Barchester Healthcare Homes LimitedBarchester Healthcare homes Ltd

BloomfieldBloomfield

Inspection Report

Salisbury Road
Paulton
Bath
Somerset
BS39 7BD.
Tel: 01761 417748
Website: www.barchester.com

Date of inspection visit: 17/04/2014
Date of publication: 17/09/2014

Contents

Summary of findings

Overall summary

Bloomfield is a care home that provides nursing and personal care for up to 102 people. At the time of the inspection there were 97 people using the service. The people who received care at the home were older people, some of whom were living with dementia.

When we visited there was a registered manager 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

On our arrival the door to the home was open; there was no receptionist on duty. People's safety could be put at risk because there was an inadequate system in place to monitor who enters and leaves the building. People could enter the home unchallenged.

People living with dementia did not always have their right to move freely around the home respected due to poor care practices, such as staff restricting people's movement by putting low tables in front of them. Not all staff demonstrated a good knowledge of dementia and how this impacted on a person's wellbeing which meant that staff did not consistently treat people with respect.

We found the majority of people had been involved in decisions about their care and the risks they took. People told us they were consulted about their needs and staff took action to meet these needs. However our observations concluded that not all staff treated people with the same level of respect and dignity. Some people received support to meet their needs; some of those living with dementia did not. This was particularly noted for people who were unable to express themselves verbally. No alternative methods of communication such as pictures or objects were considered by the staff to aid people.

Each person had a care plan that outlined their needs and the support required to meet those needs. People received care that met their physical needs. However, in one area of the home, we found there was limited support for the emotional and social needs of people living with dementia. Risk assessments had been written and measures had been put in place to minimise the risks identified by the assessments. However, the staff did not always follow these assessments, thereby putting people at risk of harm.

The system in place to ensure medicines were given as required was insufficient to protect people from the risk of the inappropriate use of medicines. The medicines auditing system had not recognised that one person was given medication on a daily basis that should have been given only when required. There was no recorded evidence that the person had required the medication at the times it had been given to the person.

People we spoke with said that staff treated them with kindness. We observed that staff assisted most people with their care needs in an unhurried manner. However we also saw that some people's privacy and dignity was not always respected through not offering them choice and treating them differently than other people living in the home.

There was a management structure in the home that provided people with clear lines of responsibility and accountability. The registered manager had carried out quality monitoring to assess the quality of care provided and plan ongoing improvements. These were not always effective because further audits had not been carried out where it was noted by the auditor that improvements were needed to ensure action had been taken.

There was always a nurse on duty whose role it was to ensure people's healthcare needs were met. The senior staff at the home provided leadership, guidance and support to other staff. However the arrangement for staff to talk with their line manager about how they supported people in order to ensure a professional and caring approach was being taken, was not happening. This meant that people may receive a service that is not good enough or poor practice may go unchallenged putting people at risk of harm.

We found the home was meeting the requirements of the Deprivation of Liberty Safeguards with systems in place to protect people's rights under the Mental Capacity Act 2005. However we also saw some care practices that could deprive people of their liberties.

Summary of findings

The concerns identified meant there had been breaches of the relevant regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010). You can see the action we have told the provider to take at the end 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.

Summary of findings

What people who use the service and those that matter to them say

During the inspection we spoke with seven people who lived at the home. We also spoke with two relatives.

People who lived at the home told us that staff were kind and polite. They told us they felt safe living at the home and that staff were kind to them. One person told us they could be “a bit forgetful” and how staff reassured them when they became anxious over things they had forgotten.

One person told us they had recently moved in and their family had spoken with the registered manager about their needs. They told us they were happy with the arrangements that had been made. Another person told us they knew about the care plans. They also told us that if they did not like anything about their care they just told staff and things changed stating “staff respond when you want to change something, I have no complaints”.

