Caring Homes Healthcare Group Limited

St Georges Care Home

Inspection report

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Date of inspection visit: 28, 30 April 2015 and 1 May 2015
Date of publication: 24/07/2015

Ratings

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

Overall summary

We carried out this inspection on 28 and 30 April and 1 May 2015 and this was an unannounced inspection. When St Georges Care Home was last inspected in January 2014 there were no breaches of the legal requirements identified.

St Georges Care Home is a 68 bed home that provides accommodation for persons who require nursing and personal care. At the time of our inspection there were 54 people living at the service.

There was no registered manager in place at the time of our inspection; the manager in charge of the home had submitted his application to the commission to become registered and was awaiting the outcome. 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 home was not suitably clean and the hygiene practices of staff did not meet the Department of Health guidance for the prevention and detection of infection.

The administration and storage of people's medicines was not in line with best practice or secure. People

Summary of findings

received their medicines on time and suitable arrangements were in place for the ordering and disposal of medicines. Records had also been completed accurately

People felt safe and staff could identify and respond to allegations of suspected abuse. The provider had safeguarding and whistleblowing policies which gave guidance for staff on the identification and reporting of suspected abuse.

We had feedback from people and relatives that the current staffing arrangements were detrimental to the quality of care that staff were able to provide. This was supported by our observations. Appropriate recruitment procedures were undertaken.

Records did not always demonstrate people's risks were regularly assessed. Although this did not present an immediate risk to people as their needs had not changed, it did not demonstrate the provider had robust review systems in operation.

Staff told us that training had been delayed and mentioned that they would like specific training in relation to the needs of people with dementia. This was significant given that the service regularly provides support to people living with dementia. Staff had not received regular supervision; the provider had not ensured that staff performance and progress was monitored effectively and that staff had an opportunity to voice their individual views.

Staff understood the Mental Capacity Act 2005 and training had been provided. The manager was aware of their responsibilities in regard to the Deprivation of Liberty Safeguards (DoLS) and where required the appropriate applications had been made. These safeguards aim to protect people living in care homes and hospitals from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely. Not all staff however were aware of which people were subject to DoLS.

We received positive feedback about the care staff and their approach with people using the service; however we observed occasions when people's dignity had been compromised. For example, we observed a member of staff speaking to a person using insulting language.

People had access to healthcare professionals when required and records demonstrated the service had made referrals when there were concerns.

Care plans were incomplete and were not reviewed as expected by the provider.

The provider had a complaints procedure and people told us they could approach staff if they had concerns.

Overall we found that quality and safety monitoring systems were not fully effective in identifying and directing the service to act upon risks to people who used the service. The provider had also failed to notify the commission of statutorily notifiable incidents.

We found ten breaches of regulations at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

The home was not suitably clean and people were at risk from poor hygiene practices.

The administration and storage of people's medicines was not in line with best practice or secure.

Staff were not organised to meet people's needs promptly.

Staff were trained in safeguarding adults and understood their responsibilities to protect people from potential abuse.

The provider undertook appropriate recruitment procedures to ensure only suitable staff were employed at the home.

Is the service effective?

Requires Improvement

The service was not always effective.

Records relating to people's care and treatment were not fully completed to protect people from the risks of unsafe care

We saw examples of good practice; however not everyone received effective care that met their needs.

Staff supervision and training was not up to date.

There was some knowledge and awareness amongst staff of the Mental Capacity Act 2005 and DoLS, however not all staff were aware of which people were subject to DoLS.

Is the service caring?

Requires Improvement

The service was not always caring.

We received positive feedback about the care and support that people received. However our observations showed that at times, people's care and dignity was compromised.

People were given choices in their daily routines; however feedback about how families had been involved in care planning was inconsistent.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Sufficient action had not been taken to ensure people's care records were fully completed. There was a lack of detail in the records to inform staff of people's life histories to provide personalised care.

Summary of findings

There were systems in place to respond to complaints however action was not taken promptly to resolve all complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

The systems in place for monitoring quality and safety were not sufficient to ensure that the risks to people were identified and managed.

Statutory notifications had not been made to the Commission for notifiable incidents.

Staff did not feel confident that their views and concerns would be listened to.

St Georges Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 28 and 30 April and 1 May 2015. This was an unannounced inspection which meant that staff and the provider did not know we would be visiting. This inspection was carried out by two inspectors and an expert-by-experience who had experience of services for older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The last inspection of this service was in January 2014 and we had not identified any concerns.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. Before our inspection, we reviewed the information in the PIR along with information we held about the home, which included incident notifications they had sent us.

