Four Seasons (No 7) Limited

The Riseborough Care Home

Inspection Report

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Contents

Summary of findings

Overall summary

The Riseborough Care Home is a nursing care home for up to 74 older people. At the time of the inspection there were 26 people living at the home. This was because the local authority had not been placing people at the home because of previous concerns. The local authority had revisited the home in February 2014 and they told us The Riseborough Care Home had met the shortfalls they had previously identified at their contract monitoring visits.

There was not a registered manager at the home although the manager had applied to be registered. There was a management structure in the home which gave clear lines of responsibility and accountability. There was always a trained nurse on duty which helped ensure people's medical needs were met. People had access to healthcare professionals according to their individual needs. People we spoke with said staff were kind and polite. We observed that staff assisted people with their care in an unhurried manner. Overall, people and relatives spoke highly of the qualities of staff.

People's needs were assessed and care plans were developed which outlined their needs and the support required to meet those needs. The risks to people had been assessed and planned for. However, we found that some care plans did not include all of the care that people needed. Some people did not receive the care they had been assessed as needing. People who needed two staff to support them told us they experienced delays in receiving care. We found the home needed to make improvements in this area. You can see what action we told the provider to take at the back of the full version of the report.

People received care that met their physical needs although we found there was limited support in place to meet people's emotional and social needs. There was some information about individual's likes and interests but there was limited social stimulation for people.

Records regarding whether people had received the care, treatment and support they needed were incomplete. This meant staff could not be sure that people had received the care they needed. We found the home needed to make improvements in this area. You can see what action we told the provider to take at the back of the full version of the report.

There were systems in place to manage medicines and staff had been trained to safely give people their medicines. However, some medicines and creams had run out of stock and this meant people did not receive their medicine as prescribed. We found the home needed to make improvements in this area. You can see what action we told the provider to take at the back of the full version of the report.

There were enough staff to meet to most people's needs during the inspection and the provider had recently assessed the staffing levels. However, people told us they thought there needed to be more staff at night. The provider agreed to follow this up with people at the home.

Most people spent time in their bedrooms and did not routinely have access to social activities or occupation. There was a newly appointed activities worker who was introducing group and one to one activities. However, they had not been able to provide activities to all of the people living at the home who stayed in their bedrooms.

People's end of life wishes were sensitively sought and plans were in place to meet these wishes. People's wishes were regularly reviewed and updated if they changed their mind. However, one person receiving end of life care did not consistently receive the treatment they were prescribed to alleviate their symptoms.

We found the service was meeting the requirements of the Deprivation of Liberty Safeguards. There were systems in place to protect most people's rights under the Mental Capacity Act 2005. However, one person's rights were not fully protected because a decision to administer medicines covertly had been made when they had the capacity to make this decision themselves.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that the service was not consistently safe and improvements were required.

Most people felt safe living at the home and with the staff. One person said: “I feel safe and I’ve never been treated badly”. However, some people told us they did not feel safe at night because of their perceived low staffing levels due to the reduced occupancy of the home. Staff were trained in safeguarding and knew how to report any allegations of abuse.

We saw that risks to people had been assessed and plans were in place to minimise any risks.

We found some medicines and creams had run out and people had not received them as prescribed.

Most staff were aware of the Mental Capacity Act 2005 and how to involve appropriate people, such as relatives and professionals, in the decision making process if someone lacked mental capacity to make a decision. We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards. While it had not been appropriate to submit any applications, policies and procedures were in place. Relevant staff had been trained to understand when an application should be made and in how to submit one.

People had their capacity assessed in relation to making decisions and, for most people, best interest decisions were made in consultation with relatives, staff and professionals.

Are services effective?

The service was not effectively meeting the needs of all of the people who used the service.

People were involved in their assessments and developing their care plans. People’s care plans did not always include sufficient information about their care and treatment needs. This meant staff may not know how care should be provided for people.

People received appropriate support from healthcare professionals when required. One person talked with us about when they were unwell and said: “Staff have been wonderful and make me comfortable”.

Summary of findings

Some people's care and support monitoring records were incomplete. This meant it was not clear they had received the right care and support.