Other people told us about what it was like to live at the home and how they experienced care. One person told us the nurses “are very kind and if I need to see a doctor then this is arranged promptly”. Another person told us the staff “are always checking, I know it’s for my own good but I sometimes don’t feel like it”. They did go on to tell us that that their health had improved since coming into the home and they were grateful for all the attention they had received. One person told us the nurse had told them about their medicines, what it did and why they needed it. They told us this made them feel at ease as they did not like to take things when they did not know what the benefits were.

A visiting relative told us “The staff always tells me what’s going on with their relative, if they have been unwell or if they have had a good day, I come in most days, the care I see is good, and people seem happy living here”.

BloomfieldBloomfield

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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

This inspection was carried out on 16 April 2014. During the inspection we spent time talking with people who used the service, members of staff and visitors to the home. Some people who lived at the home were unable to verbally express their views. We therefore spent time observing care practices and interactions in the home. We spent time observing care in two areas of home and used a short observational framework inspection (SOFI) to observe staff and people's interaction during the lunch period. (A SOFI is a specific way of observing care to help us understand the experiences of people who could not talk to us.)

The inspection team consisted of two inspectors, a specialist advisor experienced in clinical health care needs and an expert by experience. The expert had personal experience of caring for older people living with dementia.

Before the inspection we reviewed the information we held about the home. At our last inspection on 29 November 2013 we did not identify any concerns with the care provided to people.

During this inspection we looked around the premises, spent time with people in their personal rooms and in dining rooms and lounges. We observed the main meal of the day at lunch time in two dining rooms in the home. We also looked at records which related to people's individual care and to the running of the home.

At the time of the inspection there were 97 people living at the home. We spoke with seven of these people and others briefly. We spoke with one visiting relative, twelve staff members, and the registered manager.

We reviewed seven people's care records and a selection of the home's policies and procedures.

Following our inspection we spoke with members of the local safeguarding authority about our findings.

Are services safe?

Our findings

The service did not provide a consistently safe service.

People's safety was put at risk because the systems in place to monitor who entered and left the building were not effective. We entered the building at 8.45am without having to call for someone to let us in. The door was open and we were not approached by any member of staff for two minutes. This meant that anyone could come and go unchallenged which could put people at risk.

We looked at seven people's care records in relation to how risks were managed. In four of the seven care records we found that people's care and treatment was not consistently planned and delivered in a way that ensured their safety and welfare. An example of this was seen in one person's care record that they had a speech and language therapy assessment. This assessment related to how safely a person can swallow, known as a SALT assessment. This assessment and the related care plan ensured the risk of choking was minimised for the person who had problems swallowing.

We saw this person being assisted at lunch time and that the meal contained gravy. We spoke with two staff who confirmed that the person was at risk of choking but could eat food such as gravy, ice cream and jelly. We looked at the SALT assessment and care plan which stated these foods needed to be avoided as they increased the person's risk of choking. Therefore the staff were aware of the risk of choking but were less clear about the foods to avoid thereby putting the person at risk of harm. The above demonstrates a breach of Regulation 9(1)(b)(i). You can see what action we told the provider to take at the back of the full version of the report.

When people behaved in a way that was challenging to staff and others the staff did not approach this behaviour consistently. We visited the ground floor of the home designated for the care of people living with dementia. We saw that people were engaged in activities and staff spent time talking with people and reassuring them when they became anxious. This meant that staff in this area were proactive in their support of people and had strategies to support people when they became distressed. On the first floor of the home also designated for the care of people living with dementia we observed there were no meaningful activities that enabled people to occupy themselves or support staff to involve them socially. We saw that staff spent their time telling people to "sit down" and not to "wander around". This meant that staff did not respect people's right to move around as they wished nor understood the needs of a person with dementia. One member of staff told us that a person had "ants in his pants" and would not keep still. They said to the person "keep your bum in the chair." This member of staff sat very close to the person with their hand on their arm meaning that the person was being discouraged from moving.

