Bupa Care Homes (GL) Limited

Hazelmere House Nursing Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on the 17 and 23 July and 10 August 2015. The inspection was unannounced.

Hazelmere House Nursing Home House is owned and operated by Bupa Care Homes (GL) Limited. It is a purpose built 56 bedded home set in a residential area of Wilmslow. The home provides a wide range of long and short term nursing and residential care for older people including 8 bedrooms set aside for intermediate care.

Intermediate care is supported by a team of health care professionals employed by the local health authority. They work closely with other health and social care providers offering assessment, treatment, rehabilitation and support for older people and adults with long term conditions at times of transition in their health and support needs.

Summary of findings

All bedrooms in the home are en-suite and communal facilities include a large conservatory, bar area, wheelchair and full lift access and a secure keypad entrance. Car parking is available to the front and side of the building.

Our last inspection of Hazelmere House Nursing Home House took place in May 2014 when we found that the registered provider was not meeting all the standards of a service of this type. Nurse call bells were not always responded to promptly and care and treatment was not always planned, recorded and delivered in a way that would ensure each person's health and welfare. We judged that these failings had minor impact on people who used the service, and we told the provider to take action. Following our inspection in May 2014 the provider sent us an improvement plan and told us that all necessary improvements would be made by 15 August 2014. On this inspection we found that improvements made subsequent to our last inspection had not been sustained.

At the time of the inspection the home did not have 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. The previous registered manager left the home in April 2014.

Whilst we found that people were provided with care that was kind and compassionate, the home was not being managed effectively. A new manager had been appointed and was in the process of applying to the commission to become registered but withdrew their application and stepped down shortly after the second day of our inspection.

We found that concerns and complaints raised by the people who lived at the home had not been responded to effectively and managers were not learning from past events, or taking effective corrective action to improve the service.

Although some people told us they felt safe, we found that managers and staff had not always taken effective action to protect vulnerable people from abuse and neglect.

Absenteeism amongst staff was not being managed effectively. There were times when there were not sufficient staff to provide a safe service to the people who lived in the home.

We identified breaches of the relevant regulations in respect of person-centred care, need for consent, safe care and treatment, safeguarding service users, good governance, and staffing. You can see what action we told the provider to take at the back of the full version of the report.

Senior managers took action during the course of the inspection to address the shortfalls which we identified. The peripatetic manager who had been supporting the previous manager was appointed as acting manager of the home and initiatives were put in place to address long standing staff management issues. The provider must ensure that these improvements are sustained.

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?
The service was not always safe.

People told us that they felt safe and staff we spoke with were aware of how to recognise and report signs of abuse and were confident that action would be taken to make sure people were safeguarded from abuse. However, managers had not responded effectively when allegations of abuse had been made, risks were not always managed effectively and there were occasions when there had been insufficient staff on duty.

Recruitment records demonstrated there were systems in place to ensure staff employed at the home were suitable to work with vulnerable people.

Requires improvement

Is the service effective?
The service was not consistently effective.

People told us that they were well cared for by staff who were knowledgeable and skilled. We found that staff were not always receiving adequate levels of support and supervision.

People were involved in planning their care to a certain extent but the provider did not always act in accordance with the Mental Capacity Act to ensure people received the right level of support with their decision making.

Changes were needed to the physical environment to make it suitable for people living with dementia.

Requires improvement

Is the service caring?
The service was caring.

People were provided with care that was with kind and compassionate.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy.

Good

Is the service responsive?
The service was not always responsive.

Whilst people praised the staff and some reported receiving excellent standards of care we found examples where care had not always been provided in a person centred way.

Similarly, complaints had not always been investigated or responded to, or effective action taken to eradicate problems and prevent recurrence.

Requires improvement

Is the service well-led?
The service was not well-led.

Requires improvement

Summary of findings

When we started the inspection we found that the home was not being well managed. Absenteeism amongst staff was not being managed effectively, and quality assurance processes to monitor and improve the quality of the service were not being used effectively so problems were not always identified or addressed in a timely manner.

The provider responded to the concerns raised and took effective action to improve management arrangements and the standard of care provided. These improvements must be sustained.

