Moorlands (Strensall) Limited

Moorlands Care Home

Inspection report

10 -12 Moor Lane
Strensall
York
YO32 5UQ
Tel: 01759 841111
Website: www.astonbrookcare.co.uk

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Overall summary

The inspection took place on the 3 and 5 August 2015. The inspection was unannounced. This was the first inspection of the service as the provider changed on the 29 July 2015. As the provider had been registered for less than a week when we carried out our inspection, we have determined that it is to early to provide a rating for the service.

Moorlands Care home offers nursing care for up to 68 people who may have dementia care needs, a disability or may require end of life care. The home has recently been taken over by Moorlands (Strensall) Limited who are part of the Astonbrook care brand.

The home is divided into two separate units. The home is situated in a residential area of the village of Strensall which has local shops and pubs nearby. All accommodation is on the ground floor and both units have access to a small courtyard. The home has a large car parking area.

The home has a registered manager. 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.

During this inspection we identified five breaches in regulation. These included person centred care, meeting nutritional and hydration needs, premises and equipment, good governance and staffing.

Although some staff had received safeguarding adults training, others had not. Observations and feedback from our inspection demonstrate that people were not always kept safe. Staffing levels were impacting on the care people received.

Although risks were being identified and recorded, they were not always reviewed which meant that information may be out of date. There no evidence of incident and accident analysis being carried out which can help to minimise risks to people.

Although maintenance checks were completed, they were not identifying the concerns we identified during our inspection. The programme of refurbishment which had commenced needed to continue throughout the home.

Although recruitment checks were carried out on staff, there was no evidence in some of the files viewed that disclosure and barring checks (DBS) were being completed.

Staffing levels at the home require urgent review to ensure that there are sufficient numbers of staff on duty to care for people safely.

Summary of findings

Medication systems were well managed and people received their medication safely.

Although domestic and laundry staff were employed, some areas of the home were unclean and required attention.

The induction, training and supervision of staff was not up to date which meant that staff may not have the appropriate skills, knowledge and support required to care for people appropriately.

Staff understood the principles of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). DoLS are part of the MCA (Mental Capacity Act 2005) legislation which is in place for people who are unable to make decisions for themselves. The legislation is designed to ensure that any decisions are made in people's best interests.

Although risks to people nutritional and hydration needs were recorded, they were not appropriately monitored and some people were receiving insufficient amounts of fluid which increased the risk of dehydration.

We saw some evidence that consideration had been given to the environment in terms of supporting people living with dementia. This is important as it can help to orientate people.

We saw that appropriate access to health professionals was gained and professional advice was sought in relation to people's health needs.

Staffing levels at the home meant that people's care was compromised and that people were not always treated in a dignified manner.

There was little to evidence that people were involved in discussions regarding their care or to demonstrate they were involved in their assessment or care plan.

Although social activities were provided some people said they were bored.

The home had a complaints procedure in place and we saw that complaints were responded to.

Moorlands care home has had a change in registered provider; they also had a new registered manager. We received mixed views regarding the management of the home and people told us that morale was poor.

There was little to demonstrate that the service was being reviewed or that people's views were being sought to bring about improvements.

Records required improvement and the concerns identified during our visit demonstrate that significant improvements are required.

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?
Staffing levels and deployment of staff requires review to ensure that there are sufficient staff on duty to provide safe care to people.

A programme of refurbishment and redecoration is required to the premises to make them safe and fit for purpose.

Is the service effective?
Staff had not received appropriate training and supervision to support them in their roles.

Is the service caring?
The staffing levels at the home meant that people's care and their dignity was being impacted upon.

Is the service responsive?
People were not involved in the planning and delivery of care

Care files were difficult to read and we found that people's care plans

did not always represent people's needs or have information to help meet people's needs.

Is the service well-led?
The home now has a new registered provider and a new registered manager.

Systems to monitor quality, to seek people's views and bring about improvements required further development.