We observed a staff member place a low table in front of the person when they (staff) needed to leave the room. We observed other staff putting chairs and coffee tables in front of other people who were trying to walk around. This practice stopped people from moving when they chose to. We looked at these people's care records. There was no evidence that this restriction or practice was part of an agreed care plan. The staff demonstrated a lack of understanding of dementia and did not have effective systems to support people safely. This meant that people were placed at risk of trips and falls when trying to avoid furniture or moving freely as they chose. We fed this back to the registered manager who told us they look into this immediately. The above demonstrates a breach of Regulation 11 (1)(2)(a)(b). You can see what action we told the provider to take at the back of the full version of the report.

People were not consistently protected from the inappropriate use of medicines. We looked at one person's medicine records that evidenced they were receiving medicine for agitation on a "required needs" basis. This means that staff responsible and trained to give medicines can make a judgement as to when they consider it necessary for people to be given medicines as prescribed. The medicines records showed that, over a two work period prior to the inspection, the person was given medicines for "agitation" every morning. We looked at the person's care records and these did not evidence that the person had displayed any form of agitation during this period. This either meant the care records were inaccurate or the medicines were being inappropriately dispensed by staff putting the person at risk. The systems in place to ensure the appropriate use of medicines did not identify this issue which put people at risk of the inappropriate

Are services safe?

administration of medicines. The above demonstrates a breach of Regulation 13. You can see what action we told the provider to take at the back of the full version of the report.

We spoke with six people who told us the staff were kind and they felt safe at the home and with the staff who supported them. One person told us they could be "a bit forgetful" and how staff reassured them when they became anxious over things they had forgotten. This made them feel safe.

People who lived at the home, or their representatives, were involved in the assessment of risk and were able to make choices about how risks were managed. We saw risk assessments had been completed to make sure people were able to receive support and care with minimum risk to themselves and others. One person told us they had problems walking but liked to walk as this kept them mobile. They talked to us about the risks of falling and how staff tried to minimise these risks by either walking with them or just by being around.

People were safe because staffing levels were sufficient to meet people's needs. We looked at the staff rotas for the two weeks prior to the inspection. The registered manager told us during the day there were five nurses supported by 18 care staff in the morning and 16 care staff in the afternoon. At night there were three nurses supported by seven care staff. In addition to this the deputy manager, registered manager, and ancillary staff were available. We saw that these staffing levels were maintained.

People were protected against the risk of infections through the practices that staff used. There was a system in place to ensure the dirty laundry was separated to avoid cross contamination. Clinical and non-clinical waste was sorted in to separate colour coded bags and transferred to locked storage bins outside the home. The majority of the staff had received training in relation to infection control.

Two cleaners told us how they cleaned the home to ensure it was clean They told us there was a colour coding system in place used to ensure cleaning mops were only used in nominated areas identified by their colour. They also told us about their schedules of cleaning and the policies the home had in relation to infection control. We spoke to five staff who informed us who the nominated person was in relation to infection control and how they used this person for advice and guidance.

People were protected from harm as the home had a clear policy and procedure regarding safeguarding vulnerable adults. The home has informed the Care Quality Commission and other relevant authorities when allegations of abuse have been made. The registered manager had worked in co-operation with the appropriate agencies to ensure full investigations had been carried out and had taken action to minimise further risks to people living at the home.

People's human rights were recognised with regard to where they lived. However this was not consistent throughout the assessment process used at the home as initial assessments of need did not always consider people's capacity to make decisions. One application for a Deprivation of Liberty Safeguards authorisation had been submitted and proper policies and procedures were in place.

Staff told us they had received training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. We spoke with three staff about these issues and they were able to talk about how consent to receive care worked in practice. Their knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was adequate to ensure people were not unlawfully deprived of their liberty but we found they did not always demonstrate that they could put what they knew into practice.

Are services effective?

(for example, treatment is effective)

Our findings

The service was not consistently effective at meeting the needs of the people who used the service.

In four out of the seven care records viewed we found that people's care and treatment was not consistently planned and delivered in a way that ensured their safety and welfare. One care record stated that the person was at high risk as they were unable to call for assistance. The plan of care stated that an hourly check should be made on the person when they were in their room. The staff we spoke with were not aware of this plan. This care plan was not effective as there were no records to evidence that checks had been made and staff did not know about the checks which could put the person at risk of harm. The above demonstrates a breach of Regulation 20(1)(a). You can see what action we told the provider to take at the back of the full version of the report.