On the day of the inspection we spoke with 12 people who lived at the home and who were able to share their experiences and views with us. We spoke with seven people's relatives who visited the home whilst we were there and on the telephone. We also spoke with 11 people employed at the home. This included the manager, senior management, care staff and nurses. We observed how people were supported and looked at 11 people's care records. We also made observations of the care that people received.

We looked at records relating to the management of the home such as the staffing rota, policies, incident and accident records, recruitment and training records, meeting minutes and audit reports.

Requires Improvement

Is the service safe?

Our findings

The general cleanliness in the home and in people's rooms was good and people we spoke with said the staff used personal protective equipment (PPE) such as gloves and aprons when carrying out their personal care. We did however observe that on two occasions two different members of staff left peoples bedrooms having provided personal care carrying soiled laundry in their arms through the corridor of the home. No sealed bag was used to transfer the soiled linen to the laundry; this presented a clear and unnecessary risk of infection.

We also observed hoist slings hanging in the corridor that were obviously soiled; we brought this to the attention of the manager who removed them to be laundered. We also saw that single purpose slings had been re-used and that shared slings were not laundered in between use by different people. In the laundry room we saw that there was not a dirty to clean flow for laundry and an open basket which contained dirty laundry was stored next to clean laundry. There were also clean clothes and linen being stored in the laundry room. In bathrooms we saw that the lino flooring was not completely sealed. We also found that clinical waste bins were left uncovered in one of the sluice rooms as well as soiled laundry bins being left uncovered in the corridors of the home; these appeared to be uncovered for ease of access. Clean commode pots were also stored directly above the sluice. These incidences increased the risk of cross contamination and the spread of airborne infections.

The kitchen was not suitably clean. There was dirt and grease around the standing unit legs and door frames. There was also floor covering that was coming away from the wall and broken and dirty wall tiles; grease and food crumbs had become lodged in the gaps. We also saw that there were three vegetables rotting on the floor in between the kitchen units. These spaces and incidences provided opportunity for contamination and the breeding of germs and did not contribute to ensuring a safe environment.

In the kitchen there were cleaning schedules in place which were completed by the kitchen staff however we found these were not audited or monitored efficiently by the provider. The provider had recently completed an audit of the kitchen and had failed to spot the concerns we found. This meant that the provider was unable to demonstrate how the kitchen maintained an appropriate standard of cleanliness.

These were breaches of Regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed part of a medicines round taking place. We saw the nurse interacting with people during the round. The nurse knelt down to the person's level and explained they had their tablets for them. The medicines were given to people safely and a record kept of their administration. We also observed them administering eye drops to one person. The eye drops were newly dispensed and unopened. They checked the labelling, and wrote the date of opening onto the label to inform other staff of when the drops should be disposed of. They washed their hands prior to administering the drops they did not however wash their hands after giving them. This meant there was a risk of cross infection to other people who were using the service.

Medicines were not always stored safely. The nurse was in a person's room giving them their medicines and the medicines trolley was left open in the corridor. The door to the person's room was open but the nurse did not have a clear view of the trolley. This practice continued for the remainder of the medicines round. There were loose tablets in medicine pots on the top of the trolley as well as boxes and bottles of medicines in the open doors on the trolley. We confirmed that nurse competency was assessed and that the trolley should be kept locked when unattended There was a risk that people using the service or any other person walking along the corridor could take these medicines and the home's policy was not being followed.

These were breaches of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We heard two nurses discussing one person who had been prescribed a sedative to help relieve their anxiety. This was prescribed on an "as required" basis. One nurse was informing the other that the person had responded positively to them talking with them earlier that day, and

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Is the service safe?

that the sedative should only be administered as a last resort. This showed us that staff recognised the need to help people be free of anxiety without the immediate use of medicines.

One nurse we spoke with told us that the clinical lead undertook "regular" medication audits and that the results of the audits were shared with staff in order to improve practice. They also told us "Sometimes, we audit each other too, which I think is a good idea".

Most staff had received training in safeguarding adults and the prevention of abuse. The home had safeguarding and whistle blowing policies and procedures in place. Some staff told us that if they felt their concerns were not being addressed by the provider then they would go to other organisations such as CQC. Other staff were unclear about the organisations they could approach but were aware of their responsibility to raise concerns about the welfare of people in the home. This meant people in the home were protected because staff knew the processes to follow if they were concerned about poor practice.

Appropriate checks were undertaken before staff began work and there were effective recruitment and selection processes in place. New staff were subject to suitable recruitment procedures; staff recruitment records were up to date. All of the required pre-employment checks had been completed and recorded. The records showed that the majority of recently recruited staff also had previous experience of working in care.