Hazelmere House Nursing 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 17 and 23 July and 10 August 2015 and was unannounced. The inspection team for the first day was made up of an adult social care inspector, a registration inspector, a specialist advisor in end of life care services for older people and people living with dementia, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service in this case people who are living with dementia. On the second and third day it was only the adult social care inspector who visited again.

Before the inspection we reviewed the information the Care Quality Commission already held about the home. We contacted the local authority safeguarding and commissioning teams and they shared their current knowledge about the home.

During the inspection we spoke with 25 people who lived at the home together with 10 relatives. We talked with 18 members of staff including the manager, peripatetic manager, two area managers, the quality assurance manager and Area Trainer for Bupa Care Homes (GL) Limited (the registered provider). We also spoke with a visiting doctor and two visiting nurses and an occupational therapist. We looked at four care plans as well as other records and audit documents. We looked around the building including, with the permission of people who used the service, some bedrooms.

Requires improvement

Is the service safe?

Our findings

During our visit we observed relaxed and friendly relationships between the people living at Hazelmere House Nursing Home and all the staff members working there. Staff were kind and caring in their approach and we saw that people were comfortable and at ease in the home's environment.

Most of the people spoken with told us that they felt safe living at the home. On person said "yes I feel very safe, very nice staff they are kind and considerate, they are short staffed which means we have to wait, but overall my needs are met." Another person told us that the standard of care provided by staff was "good apart from having to wait up to ½ an hour for staff to respond to the call bell for assistance to use the commode". Another person told us that the standard of care in the home had deteriorated and they felt anxious because they were prone to falls, they said "I don't feel safe I ring [the nurse call bell] and they don't come and can wait up to an hour".

Another person told us that there had been "spells of agency and new staff" and they described it as difficult as "newer staff don't always know." This person's concerns were exacerbated because they had difficulties with communication due to their health condition. Another person said the staff are "busy, busy – everything a rush the number of staff cut to the bone." A visiting relative said staff "have no time to relax and chat [with residents]" and "there was added pressure if there was a member of staff down." They told us that they tried to come in each day and help ease the burden on staff. Several other people told us that they were dissatisfied with the time they had to wait for staff to respond to their calls for assistance and support.

Before we carried out this inspection we received information from the local authority which indicated that nurse call bells were not being responded to promptly. A number of people had shared concerns with the local authority informing them that on occasions they had waited between 15 and 30 minutes for their call bell to be answered.

We looked at the home's complaints records and could see that the manager had received a number of complaints earlier in the year about the times people had to wait for their call bell to be answered including one which indicated the delay had caused the person to be incontinent. Complaints records indicated that managers had failed to take effective corrective action in the light of these concerns to mitigate the risks presented to the people who lived at the home.

The manager of the local social work team told us they had received a recent complaint from a person who had alleged that they had waited for over 30 minutes for staff to respond to the nurse call alarm on one specific morning in July. The delay had caused them discomfort and stress as they needed support to go to the toilet. We looked at the nurse call records for the morning in question and found that the person had called for assistance at 8.30 am and their call bell had not been answered until 9.11am.

Records showed that several people had waited excessive times for their call bells to be answered with examples of people waiting over 30 minutes and in one instance 50 minutes. Many of the people who lived at the home were frail and vulnerable to falls and harm. It is imperative to their health and welfare that when they call for assistance their call is answered without undue delay.

We identified similar concerns at our previous inspection in May 2014 and the provider had sent us an action plan which set out what would be done to ensure people were safe and protected from harm. We could see that these improvements had not been sustained. The manager and peripatetic manger told us that they were aware of issues with call bells not being answered in a timely manner and they were aware of the risk which this presented to the people who lived at the home. However, other than asking staff to be more vigilant they had not taken effective action to ensure people were safe.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not provided in a safe way for service users because the provider had not taken effective action to mitigate the risk of harm to people who lived at the home.

We spoke with nursing and care staff and looked at the staff rotas and found that the provider had not always deployed sufficient numbers of suitably qualified and competent staff to keep people safe.