We spoke with five staff who were not nurses. They told us they had received training in areas that helped them support people with their needs such as dementia care, moving and handling, and health and safety issues. We observed that some of the staff did not demonstrate sufficient awareness of dementia. The staff in one area of the home providing care for people living with dementia did not demonstrate that they could put their training into practice. The care practices observed did not demonstrate they understood some of the specific needs of people living with dementia, such as the need to walk around.

We spoke with three people living in the part of the building designated to what the service called the "the care of the elderly and frail." One person told us how they were involved in decisions about their care and told us that staff spoke with them about their support needs. Another person told us they had recently moved in and their family had spoken with the registered manager about their needs. They told us they were happy with the arrangements that had been made. They also told us that if they did not like anything about their care, they just told staff and things change stating "staff respond when you want to change something, I have no complaints".

We looked at seven care records that showed that people who lived at the home, or people important to them, had been involved in an assessment of their needs. People were supported to have their views taken into account. An example of this was one person wished to not follow the advice of a health care specialist. A best interest decision meeting was held with the person, their relative, specialist and the registered manager of the home. The outcome was the specialist reviewed their advice and amended their proposed plan of care, and associated risk assessments to ensure the person's wishes were respected.

We looked at the systems in place for providing training and support to staff, including the arrangements in place for inducting new staff when they joined the organisation. The induction programme lasted twelve weeks and included subject matters such as person centred support, safeguarding, principles for implementing duty of care, mental capacity and equality and inclusion. The induction and training programme ensured staff had the right knowledge to meet the needs of the people living at the home.

One staff member we spoke with had recently taken up employment at the home. They told us that, although they were experienced in providing care, they had been required to carry out the corporate induction. They told us the induction training was "the best I ever had and very thorough".

People's end of life care wishes were included in the care records. We saw that staff had recorded family members' thoughts for people who were unable to state their wishes verbally. The staff we spoke with were aware of people's end of life care plans. The meant that people's wishes in this respect were fully recognised and respected.

The staff were organised to ensure key areas of care and support had a nominated staff member who would provide advice and guidance to other staff. For example nominated palliative care nurses from within the staff team were involved with people who were nearing the end of their life. There were also nominated staff responsible for areas such as falls, tissue viability and continence care. This meant that staff had access to another member of staff who had, or was developing, an expertise in specific areas of care who could provide support and guidance.

People's developing health care needs were understood by senior staff and action taken to ensure these needs were met. We observed the daily senior team meeting for the home where people's health care needs and plans to meet these needs were discussed. We also observed a doctor's visit with four people living at the home. We spoke with the

Are services effective?

(for example, treatment is effective)

doctor who told us the staff kept them informed of people's needs and worked well in ensuring health care needs were addressed. This showed the staff had identified areas of concern and had taken action to ensure that people received prompt and effective treatment.

Are services caring?

Our findings

The staff were caring but improvements were needed to make sure people received a personalised service.

People were not consistently supported to make choices and have their preferences respected. We observed lunch on the first floor of the area of the home supporting people living with dementia. The dining room did not have enough seats if everyone had requested to sit at the table, but they were not asked or encouraged to do so. People sat in the lounge chairs or sofas to eat their lunch. The people who sat at the dining room table were offered a choice of drinks and meals. They were shown the options of the meal choices. People who were sat in the lounge were not always offered the same choice and were just given a meal. They were not offered a choice of drinks. We looked at two people's care records to see if it was recorded what their drink preferences were but the records did not inform us. Therefore we were not able to establish if the people we observed had drinks that they preferred.