The home had completed an assessment of people's risks and had recorded guidance on how to manage identified risks. The risk assessments showed that assessments had been completed for areas such as nutrition, pressure sores, falls and mobility. For example, one person was at risk of developing pressure sores and we saw a risk management plan had been completed. The plan showed the person required a pressure mattress and should be prompted to sleep in their bed and encouraged to move around and change position when awake. The person had daily records of their movement and a record of their skin condition. These records had not however been completed daily as required.

People's records did not always demonstrate people's risks were regularly assessed. We raised concerns with the provider that some risk assessments and associated plans had not been updated on a monthly basis as required by the provider. The manager acknowledged that reviews should be undertaken as required by the care plan and told us that some reviews had fallen behind due to a change in staffing.

Incidents and accidents were recorded and cross referenced to the care files of people involved in the incidents. We saw that preventative measures were also identified by the provider wherever possible in relation to falls. The service had commenced a new method in the recording of falls by becoming part of the local authority falls prevention project. This project would also assist in identifying patterns of trends in falls and the provider would use designated documents aligned to the falls project to record any falls. There were however limited preventative measures identified when other incidents had taken place.

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Is the service effective?

Our findings

Care and treatment was not always planned and delivered in line with people's individual care plans. In every care plan that we looked at we found that reviews had not taken place as planned and that key information relating to people's health, risk assessments, lifestyle and preferences had not been recorded accurately or updated when required.

There was a lack of effective recording of people's nutritional intake to ensure they received enough to eat and drink to meet their needs.

Many of the people using the service were having their food and fluid intake recorded. These charts were kept in their rooms. The charts were not completed in full for many of the people and none had been totalled at the end of the day or had targets. This meant that care staff did not know how much food or fluid they should provide and assist people with, and that if people did not eat or drink enough, there was no clear action in place. For example, one chart we saw had nothing documented on it for the day of our inspection, but the notes stated "Breakfast and lunch given". At 13:00 hours, the same chart showed that the person had only received 200mls of a fortified drink all day. On another chart staff had documented that the person had refused a liquidised lunch two days before our inspection and had eaten six mouthfuls of porridge and six spoons of rice pudding all day. One of the nurses told us the person was receiving fortified drinks to supplement their poor diet. We looked at the person's care plan which stated they were receiving a "normal diet".

There were notice boards advising care staff which people were having their food and drink monitored, but there was inconsistent practice of completing the charts promptly and accurately. There was also no process in place to monitor the content of the charts or how to escalate any concerns. Without correct recording and action people are at risk of not receiving sufficient nutrition and fluids for their needs.

Where necessary people were referred to other health care professionals. One care plan showed that the person had lost weight. This had been identified by staff and there was evidence of input from the GP and a nutrition nurse. However, another person's care plan contained a weight recording from admission in January 2015, but there were no subsequent entries to monitor the person, despite the form stating "Residents must be weighed at least monthly". We asked the manager why care plan records had not been maintained we were told that agency staff did not always complete paperwork or handover all information about their shift, however the manager also accepted that there were improvements required to ensure records were maintained.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed the lunchtime service in the dining room on the first day of inspection and saw that two people were being assisted with eating and one resident was being prompted to eat by a nurse. The nurse got involved in helping people to eat with assistance when they were having difficulty. We also noted that there was some finger food for a specific resident who found it easier to eat this way.

People with pressure ulcers had care plans in place to guide staff in how to promote healing. These contained photographs of the wounds, but these were blurred and not of good quality. Staff would not be able to assess for signs of improvement, and in one picture the measurement rule that had been photographed was also blurred so we were unable to see the exact size of the wound. Staff told us "The camera is hard to focus, we need a new one". We saw that people had been referred to the tissue viability nurse and we saw notes in people's care plans from when they had visited to assess the wound.

Not all staff had received appropriate training to carry out their roles. Training records showed that some staff had completed a variety of training courses relevant to their role, such as manual handling, food hygiene, infection control and safeguarding adults. Training records demonstrated that staff had received appropriate induction training however there had been a delay in ensuring that regular refresher training had not been undertaken as required by the provider. This was further exacerbated by the training matrix which did not correlate with the actual training undertaken by staff. Further to this training records within staff files were also incomplete. For example according to the training matrix nine staff that had been employed within the last year or for over a year had

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not undertaken people moving training which was relevant to their role. The manager told us that there had been some delay in organising training due to the changes in management.