On the first day of our inspection we could see that the home was fully staffed according to the manager's assessment. The manager told us that staffing levels had been assessed according to the provider's dependency

Is the service safe?

rating scale. Numbers of staff varied throughout the day to accommodate the changing demands of the people who lived in the home. A total of 52 people were living at the home at the time our inspection started. The rota for the week showed that ordinarily there were two qualified nurses and 10 care staff on duty in the mornings reducing to two qualified nurses and eight care staff on duty in the afternoons and early evening. In addition there was an activities coordinator and catering and domestic and management staff who were employed in appropriate numbers. This provided for a care/nursing staff to resident ratio of approximately 1 to 4 in the mornings and 1 to 5 in the afternoons.

Staff told us that they could cope and meet the needs of people when the home was fully staffed with a minimum of ten care staff on duty in mornings and minimum of eight in the afternoons but raised concerns about high levels of absenteeism, lack of management oversight and poor contingency arrangements when staff took sick leave at short notice. Even though the home was fully staffed we could see that all staff were extremely busy and at times they were under pressure to meet people's needs in a timely and effective manner. An example of the demands on staff was illustrated when we observed two care assistants supporting a number of people with their meals when a person who was diagnosed with dementia asked to go to the toilet. The care staff asked the person if they could wait on three consecutive occasions before one of the care staff went to get the nurse who was busy with the medicine round but stopped to assist the person to the toilet. A visiting professional told us that in their view "the shortfall is not enough staff, they are very good, but not enough of them".

On the first day of the inspection staff told us that managers had never worked a shift and felt they lacked understanding of the pressures of work upon them. Absenteeism was not being managed effectively and in recent weeks there had been occasions when they had needed to cope with severe staff shortages. They told us that insufficient staffing was the main reason why there were significant delays in responding to peoples calls for help and assistance.

We looked at the care staff rotas and could see that in the fourteen days prior to our inspection the home had never been fully staffed during the day time period 8am until 8pm. There had been shortages of two care staff on five mornings and four afternoons and one morning when there were only seven care staff on duty.

Accident records showed that there had been an increase in the number of falls in the home in July 2015 and staff shortages correlated with excessive response times to call bells. For example one morning five people had to wait in excess of 10 minutes for their call bell to be answered including one person who waited 19 minutes and two others who waited more than 15 minutes.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Sufficient numbers of staff were not deployed to meet the needs of the people living in the home.

When we visited the home on the second and the third day of the inspection we found that the overall management of the home had been improved. Arrangements for managing absenteeism had been strengthened and a manager had worked a night shift so they were better informed about the pressures staff were coping with. Managers were taking a more person centred approach in the management of response times and were able to show us that significant improvements were being made. The provider's quality assurance manager told us that the home was aiming to ensure that all calls for assistance would be responded to within three minutes. The provider must ensure that these improvements are sustained.

We saw that the service had a safeguarding procedure in place. This was designed to ensure that any possible problems that arose were dealt with openly and people were protected from possible harm. The manager and peripatetic manager were both aware of the relevant process to follow. However, our inspection of the home's records identified two incidents of alleged abuse which had not been thoroughly reported to the commission or reported to the local authority as in accordance with locally agreed safeguarding policies and procedures.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider was not following appropriate safeguarding procedures.

All the staff we spoke with understood safeguarding procedures and confirmed that they had received training in protecting vulnerable adults and that this was updated

Requires improvement

Is the service safe?

on a regular basis. They were also aware of whistleblowing which is what happens when a member of staff wishes to report something to an agency outside the organisation they work for. A small number of staff did not know which outside agency took the lead on safeguarding vulnerable adults and therefore did not know who they would contact if the need arose although all said they would look it up on the internet.

Risk assessments were in place for each person for a range of areas such as nutrition, moving and handling, skin integrity and falls. There was however, some room for improvement in respect of risk assessment as we saw one example where a person who was assessed at risk of falls but had there was no action plan in place to minimise the risk.

We carried out a medicines check and found that medicines were stored in a locked medicines trolley which was kept in a locked medicines room when not in use. The home utilised a monitored dosage system (MDS) with medicines pre-packed by the dispensing pharmacy in bubble packs according to the prescription for each person. This helped to minimise the potential for human error in the administration of medicines. We saw medication administration records relating to the MDS system and noted that records tallied with the medicines administered from the bubble packs.