People's end of life care needs were assessed and suitable plans were in place. People and their relatives told us they were involved in decision making. Staff were working with the local palliative care training facilitator to make sure they had the right skills to be able to care for people at the end of their life. People who were receiving end of life care had access to the local palliative care team and there were established links with end of life care specialists. Some people did not consistently receive the medicines prescribed to alleviate their symptoms.

Staff received induction, training and supervision. There was a training and development plan in place to ensure staff were able to meet people's specialist or changing needs.

Are services caring?

We found the service was caring and people were listened to but they were not always treated with dignity and respect.

People spoke positively about the care they received and said that staff were kind, caring and compassionate. One person said: "They are very nice people they treat me kindly".

Overall, people's privacy and dignity was maintained. This was because staff respected people's privacy by respecting their private spaces. They knocked and waited before entering people's bedrooms. They maintained people's dignity during personal care. However, we found some staff used terminology that was not respectful to people who needed support to eat and drink.

There was limited information about people's personal preferences, life history and lifestyle choices. This meant staff did not have all the information to be able to care for and support people as individuals.

Some of the staff knew people well as they had worked at the home for a while and they knew their personal and nursing care needs and some personal information about them.

Are services responsive to people's needs?

People did not consistently receive a service that was responsive to their needs.

People knew how to raise concerns, were involved in meetings and they felt they were listened to.

Summary of findings

Most people received care at the time they wanted it. Some people who needed two staff to support them experienced minor delays in care whilst waiting for a second member of staff to arrive.

Most people were socially isolated at the home because they stayed in their bedrooms. An activities coordinator had been appointed but this had not yet had an impact on the majority of people living at the home.

Are services well-led?

The home did not have a registered manager. However, the acting manager had applied to be registered.

Observations and feedback from people, relatives and staff was that the culture of the home was improving. This was because people, relatives and staff said they felt listened to by the managers and that action was taken when they raised concerns.

The management team had systems in place to assess and monitor that there were sufficient numbers of staff, with the right competencies, knowledge, qualifications, skills and experience to meet the needs of people.

The managers of the home reviewed and monitored incidents, accidents, safeguarding alerts, concerns and complaints. The temporary and regional managers showed that learning had taken place from investigations.

There were systems in place to monitor the safety and quality of the service. The provider had identified for most of the shortfalls we found at this inspection. They had developed an action plan to address the areas for improvement.

There were robust systems in place for the maintenance of the building and equipment. There were emergency plans in place for the people who lived at the home and for the staff and buildings.

Summary of findings

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

Most people told us they felt safe at the home. One person said: "I feel safe and I've never been treated badly". Another person said: "I feel safe and I have never been mistreated". However, when we asked three people if they felt safe they said they did feel safe during the day but one person told us: "I do feel safe here but I'm always frightened at night time". People told us they felt safe when staff were moving them using equipment such as hoists. One person said: "Yes I feel safe, they know what they are doing".

Fourteen people spoke highly of the qualities of staff they had got to know well. One person said: "They are very nice people, they treat me kindly" and another person said: "On the whole they are brilliant". However, a third person told us that staff did "not always" treat them kindly.

We saw staff responded quickly to call bells and when people needed assistance. Some people told us about some minor delays if they needed two staff to assist them. They told us they always got the care they needed but because of the way people were accommodated throughout the building they had to wait for a second member of staff to come. Comments included: "It is just the way it is" and "It takes them too long".

One person talked with us about when they were unwell, they said: "Staff have been wonderful and make me comfortable". People told us their pain relief was managed and one person said: "Staff always ask if I need painkillers".

People told us there was not much for them to do and they chose to spend their time in their bedrooms. One person said: "it's different to what it used be, there used to be a bustle about the home". One person described their day as: "from here (chair by the bed) to there (her bed) to the loo" and then they added: "Staff here are fantastic you couldn't wish for better". Another person said: "I would like people to spend time with me. I asked and no-one came back. There's lots of good intention but not enough time".

We spoke with five relatives about their experiences of The Riseborough Care Home. One relative said: "when I come here I feel I am visiting their home and it is part of an extended family". Another relative said: "On the whole I'm happy with the care".

A relative spoke about the newly appointed activities worker and said she: "is a lovely lady, really enthusiastic. She took my [relative] out to the hairdresser's, something she has not done for a long time. It shows the level of trust my [relative] has in her".