Moorlands 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 3 and 5 August 2015 and was unannounced. The inspection team consisted of two inspectors and an expert by experience on the first day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had experience of older people's care services. On the second day of our visit, three inspectors carried out the inspection.

We did not ask the provider to complete a Provider Information Return (PIR) prior to our visit as the inspection was bought forward following some concerns which had been raised. A provider information return is information the provider sends us which tells us some key information about the service, what the service is doing and well and any improvements they plan to make.

We spent time talking with seven people using the service, four of their relatives and friends or other visitors, and we interviewed eight staff. We carried out a short observational framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who may be unable to share their views and experiences. We also carried out a tour of the premises.

We looked at nine staff recruitment records, nine staff training records, four people's care files in detail, five people's medication records, meeting minutes and records used to monitor the service which included health and safety and maintenance records.

Prior to our visit we spoke with the local authority to gain their feedback of the service provided. They had been carrying out their own monitoring visits as they had also identified some areas for improvement.

Is the service safe?

Our findings

Prior to our visit we received two concerns about people's safety. One relative told us that they had found their relative on the floor with a side table on top of them. They told us there were no staff around and said they had to summon help. They had raised this with the registered manager who in response had relocated the nurse's office so that staff could more easily observe people and had also implemented fifteen minute checks to people. The other concern was linked to staffing levels and the impact this was having on people's care.

People told us that call bells took a long time to answer. Comments included, "It takes ages for staff to come when I ring my bell" and "Sometimes I have to wait for assistance if they are short staffed, but staff always tell me they will be with me as soon as possible."

The observations carried out during our visit and discussions with staff confirmed that people were not always safe due to the current staffing levels at the home. On the first day of our visit, we observed people shouting for help for long periods as staff were unavailable. Call bells were ringing continuously and staff told us they were stressed and finding it difficult to provide safe care to people. On at least three occasions we had to request support from staff for people.

Whilst on Lavender unit we heard an individual shouting out, clearly distressed. They were alone in the lounge. They implored us to help them as they needed to use the toilet. There were no staff around and no call bell for them to use. We had to find care staff to provide assistance.

In the afternoon the same individual was again heard shouting, this continued for a significant time period without any staff going to check on them so we spent some time sat talking with them which calmed them. Staff told us that they knew the individual shouted and said they did not have time to sit with them. This resulted in them experiencing distress and anxiety.

We observed a number of people in their rooms who did not have call bells in reach. There were no call bells in the lounge areas which people could readily access and we observed two people in the lounge on Lavender unit for long periods without staff present.

One individual was recorded as needing to be in one to one view of staff due to previous safeguarding concerns. When we asked staff how this was managed when there were only two carers on duty, we were told that the individual was encouraged to stay in their room. They did have a door alarm sensor in place to alert staff. We spoke to a member of staff regarding this who told us that it was unfair to encourage the individual to stay in their room but said that they could not observe them if they were helping other people.

On the first day of our visit there were only two care staff on duty on the dementia unit. There was one nurse who was working between both units. We spoke with staff working across both units of the home. Comments included, "There is not enough staff on both units, usually we have enough on nursing but these are taken over to the dementia unit to plug the gaps", "Staff are stressed and tired and something really bad is going to happen. We are all tired", "The atmosphere is negative and morale is low. Staffing levels are a result of people leaving." We asked the registered manager how many staff had left in the last couple of months. We were told that from the 1 May a unit manager, four nurses, 11 carers, two chefs and a domestic had left.

We asked staff what the impact of insufficient staff was having. We were told that people were not receiving sufficient to drink, people were not being bathed or showered frequently and documentation was not up to date.

Staff also told us that they received very little direction and we saw examples of this during our visit. For example, there were four staff on duty on the nursing unit and only two on the dementia unit. The nurse worked across both units but had not arranged for care staff to be allocated across both units. We shared this with the registered provider who agreed that the allocation of staff needed to be considered.