We looked at the files for the two most recently appointed staff members to check that effective recruitment procedures had been completed. We found that the appropriate checks had been help to minimise the risk of employing unsuitable people to work with vulnerable adults. Checks had been completed by the Disclosure and Barring Service (DBS). These checks aim to help employers make safer recruitment decisions to prevent unsuitable people from working with vulnerable groups. We saw from these files that the home required potential employees to complete an application form from which their employment history could be checked. References had been taken up in order to help verify this. Each file held a photograph of the employee as well as suitable proof of identity. There was also confirmation within the recruitment files we looked at that the employees had completed a suitable induction training programme when they had started work at the home.

We found that the people living in the home had an individual Personal Emergency Evacuation Plan [PEEPS] in place. This was good practice and would be used if the home had to be evacuated in an emergency such as a fire.

Requires improvement

Is the service effective?

Our findings

People appeared relaxed in the home's environment. The atmosphere was sociable and welcoming. The views of people who lived at the home differed, some spoke of receiving excellent care in a pleasant and relaxing environment and others spoke of their frustration about receiving poor and ineffective care.

Some people recalled giving written consent to care, but most people spoken with were unable to recall seeing or signing their care plans.

The Mental Capacity Act 2005 is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards are part of this legislation and ensure where someone may be deprived of their liberty, the least restrictive option is taken.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLS). Nursing staff named several people accommodated in the home who they said did not have capacity to make decisions and would not be allowed to leave the home unsupervised as this would put them at risk of harm. This meant that all these people would need the protection of a DoLS to ensure that the decisions to limit their freedom of movement were made in their best interests. We discussed the requirements of the Mental Capacity Act 2005 (MCA) and the associated DoLS, with the management team. The peripatetic manger told us that they were aware of the requirement to apply for DoLS regarding all these people but they had not done so because of "other priorities".

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In providing care and treatment of service users the registered provider did not act in accordance with the Mental Capacity Act 2005.

Nurses and managers spoken with told us that they had received training on the MCA and DoLS and understood when a mental capacity assessment needed to be completed and when a DoLS application should be made and how to submit one. However, records showed that staff had not always acted in accordance with the Mental Capacity Act 2005.

We looked at the care records for two people who staff had told us did not have capacity, were not able to express their views and make decision about their care. We found that mental capacity assessments and processes had not always been completed in accordance with the requirements of the MCA. In one person's care file there was no evidence of MCA assessment or best interest decisions for any aspect of the person's care. In the other person's care file there was a global statement that the person "does not have capacity". This was not decision specific and therefore not in accordance with the requirements of the MCA. Another example in the same care file was the 'consent to access care document' was signed by the person's next of kin but was not supported by a mental capacity assessment and best interest decision.

In another person's care file it was documented that the person had "variable and changing decision making processes due to their diagnosis. There was no evidence of MCA assessments in relation to their care plans or capacity to give consent for their care. Their bedrail risk assessment stated that their next of kin was "in agreement" but there was no assessment of mental capacity or record of best interest process to support this decision.

This was a further breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In providing care and treatment of service users the registered provider did not act in accordance with the Mental Capacity Act 2005.

The peripatetic manager informed us on the second day of the inspection that applications for DoLs had been made for three people living at the home and consideration was being given, through person centred care planning processes, as to who else would require the protection of DoLS. The provider will need to ensure that these improvements in promoting and protecting people's rights are sustained.

Most people praised the staff for their care, skill and dedication to duty and believed that any deficiencies were not caused by a lack of training or skill but by insufficient numbers of staff on duty. One person told us that they believed some staff did not follow care plans and as a consequence they had been injured earlier in the year. One relative said "They [staff] appear to be trained, but seem to lack knowledge of specific conditions and how it affects

Is the service effective?

individuals." They added that they did not expect staff to be experts but suggested they might benefit from more awareness of some common health issues and how it might affect individual residents.