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

We inspected the home unannounced on 30 April and 1 May 2014. The inspection team included an inspector, a pharmacist inspector and an Expert by Experience with experience of older people's services.

At our last inspection in November 2013 we did not identify any concerns with the care provided to people who lived at the home.

Prior to the inspection, we looked at notifications received from the provider and other information we held about the home. We spoke with a contract monitoring officer from Bournemouth Borough Council regarding their involvement in the home.

During this inspection we looked around the premises, spent time with people in their bedrooms and in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We observed the main meal of the day in the dining room on both days. We also looked at records which related to five people's individual care and to the running of the home.

We spoke with 19 of the 26 people who lived at the home, five visiting relatives, nine staff, the nursing lead in the home and four representatives of the provider; this included a temporary manager covering the planned absence of the manager who was on holiday.

Are services safe?

Our findings

We found that the service was not consistently safe and some improvements were required.

We looked at five people's care plans and risk assessments and saw that overall they were written in enough detail to protect people from harm. Risk assessments covered falls, nutritional needs, pressure area care and safe moving and handling. From these assessments a care plan was developed. We saw that overall, risk assessments and plans were updated as individual's needs changed. The records for one person had identified them as high risk in relation to falls, pressure area care and not being able to independently use the call bell. Their care plan identified the person needed to be repositioned every three to four hours and checked hourly as they could not use the call bell. However, the records did not reflect whether the person had been checked or repositioned as detailed.

We saw that most medicines were in stock for people when needed. However we found that, for one person, who was receiving palliative care, medicine to help relieve their nausea symptoms had not been available for nearly 48 hours. We saw this had been ordered by staff and was due in that afternoon. In addition to this, we found another person had run out of cream for their legs and this had run out six days before the inspection. This had not been identified in medicines audits or in staff handovers. We saw there were gaps in the records for this person's creams that were to be applied twice a day. A third person was prescribed cream to apply during washing and this had not been recorded as used since 28 April 2014 and prior to that there were gaps of between two and four days.

We saw that medicines were stored, recorded and disposed of safely. People's administration records were accurate and we saw medicines being administered in a safe way. People were asked if they needed any 'when required' medicines such as pain killers. We saw medicines audits were completed and any actions were recorded but these audits had not resulted in consistently good medicine practices. We saw detailed policies were available to guide and support staff and medicine information leaflets were available for people.

These shortfalls meant that people did not receive their medicines as prescribed. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 because there were not appropriate arrangements for the administration, recording and obtaining of medicines. The action we have asked the provider to take can be found at the back of this report.

Most people who lived at the home told us they felt safe. They said they trusted the staff and one person said: "I feel safe and I have never been mistreated". However, three of the 19 people told us they did not feel safe at night because they felt there were not enough staff. This was because the home was not full and people were accommodated in different parts of the building. We told the provider who told us they would investigate people's concerns about staffing at night with them. They believed that people's perception may have been because not all of the bedrooms at The Riseborough Care Home were occupied. They agreed to follow this up with people living at the home.

Staff knew what to do if safeguarding concerns were raised. Staff told us they had received safeguarding training and records confirmed this. We asked four staff members what they would do if they suspected abuse was taking place. They were able to tell us the action they would take. This included reporting to managers, the local authority or CQC. The manager had reported allegations of abuse to the local authority and to us. This meant steps were taken to keep people safe and protect them from abuse and avoidable harm.

The regional and temporary manager demonstrated a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). While no applications for Deprivation of Liberty Safeguards had been submitted, we saw proper policies and procedures were in place.

Staff had a basic understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. They had completed on-line training on Deprivation of Liberty. Staff were aware of the need to involve others in decisions when people lacked the mental capacity to make a decision for themselves.

People had their mental capacity assessed in relation to making specific decisions. For example, one person living with dementia had their capacity assessed and a best interest decision recorded in relation to their end of life care. The individual's relative, GP and staff had been involved in the decision making. However, we saw in one

person's records a document about them having their medicines covertly. It was not clear why this was in place because it was recorded that the individual had the mental capacity to make day to day decisions about their care. We saw a document that had been signed by the GP agreeing to the person's medicines being administered covertly.