We observed that one person waited to be assisted for 25 minutes for their starter whilst others had already been served their main course. Those people who were independent and did not require assistance were treated with respect and dignity. Their choices and preferences were fully respected and it resembled a restaurant experience. The people who were eating in the lounge were not treated in the same way and had no choices offered and there was a lack of assistance to enable them to enjoy their meal. One person was sleeping and their soup was left in front of them until they woke up some 15 minutes later. People in the lounge were not encouraged to eat by staff who were not attentive to their needs.

We also saw the mealtime on the ground floor of the home for people with nursing or less complex needs. We saw that people who were more independent had an enjoyable meal sitting around the dining room tables with plenty of conversation. The staff spoke with this group of people and asked if they were enjoying their food and offered these people a range of drinks.

The people who required more support to eat their food or had not been offered a place at the dining room tables did not enjoy the same level of staff conversation or help. We observed they had to wait for 15 minutes before they were served their food and then only if they could support themselves. One person did not receive assistance to eat their lunch until after everyone else had eaten theirs. We saw they were frustrated by this as they could not communicate with staff and staff did not communicate with them or tell them when they would be assisted. We saw a staff member come into the room who was not on duty. They sat with the person and told them they would assist them when they came on shift and gave the person a hug. This reassured the person who sat and waited for other staff to support them.

The staff who were assisting people to eat, when they could not use their cutlery unassisted, did not talk with the person they were supporting with the exception of asking if the person had had enough to eat. We saw that one person was given food on a spoon too quickly by the staff which made the person cough to clear their throat as they had not finished the previous mouthful. The staff member who was helping the person did not appear to realise they needed to slow down and let the person eat at their own pace. The above observations at lunch time demonstrated that people who needed less help were treated differently than those who needed more help to eat their meal. These actions as detailed above did not respect all people's individuality and abilities. The above demonstrates a breach of Regulation 17(1)(a)(2)(a). You can see what action we told the provider to take at the back of the full version of the report.

We spoke with five people about whether their health care needs were met in a caring manner. People told us that staff were generally kind and caring. One person said "The staff are good and are always kind to them." Another person told us "When the staff help me they are kind and polite." One person told us the nurses "are very kind and if I need to see a doctor then this is arranged promptly" Another person told us the staff "are always checking, I know it's for my own good but I sometimes don't feel like it".

Staff met people's care needs in a caring manner, such as help to go to the toilet or help to stand. We observed that staff in some areas were attentive to people's needs and helped them when they became anxious but this was not consistent throughout the home. We observed people living with dementia on the ground floor of the home. We observed the staff that sat and talked with people, reassured them when they became anxious and provided

Are services caring?

them with things to do that interested them, such as talking about news events or recent visits by relatives. People were treated as individuals and staff took time to support people in a manner that respected their own individual abilities.

Part of the home was designated for people with nursing or less complex needs. We observed that those who were able to walk around were encouraged to go into the garden by the staff. The staff sat and talked with the people in the garden about things that interested them. We also observed that those who required assistance to move or required to be assisted from their chair to a wheelchair were not encouraged into the garden or offered the choice to join the more able people. This meant that some people missed the opportunity of a change of environment and an alternative social experience other than watching the television.

People's privacy was maintained. We observed a GP carrying out consultations with people living at the home. We saw that the GP was introduced to the person by the nurse and the person's door was then closed. This maintained the person's confidentiality and respected their privacy.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The service was not consistently responsive to people's needs and improvements were needed.

People were provided with social activities in some areas of the home, but not all. We spoke with three people in the area of the home providing care for people with nursing or less complex needs. They told us about the things they did and the things that interested them. One person told us "there is plenty to do if you want to, sometimes I join in sometimes I don't, it's my choice at the end of the day". We observed what was happening on the ground floor area where care was provided for people living with dementia. At the time of the inspection people were being supported to prepare cakes for baking. The staff were attentive to people's abilities and supported them when required.