This was a breach of Regulation 18(1) Staffing.

We asked staff if they had received safeguarding vulnerable adults training but three of those spoken with said that they had not. One staff member said, "I would report any issue of abuse," and another said, "You go and tell somebody." We looked at records of staff training and found that some people did not have up to date

Is the service safe?

safeguarding adults training. However we found that the registered manager was making appropriate alerts to both CQC and the local authority where concerns had been identified.

We looked at how risks were managed. We saw that risk assessments were included in care plans, however, although we saw that risks were being identified, we also found that they were not being reviewed on a regular basis. This meant that any changes may not be identified and addressed at an early opportunity. We shared this with staff and with the registered manager during our visit. Staff told us that they had not had sufficient time to review or update risk assessments due to the current issues with staffing levels.

We asked about the emergency arrangements in place. We were told that staff would phone the registered manager. People had transfer to hospital sheets in place which included important information which staff may need to know in an emergency. This meant information required in an emergency could be shared quickly with other relevant agencies.

There was no evidence that accidents, incidents and whistleblowing concerns were being analysed which meant that trends may not be identified at an early opportunity. We asked the registered manager if there was a system in place and they informed us that this was going to be introduced but due to the timescale they had been in post this had not been completed yet.

We looked at checks which were carried out on the premises and equipment. These were undertaken to help ensure the home was safe for people. However, despite checks being carried out on the environment we saw broken garden seats in the main garden, broken fencing to the rear of the property and trailing TV cables in the lounge area on Lavender unit. Sluices and the boiler cupboard were unlocked and a stable door was not secured which gave access to the equipment that was stored behind it which posed a risk to people living at the home. It was clear that audits of the environment had not identified these risks to people.

A programme of refurbishment had commenced prior to the new provider taking over the business and some areas had been decorated and furnished. Rooms which had been decorated were clean, bright and nicely furnished. A relative commented on the fact that Lavender unit had been in desperate need of updating as the carpets were worn and the unit smelt unpleasant. They told us that work had been carried out and said that the unit was much better now although further work was still needed.

We saw that some vacant rooms were still being used to store multiple items. For example incontinence aids and decorating items. We also saw in some of the toilets that sinks and soap dispensers were coming away from the wall.

There was clear signage on doors to lounges and toilets. However there was no memorabilia except in a lounge and the environment was very impersonal generally. The registered provider said that a continued programme of redecoration would continue throughout the home. They told us that their plans for this would be included within the action plan, which is a document completed by the provider detailing improvements which were going to be made and the timescales in which they planned to do so. This is requested by CQC once the report has been finalised.

This was a breach of regulation 12(2)b Safe Care and treatment.

We saw that each potential staff member had completed an application form, attended an interview, references had been sought and pin checks were being completed on registered nurses to check that their registration was current. However although we saw one disclosure and barring service check number recorded the others were not. We asked the registered manager if they could provide evidence that these checks had been completed but they were unable to as these recruitment checks had been completed prior to them starting in post.

We recommend that the registered provider carries out an audit of the recruitment files to ensure that they contain the required information so that they can be assured that any staff employed had been assessed as safe to work with vulnerable adults.

When we looked at people's medication records we saw that people were receiving their medication as prescribed by their doctor. Any medicines which had been given were recorded on people's individual medication administration records (MAR). There were clear directions on MAR sheets regarding how people should be given their medication. For example, one person needed to be given their medication covertly and the directions state 'prefers to take

Is the service safe?

with lemonade, one tablet at a time.' Where people were given medication covertly this was clearly recorded within their care plan and signed by those who had been involved in the decision process. Covert administration of medicines is only used when medication needs to be given in a disguised format, for example in food or a drink, without the knowledge of the individual and only when the decision to administer medication in this manner, has been discussed and agreed with those involved in their care and has been deemed in their best interests.