However, the nursing lead had identified the person normally consented to take their medicines so this meant they were not routinely given covertly. We also saw the nursing lead had requested the GP review this decision with the person.

Are services effective?

(for example, treatment is effective)

Our findings

The service was not effectively meeting the needs of some of the people who used the service.

One person was having their fluid intake monitored to ensure they had enough to drink. We saw the person having drinks, however. When we looked at monitoring records for the previous 14 days we found records were not fully completed and their target amount of fluid was not met. Documentation did not show whether action had been taken when the individual did not reach their target amount of fluid. The nursing lead told us the individual had additional fluids but these were not recorded and this information was not reflected in their care plan.

These shortfalls in record keeping were breaches of regulation 20(1)(a). The action we have asked the provider to take can be found at the back of this report.

We spoke with 19 people who all told us they were involved in their assessments and care planning. Four relatives told us they had also been involved. Three people told us they would be interested in reading their care plan but this had not been offered.

We looked at five people's care records. This included a brief summary of the individual's care plan called my journal which detailed people's preferences in relation to daily living, their communication and their care needs. We also spoke with these individuals and three of their visiting relatives. Overall, people's care plans reflected their personal care and nursing needs. However, care plans were task focused and not personalised with people's care, support and treatment needs were identified and planned for but their social and well-being needs were not included.

None of the care plans detailed whether people were able to independently manage their foot care, whether staff needed to care for their feet and whether they saw the chiropodist. For example, one person had broken skin on their foot from a blister. A body map had been completed and showed that staff should wash and cream the individual's feet and review in three days. There were no further records or care plans to reflect this care had been provided. One member of staff we spoke with told us they had been washing the individual's feet but they could not be sure whether everyone was. This meant that all the staff did not have the information they needed to provide appropriate care.

We were told by the nursing lead that one person had a red sacrum that they were monitoring. This person chose to sleep in their recliner chair and this had been risk assessed and their care plan reflected that the individual needed to be repositioned every three to four hours. However, records showed the individual was routinely not repositioned from late evening to 6.30am the next day. We spoke with the nursing lead and they could not be sure from the records whether the person had been repositioned. We saw in the records that the individual's sacrum was red and that nine days prior to the inspection there had been a dressing applied to their sacrum. The records showed that on 25 April 2014 the GP had been faxed to request alternative treatment for the pressure area. At the time of the inspection the outcome of this request was not recorded in the individual's care records. This meant the records for this individual did not show they were receiving the care and treatment they had been assessed as needing.

The shortfalls we identified in the assessment, planning and delivery of care and treatment were a breach of regulation 9(1)(a)(b). This was because some people's needs had not been fully assessed and planned for. There was a risk that some people did not receive the care and treatment they needed.

Most people living at The Riseborough Care Home stayed in their bedrooms and some were being cared for in bed. The nursing lead told us they were arranging for people to have occupational therapy assessments to look at suitable seating so people could get out of bed and or go into the lounge areas. We spoke with two people who were cared for in bed and their relatives. They told us they were "comfy" and they were "ok". Pressure relieving mattresses were in place where assessments had highlighted a risk of pressure damage to the person's skin. We saw from records that these people were repositioned as detailed in their care plans and the mattresses were checked daily.

People told us and we saw in records that people saw their GP, district nurse, optician, dentist and specialist health professionals as needed. One person talked with us about when they were unwell and said: "Staff have been wonderful and make me comfortable".

Three people and two relatives told us that staff at the home had discussed their end of life care wishes with them. We saw that people's wishes in relation to end of life care were sensitively recorded in their care records.

Are services effective?

(for example, treatment is effective)

The nursing lead told us they had recently asked staff to complete a questionnaire about their knowledge of end of life care to. This was so they could identify any knowledge gaps and provide specific training.

A member of nursing staff told us they had recently provided end of life care for someone. They told us they had the necessary equipment to ensure the individual received the pain relief they required and remained comfortable.

Staff had effective support, induction, supervision and training. The temporary manager told us that new members of staff had up to six weeks to complete mandatory e-learning and worked alongside experienced colleagues as part of their induction. We spoke with a recently recruited nurse who confirmed they had been supernumerary for a week and they were given time to complete their e-learning.