We spent some time observing how people spent their time on the first floor area supporting people living with dementia. These people were not provided with social activities related to their interests or anything to do except watch television. One person living with dementia told us "there is nothing to do in here". We observed that people did not have conversations with staff with the exception of staff telling people to sit down. We did not see an activities programme for people living in this area that would demonstrate that what we observed was not typical. The above demonstrated that some people had things to occupy themselves with staff support but for others, their experience of activities or positive staff communication was poor. The above demonstrates a breach of Regulation 17(1)(a)(2)(a). You can see what action we told the provider to take at the back of the full version of the report.

We looked at the care records of three people living with dementia to see how people's mental capacity was established. The care records we viewed did not consistently consider issues of mental capacity during the initial assessment process. (the initial assessment process is where the home carries out an assessment of the person's needs to establish if they can meet these and to discuss with the person if the home is appropriate for them to live in) This may lead to a care service that is inappropriate as the person's ability to make decisions about moving in to the home may not have been properly considered.

The staff were organised to ensure that each person knew who their key worker was. A keyworker is a member of staff who is responsible for ensuring the person has a single point of contact within the staff team who knows their needs well and can discuss concerns with them, or people important to them. The staff members told us about the key worker system in place. They told us about some of the roles of key working such as ensuring that housekeeping issues were maintained regarding the person's room. They told us the key worker should know the person's needs well and they were usually the first point of contact for the family to discuss concerns or emerging issues.

However the key worker system did not work effectively in practice. Not all staff were responsive to people's needs as they did not demonstrate sufficient knowledge of the content of people's care records. We spoke with three staff on the first floor of the home supporting people living with dementia about the support needs of two people. Whilst they were able to tell us about some of the tasks they performed, such as washing and dressing, they were less clear about the plans in place to keep people safe. This was demonstrated in two people's care records that stated these people needed to be checked, on a regular basis to ensure their safety, as they could not use a call bell to summon assistance. The staff we spoke with, about these people but who were not keyworkers for them, were unaware of these instructions. This meant that the keyworker system did not effectively ensure that key areas of people's needs, such as risk, was not effectively communicated to other staff members putting people at risk of harm.

Staff encouraged friends and relatives to visit at any time of the day. This enabled people who lived at the service to maintain relationships with their friends and relatives. On the day of our inspection we observed that some people were being taken out by their relatives. We spoke with people in the nursing part of the home who told us that visitors are welcomed at any time. One person told us their relative often stayed for lunch with them. They told us this meant that their relative could stay longer and was less rushed. Another person told us that whilst they did not have any visitors they liked to see their friend's visitors and often chatted with them.

The home worked with other health care professionals to meet people's needs. Some people living in the home had health conditions that required specialist intervention and

Are services responsive to people's needs?

(for example, to feedback?)

support, or were taking medicines for specific conditions. For example we looked at one person's care records that evidenced the person was anxious and losing weight. The records showed that local health care professionals had been involved in the decision making process regarding the person's specific needs. There was evidence that they had provided guidance and instructions to staff to ensure the individual's mental health needs were met. We spoke with staff that were aware of this person's care plans and were taking action to meet this person's needs. This meant that the person's specific needs were being met.

Are services well-led?

Our findings

The home was well led in some areas but not all and improvements were needed.

There was a system in place to monitor the effectiveness of health care support provided to people. The provider carried out a yearly audit and produced an improvement plan intended to ensure that people's health care support improved. This audit covered areas such as the numbers of "home acquired pressure ulcers, reportable medication errors and falls at the home". From this audit improvement targets were set but there was no guidance on how these targets should be achieved. This meant there was no plan in place to demonstrate how the improvements that were required would be achieved or progress monitored.

A health and safety audit had been carried out in February 2014. This audit identified that a number of risk assessments needed to be carried out or updated, such as reviewing the fire safety procedures at the home. There was no evidence of the management at the home having a plan in place to address the issues identified in the audit. We looked at the last infection control audit carried out in May 2013. This identified a number of issues that needed to be addressed but there was no evidence that these had been actioned. This meant that, whilst there was a system in place to monitor aspects of the service provided, there was no plan in place to ensure that areas of concern would be improved. The above meant there had been a breach of Regulation 10(a)(b). You can see what action we told the provider to take at the back of the full version of the report.