All medication was administered by the qualified nurse on duty. We saw that MAR charts were in place for topical ointments such as creams. We saw that a medication audit had been completed in July. There were two action points from this which had both been addressed when we carried out our visit. Medication was appropriately stored in a locked treatment room.

We looked at infection control systems. The home employed domestic and laundry staff to clean the home. We found some areas of the home were dusty, paintwork was flaking in areas and some bedrooms were smelly. Other rooms were clean and nicely decorated. Prior to our visit we received concerns from a relative about standards of cleanliness. We shared our concerns with the registered manager during our visit.

Is the service effective?

Our findings

We looked at the induction, supervision and training records staff. We were told that all new staff had commenced the care certificate as part of their induction.

Some staff raised concern about their training. They told us a number of courses had been cancelled. We identified gaps in some of the training records we looked at. We asked the registered manager if they had a training matrix available but they told us they were in the process of trying to formulate one. One member of staff said, "I was meant to have dementia training but it was cancelled."

Staff were not receiving regular supervisions and this was confirmed by staff we spoke with and from the records of supervision seen during our visit. One staff told us, "I have received one supervision in the last year. I don't feel supported," another said, "I have never had any formal supervision." The registered manager told us that they had not yet had the opportunity to review the training and that they were going to develop a staff training matrix which would identify any gaps in training. They then planned to implement a programme of training for all staff working at the home.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the MCA (Mental Capacity Act 2005) legislation which is in place for people who are unable to make decisions for themselves. The legislation is designed to ensure that any decisions are made in people's best interests. The registered manager and staff we spoke with understood the MCA and DoLS. They understood the importance of making decisions for people using formal legal safeguards. We saw evidence that applications had been made and the relevant DoLS authorisation was valid and we saw copies of the capacity assessment and best interest paperwork to support the decision making process.

We saw some examples where people had signed their consent, for example, for the use of photographs. However the registered manger may need to consider further ways to demonstrate that people and/or their relatives (where appropriate), were involved in decisions regarding their care and treatment, to ensure that people's views and opinions were sought.

We saw that some people had 'Do not attempt cardio pulmonary resuscitation' (DNACPR) forms in place which enable people to express their wishes regarding resuscitation.

The home does not carry out restraint on people and some staff had received training in supporting people with distressed behaviour. This training is beneficial particularly where people have a dementia illness and may not be able to communicate their needs to staff.

We observed lunch being served in both units of the home. On the nursing unit everyone ate in their rooms which meant that a social opportunity may be missed as this meant people did not sit and eat together at mealtimes. We were told that ten people required support with their meals on the nursing unit. We were told that three care staff and a laundry assistant were supporting people with their lunch.

We received mixed comments regarding the food. These included; "The food is not bad, some days I get fed up of soup at teatime; it is the only choice other than sandwiches which I don't really like. If I don't like any of the two choices we are given at lunch then I have soup, sometimes twice a day." "The food is a disaster a lot of the time. I can't eat it as I have no teeth," and "Sometimes I get asked what I want to eat. I get enough to eat and drink. Sometimes they tell us they don't have any sandwiches so we go without," and "I get enough food during the day but not at night times, sometimes they say there isn't any food left."

The food looked bland and unappetizing and portions looked small. We were told that a new chef had recently been appointed. One relative said, "My relative has eaten everything that they have cooked." There were no pictorial menus available; the only menu seen was that which was displayed on a blackboard on the nursing unit. This meant that people were not aware of what meals were provided until it was served. We did observe people being offered a choice.

We saw that people were not given a drink either mid-morning or mid-afternoon. We did not observe people being offered snacks, fruit or drinks between meals. We did see that a water dispenser was available in the dining room; however a lot of people living at the home were unable to access this independently. We asked staff why and they told us that the current staffing levels meant that they did not have time to do the morning or afternoon drink rounds.

Is the service effective?