We spoke with four staff and they told us they were well supported by the manager and nursing lead and had one to one and group supervision sessions with managers. Staff told us they had confidence in the acting manager, temporary manager and the nursing lead and they could approach them with any concerns. Staff told us they had regular team meetings and handovers.

We looked at staff supervision records and found there was a supervision schedule in place. We looked at the records for a staff member who received an additional supervision session following a concern being raised by someone who lived at the home. The supervision record included brief details about the discussion but it was not dated which would be useful to show it related to this concern.

The staff training matrix showed the majority of staff had completed core training that was mandatory to enable them to undertake their roles and responsibilities.

The nursing lead told us they had provided sessions on how to safely move people following a number of people receiving minor injuries during transfers prior to the inspection. This staff member was a moving and handling trainer and provided a moving and handling practical session to new staff during the inspection. This was so they knew how to safely move and support people during transfers.

Are services caring?

Our findings

People's preferred names were recorded in their care plans and we observed staff using these when speaking with people. However, we heard staff referring to people who needed support to eat and drink as "feeds". Although this was not done within people's hearing it showed a lack of respect and identified people by their needs rather than their names.

People's end of life wishes were sensitively sought and plans were in place to meet these wishes. Staff told us they had access to the palliative care team and the district nurses and GPs for access to end of life medicines. One person was receiving palliative care treatment from the hospital and was supported by the palliative care team. Their wishes in relation to their end of life care were recorded and regularly reviewed with the individual. We saw they had changed their mind about whether they wanted to be resuscitated and this was clearly documented. However, we found shortfalls in the availability of this person's anti sickness medicines and that they had not received their medicines as prescribed to manage and alleviate their symptoms. This meant that the treatment that had been assessed and planned for was not consistently provided.

We observed the main meal in the dining room on both days of the inspection. Overall, we saw that staff treated people kindly. They supported them at a suitable pace to eat and drink. On the first day of the inspection we observed that staff responded when people needed help but did not encourage any interaction with and between people. This meant that this meal time did not feel like a social experience. On the second day of inspection, we saw good interactions between staff and people. A member of staff sat chatting with people whilst they supported an individual to eat and drink. We saw that this was a good experience for this person because they were engaged, smiling and joining in with the conversation. We observed another member of staff supporting one person to eat and drink. They assisted the person at their own pace. They talked with the person throughout the meal, explained what they were eating, and checked when they were ready for the next mouthful. We saw another person became unsettled with other people sitting at the same table. Staff gently reassured the individual and introduced some humour and smiles which relaxed the situation.

The nursing lead and the temporary manager told us they had recruited to all of the vacant posts and they were not routinely using agency staff. New staff said they had always worked with more experienced staff to enable them to get to know people and how they liked to be assisted. People we saw throughout the day were clean and physically well cared for. This showed that staff took time to assist people with personal care. However four of the five care plans we saw contained only basic life histories. There was a lack of information about people's interests or preferred daily routines. Therefore staff had very limited information about the lifestyle choices and preferences of the people they supported. This meant that staff may not be able to provide care in an appropriate manner if the person was no longer able to express their wishes.

We spoke with 19 people about the way they experienced their care, treatment and support. People said staff assisted them in a manner that was gentle and respectful. We observed staff treating people gently and in a caring manner. Fourteen people spoke highly of the qualities of staff they had got to know well. One person said: "They are very nice people they treat me kindly" and another person said: "On the whole they are brilliant".

We spoke with five relatives about their experiences of The Riseborough Care Home. One relative said: "When I come here I feel I am visiting their (relative's) home" and "it is part of our extended family". Another relative said: "On the whole I'm happy with the care". Although people and their relatives told us they were satisfied with the care, support and treatment they or their relatives received this was not reflected in some of our findings.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

People did not always receive a service that was responsive to their needs.

Five people who needed two staff to support them told us they experienced delays in receiving care. One person told us they had not been able to have a shower due to staff shortages but had not been offered any subsequent support to shower later in the day. The temporary manager confirmed there had not been enough night staff of the right gender to be able to provide personal care to this individual.