We looked at the last medicines audit carried out in 2013. This audit identified areas for improvement and considered the medicines errors that had occurred. We saw evidence that the staff had learned from these mistakes and that the action plan put in place following the audit had been carried out.

The registered manager had a system to ensure staff annual appraisals were carried out. The registered manager told us they had completed appraisals for 64.96% of the staff. Although there was a plan in place to ensure all staff received regular formal supervisions this was not effective. At our previous inspection of the home in November 2013 we saw there was a plan in place to ensure all staff received supervision by 20 May 2014. We looked at the record of staff supervisions that showed the overall completion rate for supervisions equated to 51.28% to date. We spoke with the registered manager who told us that, whilst they had a plan to address this issue, at present there were inadequate support arrangements in place which monitored and reviewed members of staff involved in delivering care, treatment and support. The above meant there had been a breach of Regulation 23(1)(3)(a)(b). You can see what action we told the provider to take at the back of the full version of the report.

There was a system in place to ensure that nurses had their qualifications checked prior to employment. The system also ensured that nurses maintained and updated their registration in line with the expectations set out by the Nursing and Midwifery Council. We spoke with three nurses and established they were responsible for taking blood, when required, from people living at the home. We asked the registered manager to see the home's venepuncture policy (a policy that staff must comply with when taking blood from people) but none was available on the premises. The registered manager telephoned the staff member responsible for providing guidance and support in relation to health care matters to the organisation and established that the provider followed the 'Marsden Policy' (from published clinical guidance). We asked to see the certificates in relation to the nurses' training to carry out venepuncture but there were none. This meant there was no safe system to establish if nurses had the necessary skills to carry out this specific nursing task competently.

There were sufficient members of staff on duty to meet people's needs. There was a staffing structure which gave clear lines of accountability and responsibility. There was always a nurse on duty who took a lead role in ensuring people's nursing needs were met. There was also a senior care worker in each area of the home responsible for ensuring other care staff knew what their role was for each shift. These staff did provide consistent guidance and support to other staff members.

People who could articulate their views and opinions were encouraged by staff to discuss their views of the service they received. The people we spoke with could identify who the registered manager was and told us who they would raise concerns with should they have any.

One person told us that, if they had a problem, they would speak with their keyworker who "always sorts things out for

Are services well-led?

me". Another person told us they had met the registered manager who had asked them if their needs were being met. They also told us that their family members sorted out issues for them, but they had no complaints.

For people who could articulate their views and opinions the staff at the home worked with people's relatives and people important to them to establish if people's needs were met. We saw there were notices advising people about advocacy services, (an independent person who can represent people who find it difficult to represent themselves) around the home. We spoke with the registered manager who told us that, if required, they would contact advocacy services on behalf of people. They also told us they would use independent mental capacity advocates' in certain cases. These approaches ensured that people had their views listened to and, where people could not articulate their views, there were systems in place to provide independent support and advice.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 (1)(b)(i) Care and treatment was planned but it was not consistently delivered in a way that ensured people's safety and welfare.

Regulated activity	Regulation
	Regulation 10(a)(b) The provider had a system to regularly assess and monitor the quality of service that people receive but this was not consistently effective.

Regulated activity	Regulation
	Regulation 11(1)(2)(a)(b) People who use the service were not protected against the risk of unlawful or excessive control or restraint.

Regulated activity	Regulation
Family planning services	Regulation13 Medicines were prescribed but were not consistently given to people appropriately.

Regulated activity	Regulation
	Regulation 17(1)(a)(2)(a). People's privacy, dignity and independence were not consistently respected.

This section is primarily information for the provider

Compliance actions

People's experiences were not taken into account in the way the service was provided and delivered in relation to their care.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 20(1)(a) People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

Regulated activity	Regulation
	Regulation 23 (3)(a)(b) People were not cared for by staff that were supported to deliver care and treatment safely and to an appropriate standard. The provider had not worked continuously to maintain and improve high standards of care by creating an environment where clinical excellence could do well.