Nursing staff told us that they had regular one-to-one supervision meetings with the clinical services manager which was beneficial to them. This along with what they described as excellent training opportunities helped them maintain their skills, knowledge and continuous professional development in accordance with the requirements of their profession.

Care staff told us that they were not well supported, morale was low amongst the care staff team and mangers did not understand or have insight into the pressures of work upon them. They told us that they did not feel involved or appreciated. Four of the nine care staff we spoke with told us that they did not have time to read people's care plans and they were unable to respond to people's calls for assistance in a timely manner. Whilst they said they were aware of the risks these delays presented to vulnerable people in need of help and assistance they advised this was because they were often engaged supporting other people and were unable to leave them to answer the call. We asked whether they had the opportunity to raise these issues with the managers and they told us that managers were either unapproachable or were approachable but did not listen or act on what they told them. Of the seven staff spoken with one told us that they had not had the benefit of a structured supervision meeting with a line manager since they started work at the home in early 2014, and all the others had only two supervision sessions in the last 12 months. Supervision records showed that six other care staff had not received supervision in the last 12 months and all others had only one or two supervision sessions with a line manager.

This was a further breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider has not ensured that persons employed in the provision of the regulated activity have received such support supervision and appraisal as is necessary to enable them to carry out the duties they are to perform.

The peripatetic manager told us that it had been recognised that care staff had not received the support they needed and a concerted effort had been made to re-start the home's staff supervision programme. Records showed that 15 of the 31 care staff employed at the home had been offered one-to-one supervision in July 2015. The provider will need to ensure that these improvements in staff supervision and support are sustained.

A significant number of people accommodated at the home were living with various stages of dementia. The décor throughout the home whilst pleasant and coordinated did not support people with dementia to orientate themselves to get around independently. Other than names on doors and room numbers there were no signs to support people to find their own rooms or bathrooms, or toilets. All the corridors looked the same and all members of the inspection team found themselves disorientated from time to time, during the inspection. We also saw that a visiting manager found themselves on the wrong corridor on one occasion. We could see that changes were needed to the physical environment to make it suitable for people living with dementia.

A tour of the premises was undertaken. This included all communal areas including lounge and dining areas plus and with consent a number of bedrooms. The home was well maintained and provided a comfortable environment that was furnished and decorated to standard which met the approval of the people who lived there. The home provided adaptations for use by people who needed additional assistance with their mobility. These included bath and toilet aids, hoists, grab rails and other aids to help maintain independence.

We spoke with seven care staff and two nurses about the quality and relevance of training provided. All, with the exception of one staff member, made positive comments about training opportunities on offer. Two staff spoken with told us training opportunities were brilliant and another two described training as excellent. The staff training matrix and individual staff training records confirmed that staff received induction training when they started work and regular on-going training throughout their employment. Training courses included a range of appropriate and training courses and care staff were encouraged to access NVQ courses (National Vocational Qualification) and also undertake competency assessments to enable them to demonstrate their understanding of the training they had completed.

Comments about the standard of catering also varied but most of the people spoken with made positive comments about the standard of food and told us they enjoyed a

varied and nutritious diet. Comments included, "It's not bad", "Food alright no complaints", "food excellent and [we have] choices" "food good – not everything to my taste, but food excellent. If I don't like anything they'll get me something else", and "Change the catering. Sometimes I get what I don't want, could do better, and chips not properly cooked", "I have my food pureed and sometimes get very strange combinations such as fish and gravy". One relative mentioned the chef has his own meetings with residents and relatives. The said "this provides an opportunity for him to obtain feedback on the food and people's likes and dislikes. He's a great guy, I feel he listens." They added when their loved one did not like any of the choices on offer the chef had suggested they could "Make a fresh cheese omelette" which they enjoyed.

The menu provided a choice and variety of food for the people using the service. The catering staff we spoke with explained that the menu was discussed with the people living in the home all of the time and was based on what people wanted to eat. Choices were available and people could decide what they wanted at every mealtime. The assistant cook told us that any special diets or dietary needs such as gluten free and diabetic meals were provided if needed. People we spoke with confirmed that they could choose whether to eat their meals in their own room or the dining room. We could see that people's individual choices were respected, in the main. However, further consultation may be required to ensure meals meet the choices and personal preferences of those who need their food pureeing.