Three other people told us they sometimes experienced minor delays in receiving care and support because they needed two staff to assist them. A relative told us that staff would sometimes ask for assistance from the staff member who was supporting his relative with care. They told us staff were always polite and apologetic for the disturbance. The relative said: "I think they just need one extra member of staff". One other person told us: "We have to wait for staff to come from another floor". Staff we spoke with and the managers at the home told us there were enough staff to meet people's personal and nursing care needs. However, because the home was not fully occupied and people were living in different living units this presented some difficulties and this meant they were not always able to respond as quickly as they would have liked.

People we spoke with told us that staff did not have time to spend time talking with them apart from when they were receiving personal care. One person said: "It's different to what it used be. There used to be a bustle about the home". Another person said: "I would like people to spend time with me. I asked and no-one came back". In addition to this we saw there were few planned activities and little to entertain or stimulate people. The temporary manager told us they had also identified the lack of activities at the home and had recently appointed an activities worker. We spoke with this staff member who told us they were trying to organise two day trips each month and were spending one to one time with people in their bedrooms. We looked at the records and saw that group activities such as cake baking and afternoon teas had been attended by some people. There were records of one to one time with people. However, this had only included approximately half of the 26 people living at the home. This meant that some of the people living at the home were not having any social stimulation or having their emotional and well-being needs met.

We saw that most people stayed in their bedrooms which meant they were at risk of social isolation. Some people told us they chose to spend time in their bedrooms but others were not able to leave their bedrooms because they were cared for in bed. One person told us they stayed in their bedroom because there was nothing to leave their bedroom for. When we asked about what their day consisted of they said: "from here (chair by the bed) to there (their bed) to the loo".

These shortfalls in the assessment of, planning and delivery of care and support to meet people's social, emotional, wellbeing and care needs were a breach of regulation 9(1)(a)(b). There was a risk that some people did not receive the care, support and treatment they needed.

People were given information about the home and how to raise concerns. One person told us: "it's all in that book (service user guide) if I need to find anything out". Most people and relatives told us their views were sought about their care and treatment. We saw in care plans that people and relatives had been asked their views. People told us the acting manager was available for them to speak to if they were concerned.

People told us there had been residents' meetings and they had the opportunity to contribute to how things were working at the home. Three relatives also told us there had been relatives' meetings when they had the opportunity to be kept informed and give their views. They told us that things they raised were acted on.

People had access to some of their records. Daily and monitoring records were kept in people's bedrooms including a brief summary of the individual's care plan called my journal. This included people's preferences in relation to daily living, their communication and their care needs. These records also included any monitoring records such as food and fluid, repositioning and hourly checks. One person and one relative told us they looked at these records and they were satisfied with what was recorded.

Overall, staff made sure that people had the time they needed to make decisions about their care and support. Staff and people told us that people made choices about their meals the day before. We observed that staff offered

Are services responsive to people's needs?

(for example, to feedback?)

people a visual and verbal choice of drinks throughout the day. However, we saw that when staff served people their meal they did not remind them of what they had ordered or checked whether that was still what they wanted. This meant that people living with dementia may not have recalled what they had ordered and they were not reminded. All rooms had call bells to enable people to summon assistance. We saw that some people had been provided with pendant call bells. During the inspection people's call bells were responded to promptly.

People were able to maintain relationships with their friends and relatives. People told us their relatives could visit whenever they wanted. Relatives told us they were made welcome at the home. Four of the five relatives we spoke with visited most days. People we spoke with told us they maintained contact with their friends and relatives by mobile phone.

Are services well-led?

Our findings

At the time of our inspection visit, the home did not have a registered manager in post. The acting manager had applied to be registered with CQC.

Observations and feedback from people, relatives and staff was that the culture of the home was improving following the appointment of the acting manager. They told us that the acting manager, temporary manager and the nursing lead had provided some leadership and listened to what people, relatives and staff said. One member of staff said: "It's good when you walk through the doors now, there's not the heavy pressure like there used to be".

We saw from the last relatives meeting they had raised concerns about staff at the weekends. The acting manager then undertook unannounced spot checks to check on practices at the home. The nursing lead also worked occasional weekends to provide guidance by working alongside staff to promote good practice.

Staff we spoke with were supported to question practice and raise concerns. Two staff gave us examples of where they had recently raised concerns with the acting and temporary managers and they felt they had been listened to and action taken. Staff knew how to raise concerns both within the organisation and externally.