We saw that a number of people were on fluid monitoring charts, these were in place to record how much fluid people had been given. They were used as people had been assessed as at risk of dehydration. However we found that these charts were not being completed appropriately and people were not receiving enough to drink throughout the day. This meant that they may be at an increased risk of dehydration. We did see evidence that people were being referred to the dietician or GP where concerns about their weight had been identified.

We also found that people at risk of malnutrition were not being weighed often enough despite the care plan highlighting that this needed to be done. We saw a number of people's records which included care plans and weight records which had not been reviewed or updated since May 2015. This meant that staff were not alerted if people lost weight.

This was a breach of Regulation 14 Meeting nutritional and hydration needs.

We saw some evidence that people's health needs were being monitored with appropriate referrals made where concerns had been identified. This included involvement from the tissue viability nurse in relation to people's pressure care and other referrals to speech and language therapists and occupational therapists had also been made. There was always a nurse on duty at the home and the GP visited the home regularly. People told us that they could access health appointments when they needed to.

During our tour of the home we saw that brightly painted doors and signage were in place to help orientate people living with dementia. Each unit had access to enclosed garden space although the furniture was in a poor state of repair and in need of replacement. There was communal lounge space available in different areas of the home which meant that people could see their visitors in private.

Is the service caring?

Our findings

We saw both positive and negative examples of care being provided to people during our two day visit. Staff were kind in their approach and we saw them speaking to people politely. However the staffing levels at the home were impacting on the care being provided.

Comments from people included; "I find the staff alright; they always speak to me in a kindly way. They never hurt me or are rough with me." "Nobody bothers to talk to me. I have been waiting to get up and it is now 12:30." "It takes ages for staff to come when I ring my bell." "Staff do what they think, they are dying to get me back into bed, which can be anytime of the day, I don't like it and I have no say in what happens." "They treat you like a commodity, very impersonal. They don't listen to me, in fact they don't talk to you, and they don't communicate at all. I find it very strange; you are not supposed to have any life whatsoever."

Another person told us "I find it very dull. I want to join in with things but no-one takes me. It's important as I am stuck here. I am desperate to get out of here, nobody comes and I spend my day in my room. I am bored this makes me feel like I am no good."

We saw people looking dirty, unshaven and generally unkempt and some people's clothes were worn, frayed and dirty and their hair not brushed. One lady had an arm support on which was covered in dry food. We observed another lady wearing a nightdress which was dirty and had food and drink all over it. We saw one person who was wearing a wet night dress and we had to ask for staff to come and change them. Another person was wearing a dirty jumper.

Another person was in their room shouting for help they had started to get themselves undressed. We called the alarm for staff to come and assist but the staff member who arrived said they were busy helping someone else.

Staff told us that they were unable to bath or shower people as often as they should be as they did not have time. This was supported by records viewed during our visit.

Relatives also expressed mixed views regarding the care provided. Comments included; "We are quite pleased (with the care). We are kept fully informed of any changes to their health." "My relative is totally dependent on nursing care and staffs always anticipate all of their needs." "Staff come in when they are passing the room, I have no issues." Other comments included "The staffing levels are impacting on the care. There are not enough staff" and "I have concerns about my relatives care as I don't think there are enough staff around."

All of the relatives we spoke with said that they could visit whenever they wanted and some people visited daily.

We saw very little evidence that the home delivers person centred care. Staffing levels meant that care was minimal which focused on essential personal care only and we saw many examples where that was lacking. There was no evidence that individual preferences or choices were being taken into account in regards to care delivery. Comments included, "I am told when I can have a bath or shower; I have no choice it can be any time of day. Once a week I have a shower, you have no say when it is."

This was a breach of regulation 9 Person centred care.

We found that people were not always treated with dignity and respect, for example we heard a staff member refer to one individual in a derogatory way. We saw examples throughout our visit where people's dignity was not maintained for example, people wearing dirty and/or wet clothes, people left shouting for help and people who were in various stages of undress without support from staff.