We undertook a SOFI observation in the first floor dining room over lunch on the second day of our inspection and saw that people were being supported appropriately. We saw staff members responding to people's needs for assistance, offering choices, and supporting them with timely prompts to encourage them to eat and enjoy their lunch. In all cases staff sat next to the person and chatted whilst they were helping them. All the interactions observed and overheard were caring, kind and compassionate.

We recommend that the home seek to implement National Institute of Clinical Excellence guidelines on "Supporting People with Dementia and their Carers in Health and Social Care" including where appropriate environmental modifications to aid independent functioning, including assistive technology, with advice from an occupational therapist and/or clinical psychologist.

Good

Is the service caring?

Our findings

Whilst many people were concerned about the time they had to wait for support most spoke positively about the care and support they received and praised the staff for the way they carried out their duties and responsibilities. Comments included: "Staff very good, very caring however there's just not enough of them," "Staff treat me well and asked what I wanted to be called," "Staff know me O.K. they look after me well they're cheerful, and respectful," **"**They have time for a chat, except peak times", "Mutual respect and treat me with respect and consideration," "They treat me with respect," "They're very good they speak calmly," "Very caring. Don't speak down to me," and "Very caring, very helpful." This person added "I couldn't come to a better place."

Relatives also described the staff as "kind and caring". One relative said "privacy and dignity respected throughout the home, care is outstanding." Another said "no complaints about the standard of care, not at all, everyone does their best but there is a lack of communication we have not been involved in the development of care plans and although [their relative] was nearing the end of their life there had been no discussion about end of life and we have no idea as to how the staff will approach it." They told us that they had never been approached by any member of the management team to discuss this sensitive but important issue.

We looked at the care plans for two people who we were told were nearing the end of their life .We could see that there had been some discussion with these people about their end of life preferences. However, there was nothing to indicate important issues such as Preferred Place of Care, Advance Decision to Refuse treatment or Lasting Power of Attorney had been discussed, even where the person had capacity to make these decisions.

The manager told us that they had engaged with a local hospice to implement the 'Six Steps Care Home Programme'. This is a framework for supporting people to live and die well which can equip nurses and care staff to recognise end of life situations and manage them more effectively, working in partnership with the individuals, their families and other organisations to deliver the best quality of care possible. The manager advised us that the home had been working through this process since early 2015 However, they also told us progress had been hampered by organisational and managerial difficulties and further work was required to ensure the Six Steps Care Home Programme was fully implemented

The manager told us that they were in process of evaluating progress on implementing the Six Steps Care Home Programme with a view to taking further action and ensuring that this sensitive but vitally important aspect of person centred care planning is fully implemented in the home.

People were very comfortable and relaxed with the staff who supported them. We saw people laughing and joking with staff members, which showed there were trusting relationships between the staff and the people who used the service.

Staff we spoke with showed a caring attitude towards those in their care. We saw that staff were patient, friendly, supportive and used people's preferred names. They continually interacted with the people in their care, offering support and encouragement. People were given choices, such as whether they wanted to stay in their room or go to the lounge.

We also saw staff treating people with dignity and respect. When they provided personal care, people were discreetly asked if they wanted to use the toilet or to have a bath or shower. Staff always knocked on bedroom doors before entering and ensured doors were shut when carrying out personal care. All the interactions we observed and overheard throughout the inspection were caring, kind and compassionate.

Requires improvement

Is the service responsive?

Our findings

The atmosphere in the home throughout our inspection was relaxed and sociable.

Although only a minority of people spoken with could recall seeing their care plans some people told us that they felt involved in decision making and care planning and managers and staff respected their views. Other people told us that they did not feel involved in decisions taken about their care and welfare. One person told us that they did not think staff always read care plans and as a consequence of this they had been injured in the provision of care on two separate occasions.

