered nurse practice have been recommended by the Department of Health. Preceptors have an important role in ensuring successful transition of the newly qualified nurse, however they also require practical guidance on how best to support the nurse. The registered nurse supporting her had not done the training for this programme although the manager said this was being addressed. This meant that best practice was not being observed in supporting a new staff member.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). The Mental Capacity Act (MCA) and DoLS provide legal safeguards for people who may be unable to make decisions about their care. Training records showed that this training was available to staff by e-learning. However staff and management did not demonstrate a clear understanding of the procedures in regard to a situation we found affecting the liberty of a person living there.

We found a lack of clarity from nursing staff and management around the understanding and application of DoL safeguards. The manager told us that there were no Deprivation of Liberty Safeguards (DoLS) orders in place and that no applications had been made to a supervisory body. A member of staff told us that there was one order in place, although there were no care records on this to support that belief. We found there was one person who had received one to one supervision for 24 hours a day since their admission. Concerns had been raised by the registered manager in July 2014 about whether an application needed to be made to a supervisory body to make an assessment as to the restrictions on the person's liberty. We were told that the level of supervision had reduced at night but no plan was in place to support this either.

The registered manager told us they had spoken with social services about this but not acted to submit an application to a supervisory body. Where the registered manager

Inadequate

Is the service effective?

believes that a person's liberty is being curtailed it is their responsibility to make the appropriate applications to a supervisory body to ensure that a person's rights were upheld and their liberty respected.

We spoke with the service's dementia care project manager who was implementing the organisation's dementia care accreditation. This was called 'Positively Enriching and Enhancing Resident's Lives' (PEERL) and this had just commenced. The programme included an extensive range of in house training and person centred planning activities with the aim of improving the care and person centred support of people with dementia. A 12 month action plan was in place to help the service achieve the accreditation and was still at the early stages of implementation.

Good

Is the service caring?

Our findings

We spoke with people living at Blackwell Vale and with their visiting relatives about their care. One person living there told us that the staff were “Very good and kind” and another person said “I am very happy with my care and that the staff are very good”. Their relatives we spoke with also said they were happy with the care being provided.

We did see some good and genuinely caring interactions between staff and people living in the home. For example, staff singing songs with people and trying to engage people in conversations and discussions in the lounges. However this was limited as staff were very busy attending to personal care needs and they were not always available in the lounges to spend time with people. Where we did see staff supporting people with meals and drinks they did it in a gentle and friendly way. We saw that staff spoke in a respectful and polite way. A relative told us they had found that “They’re (staff) good, friendly and professional”.

People’s privacy was being respected. We saw that staff protected people's privacy by knocking on doors to private rooms before entering. We saw that staff maintained people’s personal dignity when assisting them with mobility and in using the mobility equipment they needed. All bedrooms at the home were used for single occupancy. This meant that people were able to spend time in private if they wished to.

We asked relatives if they were happy with the way people’s privacy and dignity was upheld in the home. One person told us, “I have no complaints really except that people do wander in and out of their room. This happens when I am here so I expect it happens when I am not”.

Visitors and people living there told us there were no restrictions on visiting and people could see their visitors where they wanted. We saw that bedroom doors were kept closed when people were being supported with personal care.

Bedrooms we saw had been personalised with people’s own belongings, such as photographs and ornaments to help people to feel at home. We saw staff talking to people in a polite and friendly manner and using their preferred names as stated in their care plans.

The management team told us that advocacy information was available in information leaflets in the foyer. However there were none there on the day of our visit for people to take and use. The manager said this would be addressed straight away. The manager had some details on file for contacting an advocate if someone wanted or needed this service.

Care plans contained some information on people’s wishes at the end of life and any religious or spiritual preferences. We could see that people had been supported to attend religious services and take holy communion as they wanted.

The service had not taken part in 'The Six Steps' palliative care programme, although the manager told us that this was being looked into with a view to taking part. The ‘Six Steps is a developmental programme aimed to enhance end of life care through facilitating organisational change and supporting staff to develop their roles to provide good care at the end of life care and so promote best practice. There were however procedures in place for staff to use following a death.

Inadequate

Is the service responsive?

Our findings

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

We spoke with people in their bedrooms and communal areas. They told us "The staff are very kind but I do stay in my room most of the day as there's not really anyone to speak to much". People told us that one of the main things they would like to change was "The cup of tea". The person said, "It is always too milky and never hot and I do so love a hot cup of tea". More than one person told us they were given "milky" and "tepid" tea and we were told, "They (staff) just give it to me they don't ask how I like it". We were told by one person "I hate milky tea but that's how it always comes and lukewarm. No one asks if I might want something different for a change".

We also spoke with one person at 10am, who was in their bedroom. They told us they wanted their breakfast but "no one has been in". We asked staff to bring some breakfast but the meal they brought was not what the person had asked for. We noted as we went around the home and observed staff as they went about their duties and spoke with people living there that staff were very busy and did not always ask people what they wanted for their breakfast, or how they wanted their tea or what juice they would like. Although people made positive comments to us about staff, we saw that care was mainly based around completing tasks and did not take high account of people's personal preferences. This indicated to us that people's individuality and preferences were not always being respected.

People's care records provided evidence that their needs were being assessed prior to admission to the home. The plans that were developed indicated that people had their personal and health assessed following their admission. The assessments included personal and daily care needs, mouth care, nutrition and mobility and moving and handling needs. However, people's assessed needs, were not always being reviewed frequently and planned or delivered consistently. In some cases, this meant that people were not having their individual care needs met.