We saw one person on the floor outside of their room in their nightwear which was torn with their dignity greatly compromised and requiring personal care. We had to find care staff to provide assistance. Another person was very distressed in a lounge area and told us, "I'm frightened," no staff were around to support this person. When we spoke to staff they told us "I cannot sit with x as we don't have the time, I feel like I can't attend to peoples mental health needs."

Staff were heard and seen being kind in their approach to people, they generally knocked on doors before entering people's rooms and we did not hear anyone speaking rudely to anyone. However the staffing levels meant that people did not receive attention quickly enough and this impacted on their dignity. One person said, "Staff are kind and polite." We spoke with a nurse who said, "The carers are very professional."

Is the service responsive?

Our findings

We saw the one person's records stated they wished to be involved in the development of their care plan; however there was no evidence of the person consenting to their plan of care. Only one of the relatives we spoke with had been involved in any formal reviews of their relatives care.

The service did not respond appropriately to people's needs for care and support and this was reflected in care files we looked at. Care files contained pre admission assessments, personalised care plans and risk assessments on choking, dehydration, falls, moving and handling and the use of bed rails. We found that risk assessments were not always reviewed and this had lapsed in some areas.

One person's care file showed their eating and drinking assessment was completed on 27.10.2014, food and fluid recording was in place but not completed. We saw evidence of one person having a visible medical issue, we asked staff about this and they told us, "This had been reviewed with the persons GP about a year ago, advice was given through a dietician referral and the person has chosen not to follow this." There was no evidence to show that this had been followed up since the assessment of need on 27.10.2014. Inconsistency with completing charts and records was evident and did not always support that people received the care they required in all areas.

Another person's fluid records indicated low amounts of hydration, over a one week period amounts showed 750mls, 465mls and 1050mls. We looked at eight other people's fluid monitoring charts we saw that there were significant gaps and that people were not receiving sufficient amounts to drink. We talked to staff about this. They told us that they did not have time to do morning and mid-afternoon drinks. Following our inspection we shared our concerns regarding people's nutritional needs with the local authority and the registered provider who agreed to look at this further.

We were shown a copy of the activities record. Activities included dominos, memory games, baking, and manicures, sing a longs and one to one activities. In addition we saw that walks into the local village and an outing to the railway museum had been planned.

We observed a group activity of dominoes taking place with 3 people joining in. We saw that the activity was an enjoyable and relaxed experience for people with good, pleasant interaction with staff and each other. However we saw some people in their rooms shouting for help and assistance. People told us they were bored and that they were left in their bedrooms. One person said, "I sit in my room for ages and ages, I find it very dull. I want to join in. I can't go on my own; I rely on staff taking me. I'd participate in anything given the chance." The inspector asked the activities co-ordinator why this individual was not involved in the activity. They agreed to bring them down to the lounge and we saw this person joining in with a game of dominoes.

Another person told us, "I get fed up. I stay in my room all day. We don't know what to do; there are not many activities here."

We observed a group activity in the dining room of Lavender Unit. Staff responded appropriately to people taking part regularly prompting verbal contact with everyone. We saw people responding well to this contact and enjoying the game. People that did not want to take part were kept involved by the staff and enjoyed watching the group activity. Staff spoke to people in a kind and caring manner.

The activities co-ordinator told us that there were 58 hours per week of activities. They tried to split their time between the two units. When people were involved in activities they appeared to be enjoying them, however further attempts to involve people could be made.

We saw there was a complaints policy. The registered manager kept a file of all complaints received. We saw complaints were appropriately addressed and recorded. However, one member of staff told us, "Complaints are not discussed with us and no lessons are learned". We spoke with the registered manager who confirmed one recent complaint had been discussed with staff; however there was no evidence to confirm this. One person told us, "I would complain to the boss if I had to."

Is the service well-led?