Another person told us they were anxious about their condition and treatment and on coming out of hospital at beginning of July had asked for certain checks to be made on a daily basis but this had not been done and they felt their concerns were not being taken seriously. The quality assurance manager confirmed that they had spoken with this person and had agreed that such checks should be made in the interest of their wellbeing but records showed that staff had not adhered to this commitment. In the previous ten day period these checks were only recorded as being done on three days. The relevant care plan relating to this person's condition was not updated with the requirement to carry out such checks, until the 10 August 2015. This lack of person centred approach to care had exacerbated the person's anxiety about their condition, which in turn had a negative impact on their quality of life.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not provided in a person centred way that met the person's needs and reflected their preferences.

When we carried out our last inspection of the home in May 2014 we found that people were not always protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records about their care were not always maintained. Following our previous inspection the provider sent us an action plan which set out what would be done to ensure people were protected from the risks of unsafe or inappropriate care. We could see that these improvements had not been sustained.

Information provided by the local authority indicated that they had raised concerns about certain aspects of person centred care and care planning in January 2015 and had set out what the provider needed to do to improve. Subsequent follow up visits carried out by the local authority in June and August 2015 had found that satisfactory progress had not been made to meet the requirements of the improvement plan, particularly regarding accurate and contemporaneous recording of care interventions.

We asked to see the daily care records for a person who required half hourly checks because of their vulnerability and frailty. The nurse told us that they did not know where the records were. Five minutes later we found the nurse writing up the records retrospectively. Records of all care interventions must be written up contemporaneously so as to provide accurate and reliable information which may reliably inform care practice.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not maintain accurate, complete and contemporaneous records of care provided.

The home had a complaints policy and procedure to record and respond to any complaints, ensure that concerns were addressed within given timescales and ensure that effective action was taken to improve the service, where necessary. Complaints were recorded in a file along with records of the investigations which took place and the outcome achieved. However, we could see that managers had not always acted in accordance with the complaints procedure. We noted that one complaint received in March 2015 was not responded to until 30 April 2015. The complainant raised serious concerns about the standard of care provided to their relative which amounted to allegations of neglect. An area manager wrote to the complainant offering an apology but there was no evidence the complaint had been investigated and no evidence of any follow up action to address the shortfalls identified by the complainant.

Before we carried out the inspection the manager of the local social work team told us that they had received a complaint from a person who lived at the home via their representative. The person had alleged that they had waited for over 30 minutes on one specific morning in July when they had used their call bell to call for assistance to use the toilet. The manager from the social work team told us that they had asked the peripatetic manager of the home to investigate and their response had been that the

Requires improvement

Is the service responsive?

complaint was not substantiated. However, when we checked the nurse call bell records we found that the allegation should have been substantiated. The records showed clearly that on that specific morning in July the person had waited in excess of 40 minutes for their call bell to be answered. Given this person needed assistance to use the toilet it would have undoubtedly caused the person discomfort and distress as they had alleged. There was no record of this complaint or the associated investigation in the home's complaints records.

Information provided by the manager before the inspection confirmed that the home had received and investigated a complaint from a person who lived at the home who had alleged poor, inappropriate and an undignified response from staff when they had asked for assistance to use the toilet. The manager told us that the complaint had been found to be substantiated and had told us that action would be taken to address the matter with the relevant staff members at their next supervision meeting. We asked to see the relevant supervision records and found that the matter had not been raised or discussed with the staff in question. We asked the manager why this corrective action had not been taken and was told that it was on oversight.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not always fully investigated complaints or taken necessary and proportionate action in response to the failure identified by the complaint or investigation.

People told us that they enjoyed a range of activities and the activities organiser was described by many as excellent. Activities included quizzes, bingo and singing in a choir, outings, to shopping centres, canal trips and other attractions. People told us that the home had purchased iPads and the activity organiser was helping people to use them. This included emailing, video conferencing such as "Skype" and other forms of social media to maintain contact with friends and family. On the first day of our inspection five people were sitting in the hairdressing room having their hair done. The atmosphere was very sociable and cheery. All were really enjoying each other's and the hairdressers company with lots of smiles and laughter.