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 on duty who was responsible for ensuring other care staff knew what their role for each shift was. The nursing lead and the manager were supernumerary so they could provide leadership and oversight over the home.

The provider had developed a tool that considered the needs of people and the staffing levels needed to meet them. We saw that overall there were enough staff on duty to meet people's personal care and nursing needs during the inspection. However, based on the feedback from people and relatives, staff were not always deployed to best meet the needs of the people who lived at the home. This was because the home was not full and people were accommodated in different areas of the home. The managers we spoke with had a plan to recruit additional staff prior to more people moving into the home.

We looked at the previous three weeks staffing rotas and, overall, staffing levels were maintained at the levels assessed by the managers. We found that, in the afternoons of the previous two weekends, the staffing numbers had fallen below these levels. This meant there would not have been enough staff on those afternoons and evenings to meet the assessed needs of people living at the home. We asked the person in charge who explained they had attempted to cover the short notice staff absences.

Concerns and complaints were used as an opportunity for learning or improvement. We saw that the manager had followed up with staff when an individual had raised concerns about the staff member's practice.

Safeguarding investigations and incidents were also used as a learning experience. Staff at the home used an electronic incident and accident recording and monitoring system that was in place across all of the provider's services. All staff could access this system and log any incidents, accidents, complaints or concerns. This meant the acting manager and regional manager could monitor and review any accidents and incidents to ensure that appropriate plans were in place for people. The records could not be closed without staff entering the action taken and what lessons were learnt from the incident.

The provider sent surveys to people and their representatives annually. They were analysed and the results were on display in the foyer at the home. Any actions identified were included in the home's action plan

There were systems in place to monitor services at a local, regional and national level. We spoke with the provider's Head of Standards who had overall responsibility for quality monitoring within the organisation. They had recently introduced a new role within the quality team and this member of staff assessed each home against the areas CQC inspect against. From this they produced a report with an action plan to ensure the services met the required standards. The provider told us the report reflected the shortfalls we identified during this inspection.

There were systems in place to monitor the safety and quality of the service. These included health and safety, infection control, call bell, medication, mattress and bedrail audits. These audits were then considered at the health and safety committee meeting. We saw that action was taken where shortfalls were identified. For example,

Are services well-led?

poor lighting was identified as an issue in the car park and this was then addressed. However, the medicines audits that were completed had not identified where medicines had ran out.

We saw there was an on-going action plan in place for the home. This action plan identified areas for improvement during internal audits, the provider's quality monitoring visit, contract monitoring visits and the amount of training completed. The acting manager had updated the action plan with the actions taken. The regional manager then signed off and closed the actions when they were completed. We saw in the action plan that people's assessments, care planning, call bells, medication and the reporting of bruising had been identified as issues on 6 April 2014. The action plan had been updated with what action needed to be taken and these actions were still in progress. This showed us the provider had identified the same shortfalls as we identified at this inspection and had plans in place to address the issues.

There were emergency plans in place for people, staff and the building maintenance. In addition to this we saw there were weekly maintenance checks of the fire system and water temperatures. There were robust systems in place for the maintenance of the building and equipment. This meant the environment was well maintained and safe.

The provider had worked closely with the local authority contract monitoring to improve standards at the home and, until two weeks before the inspection, the home had not admitted any new people. This was why there were only 26 people living in the home when they could accommodate up to 74 people. The home had agreed a plan with the local authority to assess and admit two people per month. This was so they had sufficient time to fully assess people's needs and to ensure they had recruited enough staff.

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 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010** **Care and welfare of service users** The registered person had not taken steps to ensure that each service user was protected against the risks of receiving care and treatment that was inappropriate or unsafe. This was because the assessment, planning and delivery of care did not meet the individual service user's needs and ensure their welfare and safety.

Regulated activity	Regulation
	Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 **Management of medicines** The registered person had not protected all service users against the risks associated with the unsafe use and management of medicines.

Regulated activity	Regulation
	Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 **Records** The registered person had not ensured that service users were protected from unsafe or inappropriate care and treatment. This was because there were not accurate records which included the appropriate information and documents in relation to the care and treatment provided to each service user.