Our findings

Moorlands care home has had a change in registered provider who took over the home on the 30 July 2015, the week before our inspection. The home also had a new registered manager who was registered on 30 July 2015. We received mixed views regarding the management of the home.

There was little to evidence that staff were being given direction or clear leadership, for example on the first day of our visit there were only two care staff on duty on the dementia unit despite there being five staff on the nursing unit. This meant that allocation of staff had not been taken into account to ensure the safety and welfare of people living at the home.

All of the staff we spoke with told us that morale was poor at the service. A lot of staff had left which meant that those still working at the home were covering extra shifts and were working under pressure. Staff did not speak positively of the culture at the home although they did recognise that the registered provider had only just taken over the running of the home. One member of staff said, "I don't feel supported; we get blamed for a lot of the deficiencies here." We shared this feedback with the registered provider after our inspection and they told us they needed time to address the concerns. They told us that a staff meeting had taken place since our visit.

One relative told us that they had requested that their relative's notes were kept in their room so that they could check what they had eaten and drunk. They told us these notes were not available. We did observe that people did have food and fluid charts in their room when we carried out our visit.

Family members told us they had completed a feedback form last year and they had received a letter from the new owners outlining the future plans for the home. They were aware the home was under new ownership but had not yet met the new registered provider.

Another relative said that they had attended relative meetings when they had taken place previously but had not attended any recently. We asked to look at the record of meetings which had taken place, the last staff meeting had been held on the 1 June 2015 and the last relatives/ resident meeting had been held on the 12 March 2015. When we met with the registered provider after our inspection they told us that a relatives meeting was planned for the 2 September 2015.

A relative told us that they knew the home had a new manager but said they had not been introduced despite them visiting the home daily.

We asked the registered manager if audits were completed to monitor the quality of the service. We were told that some had been completed but that they were not totally up to date. We saw a recent audit of medication which had been completed. However, checks of the environment did not highlight the safety issues identified within the safe section of our report.

We identified a number of shortfalls during our inspection. There was little to evidence that people and staff were actively involved in developing the service. There was insufficient evidence to demonstrate how people and their relatives were encouraged to view their opinions or to make suggestions for improvement. The systems in place did not demonstrate that the registered manager was measuring and reviewing the delivery of care against current guidance. The registered provider told us that they knew work needed to be completed and that the concerns we had raised were being taken seriously. They told us they needed time to look at the issues and to take the appropriate action to address.

There was no evidence to demonstrate that the home was involved in any accreditation schemes or that staff were aware of the visions or values of the service. There was little evidence that the staff had considered best practice dementia guidance or research. The registered manager told us that they were going to look at research and best practice guidance in relation to dementia care so that they could bring about improvements at the home.

Records at the service required further development and review. They were not person centred. They were not being reviewed regularly and were not being completed accurately therefore they were not fit for purpose. Policies and procedures were not being followed and they required reviewing and updating. The systems in place did not demonstrate that the manager was measuring and reviewing the delivery of care against current guidance.

We spoke with the new provider following our inspection. They told us that they needed time to address the concerns

Is the service well-led?

raised. They knew a number of improvements were required. They told us that a week was insufficient time to address our concerns but that action would be taken to bring about improvements. We recognise the timescale involved. However, the level of concern was such that people's health and welfare was impacted upon.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 receiving care which was appropriate, meets their needs and reflects their personal preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The premises were not appropriately maintained to ensure people's safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have an effective system to monitor quality, seek people's views or to bring about improvements.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People were not receiving adequate hydration to promote good health and reduce the risks of dehydration. We are taking enforcement action against the registered provider and will report on any action once it is completed.

The enforcement action we took:
We have issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not have sufficient numbers of suitably qualified staff who received appropriate training and support to enable them to carry out their roles effectively. We are taking enforcement action against the registered provider and will report on any action once it is completed.

The enforcement action we took:
We have issued a warning notice.