One person told us that they enjoyed the activities provided but had been upset because they had been unable to take part in a particular activity because the private activity provider did not provide facilities for people who used a wheelchair. We shared this with the manager who told us that this would be addressed through person centred care planning as although the home did not have control over third party activity providers, alternatives could have been explored.

People told us that residents and relatives meetings were held on a regular basis and one relative described them as "very constructive and the opportunity to share information".

Requires improvement

Is the service well-led?

Our findings

When we started the inspection we found that the home was not being well managed. Absenteeism amongst staff was not being managed effectively and there were times when there had been insufficient staff to provide a safe service to the people who lived in the home. We found that concerns, complaints and safeguarding matters raised by people who lived at the home and their relatives had not been responded to effectively and managers were not learning from past events or taking effective corrective action to address problems and improve the quality of care provided.

The provider had an established quality assurance system but this was not being fully implemented or adhered to. A nutritional audit planned to take place in July 2015 had not been carried out despite the local authority raising concerns about the recording of food and fluid intake. The previous nutrition audit had not been completed, was not dated or signed by the author. A medicines audit had been completed but did not provide an action plan to address identified errors. The manager told us that they had completed an infection control audit but was unable to produce this at the time of the inspection. The homes "Health and Safety Committee" had met on the 27 July 2015 and had been tasked to review all recent accidents but the records showed that only a sample of accidents had been reviewed. The peripatetic manager told us that this was the result of an oversight

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems and processes established to ensure compliance with the regulations were not operated effectively so the health and well-being of the people who lived at the home was not assured.

At the time of the inspection the home did not have a registered manager. The previous registered manager had left the home's employment in April 2014. A new manager had been appointed and had applied to the commission to become registered but withdrew their application and stepped down shortly after the second day of our inspection.

The home has a condition of registration that it must have a registered manager but does not have one. The provider must take effective action to ensure that a suitably qualified and competent person is registered with the commission without any further delay. Failure to take satisfactory steps to register a manager within a reasonable timescale is a potential a breach of the provider's conditions of registration and therefore an offence under section 33 of the Health and Social Care Act 2008. We are corresponding with the provider to address this issue.

Our inspection of the home's complaints records identified two incidences of alleged neglect which should have been reported to the commission without delay. The commission had not received notification of either incident until August 2015 following the matter being raised with the peripatetic manager on the last day of the inspection.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) regulations 2009. The registered provider had not notified the commission of two incidents of alleged abuse without delay. We are corresponding with the provider to address this issue.

On the third day of our inspection the area manager confirmed that action had been taken to improve the overall management of the home. The peripatetic manager who had been supporting the designated manager had been asked to step up to take overall management responsibility for the home and apply for registration with the commission. Action had been taken to address some of the fundamental issues including the management of call bell response times and staff absenteeism with significant effect. A relative told us that these changes had an overall positive impact on the atmosphere in the home and improvements in staff morale were evident. A person who lived at the home who had been frustrated with poor call bell response times for over 18 months told us that things were finally improving with a more person centred approach to the problem delivering positive results. On the 18 September 2015 we received written confirmation that a qualified and competent person had been appointed to manage the home and would subsequently apply for registration with the commission.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users because the provider had not taken effective action to mitigate the risk of harm presented to people who lived at the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of staff were not always deployed to meet the needs of the people living in the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent In providing care and treatment of service users the registered provider did not act in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider has not ensured that persons employed in the provision of the regulated activity have received such support supervision and appraisal as is necessary to enable them to carry out the duties they are to perform.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care and treatment was not always provided in a person centred way that met the person's needs and reflected their preferences.
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Any complaint received must be fully investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered provider was not always operating appropriate safeguarding procedures to ensure vulnerable people were protected from abuse or neglect.**

The enforcement action we took:
We served a warning notice under Section 29 of the Health and Social Care Act 2008. We told the provider that they were required to become compliant with Regulation 13 of Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 by 30 October 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems and processes established to ensure compliance with the regulations were not operated effectively so the health and well-being of the people who lived at the home was not assured.**

The enforcement action we took:
We served a warning notice under Section 29 of the Health and Social Care Act 2008. We told the provider that they were required to become compliant with Regulation 17 of Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 by 30 October 2015.