For example, in one care plan we saw a person had an assessment of their mouth care needs that had not been reviewed for two months, despite their being an oral fungal infection requiring treatment. There was no management plan in place regarding the treatments being used and the plan to manage the problem and promote good oral care. Daily checks had not been completed to show when mouth care had been done and we saw that the person's lips were cracked and their mouth and tongue dry. We saw another person whose lips were cracked, had bled and were sticking together. Their care record stated they had just had mouth care although this was not evident from their condition. Their care plan had no management planning for their mouth care needs or evaluation of the treatment of the problem.

We also looked at records of positional changes for people assessed at risk of skin damage. We saw on the charts being used that for some people there had been long periods between repositioning. On the day we visited we saw for one person this was over six hours and that could increase their risk of skin damage.

People we spoke with in the lounges said had enjoyed the week's organised entertainment from school children singing carols and a male voice choir. There was a programme of organised activities that was delivered by the home's own activities coordinator.

The service had a complaints procedure that was available in the home for people. People who lived there we spoke with told us they had not felt the need to make a complaint but would feel comfortable raising anything they were not happy about. We were told by one person that they would "Speak to someone in charge if they had a complaint and if they didn't their daughter certainly would". We looked at the home's complaints log and could see that the registered manager had investigated complaints and responded in writing.

We found that equipment people needed was not always accessible to people to use. We could see from medication records that there was a person in the home who had been prescribed the end of life 'core drugs'. These were anticipatory medications and would be administered via a syringe driver should the person's condition change and they needed symptom control. The service did not have this piece of equipment ready for use when it was needed for the 'core' end of life drugs. The registered manager told us that if needed they would borrow one from another home belonging to the organisation. However this meant that if the syringe driver was required quickly should the person's condition deteriorate the person would have to

Inadequate

Is the service responsive?

wait until it could be obtained. This indicated that the service did not have the necessary equipment to respond to changes in a person's condition and symptom control needs.

We observed that people could not always summon assistance when they needed it. In one bedroom we found the call bell hung over the back of the bed so it could not be reached by the person in the bed. Another person could not use their bell as it would not reach them in bed because the flex was too short. This meant that these people could not be sure they could get staff help when they needed it.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in post as required by their registration with the CQC. The registered manager had been in post since March 2014.

We found there was evidence of a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Although there were systems to assess aspects of the quality of the service provided in the home we found that these were not always effective. We found that care records checks were not effective as management plans were not always in place for as assessed need or problem such as mouth care management. Care records were not always dated or being completed or did not contain the right information for staff to follow, such as the level of fluid intake people needed. We saw that positional change charts had not always been completed by staff. These things had not been revealed by the management checks in place and omissions had not been followed up by the management team to prevent a reoccurrence or address staff performance issues.

The registered manager told us that staff carried out checks within the home. They had carried out monthly checks or audits and we could see that they had taken action over environmental and premises work that needed to be done. Regular medicines audits were completed to help ensure that should any shortfalls be identified. Appropriate systems were in place for reporting and assessing medicines errors to help reduce the risk of reoccurrence.

Staff we asked told us that meal times were busy and staffing levels fluctuated on shifts. During our inspection we found that there were not enough staff over a meal time to provide the support that people with dementia required. There had been staff meetings to gather the views of the staff employed in the home, these had not identified that staffing needed to be reviewed to ensure people received the support they required.

We saw a complaint that had been made to the registered manager and the matter had been addressed through investigation and a written response. However we found that this process was not well monitored as we saw the same issues raised in the concern occurring during our inspection. This indicated to us that concerns raised were not monitored to make sure they did not reoccur and lessons were not being learned from the complaints made.

People we spoke with did not recall having regular meetings about how their home was run. Records indicated that people had the opportunity to attend meetings held for the people living there. People also told us that they could always talk to staff if they “wanted anything” or had a suggestion to make.

The service had procedures on how staff could raise concerns or ‘whistle blow’ and the support they would receive. Care staff we spoke with told us that they knew about this and told us they would challenge poor practice if they saw it and tell the nursing staff. All the staff we asked said that they would be confident to speak to the registered manager if they had any concerns about another staff member.

There was an accident and incident reporting system in place and the registered manager had made notifications to the Care Quality Commission (CQC) when they had been required to. This meant CQC could check that appropriate action had been taken.

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 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: The health, safety and welfare of people who used the service were not safeguarded because there were not sufficient staff available to meet people's needs and preferences. Regulation 22

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: The service's own policies and procedures and current best practice were not always being followed to ensure the effectiveness of medications and to help protect people from the risks associated with medication. Regulation13.

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 How the regulation was not being met:

This section is primarily information for the provider

Action we have told the provider to take

The registered provider had not ensured that people living in the home were being protected against the risks of inadequate hydration.

Regulation 14 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: The registered person had not ensured that all staff had received training and development appropriate to their roles. Regulation 23 (1)

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 How the regulation was not being met: The registered person was not always carrying out care to meet the person's individual needs and preferences. Regulation 9 (1)(b)

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 provision How the regulation was not being met: People were not protected against the risks of inappropriate or unsafe care or treatment.

This section is primarily information for the provider

Action we have told the provider to take

Regulation 10 (1) (a) (b)