Staff said they had received performance supervision however this had been irregular; the supervision records we looked at supported this. We looked at six staff files; one new member of staff did not have a supervision recorded as they had been recently employed. The other five staff files were for staff who had been employed for over a year. Of these; three staff members had received one supervision within the last 3 months but had no others on file. The other two staff members had no recorded supervisions on file at all. Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff. The manager told us that some supervisions had been delayed since the change in management. This meant that the provider had not ensured that staff performance and progress was monitored effectively and that staff had an opportunity to voice their individual views. We also noted that staff had repeatedly asked for dementia training and that this had not been fulfilled.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had completed training on the Mental Capacity Act 2005 (MCA) and DoLS. This is legislation to protect people who may not be able to make certain decisions for themselves. They said this had been done through the both practical and on-line training. Staff told us how they supported people in making decisions and promoted their independence with their daily lives. Staff showed an understanding of what may constitute a deprivation of liberty and said matters such as this would be reported to the manager. One member of staff clearly demonstrated they aware that although people could make decisions about their daily care, more important decisions required a process to be followed. They told us about how best interest decision meetings could be held with people's families and other suitable healthcare professionals. They said this was to ensure important decisions were discussed formally and ultimately to ensure any decisions were made in the person's best interests.

The manager was aware of their responsibilities in regard to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. The manager had responsibility for making DoLS applications and supporting records showed there were two people in the home who had an authorisation in place to deprive them of their liberty in their best interests. Not all staff however were aware which people were subject to DoLS when they were asked. This meant there was a risk that people's rights would not always be upheld in line with their DoLS requirements.

People were supported to use healthcare services. People had regular health reviews with their GP and other healthcare professionals. People had regular access to dentist, opticians and chiropodists when they needed to. People could see their GP when they needed them.

When a person required additional regular clinical support this was provided. We saw within everyone's support plan that regular visits or appointments with dentists, opticians and chiropodists happened when required.

We recommend that the service reviews the process for ensuring they comply with conditions attached to a DoLS authorisation based on current best practice.

Requires Improvement

Is the service caring?

Our findings

We observed that due to the numbers of people that required regular assistance staff did not stop to spend much quality time with people. The manager told us that the staff numbers were based on the needs of people (dependency) and that more staff could be employed if the dependency need arose. The manager had carried out a needs analysis as a basis for deciding sufficient staffing levels and used agency staff to cover shortfalls. The manager reported that recruitment of staff was a priority to establish a stable staff team and reduce their reliance on agency staff. The manager was undertaking a recruitment drive to ensure that staff with experience of care would be recruited into the vacancies.

The staff were divided into teams on each floor of the building of the home to cover specific areas and people. We saw that in practice this didn't work well when one particular area was busy as staff from other 'teams' appeared to ignore call bells or calls for help from people outside of their 'area'. We observed four occasions when people were actively ignored when calling for help until the inspector asked staff to assist. We also observed a person calling for a drink of water whilst three members of auxiliary staff were stood outside of their open bedroom door; none of these staff went to assist or called anyone else to assist. We further observed that a person had to wait 30 minutes to be hoisted during the lunchtime period and a relative also told us that the person they were visiting recently had to wait 90 minutes to be assisted after the relative had made three requests for help from staff. Call bells were also going into 'alarm mode' throughout our inspection.

People and their relatives confirmed that staff did not answer their call bells promptly and that this had been a matter of concern for some time. We asked the manager to provide us with formal records of staffing level reviews to show that staffing was being continuously monitored to assess impact on people. The manager had been able to show us how staffing numbers were allocated in relation to people's dependency levels however he was unable to show us that there was effective monitoring of the organisation of staffing and how well that organisation met people's needs. This meant that the manager was not able to assess the impact of this on people. People were therefore placed at risk due to the lack of effective quality and safety monitoring systems in relation to staffing.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always treated with respect. We observed a member of staff speaking to a person using insulting language and we raised this with the manager. We also saw that some staff did not always consider the views of people they were caring for. For example on the first day of inspection we noted that there was loud heavy pop music playing whilst people were eating their breakfast in the upstairs lounge. We asked the three people present if they were enjoying the music, all three people gave a negative response and one person added that the staff put the music on for themselves. We asked a member of staff to alter the music to suit the people eating in the lounge. On the second day of inspection the loud pop music was on again whilst people were eating breakfast. When we asked the people in the lounge about the music they said they would like the music turned off, one person told us that the loud music was put on by staff every morning and no one asked if they liked it or wanted it on. They added that they could barely hear each other at breakfast.

People's privacy and dignity was not consistently maintained. For example, we observed one member of care staff walking into one person's room, without knocking, and pulling the curtains open without asking if the person wanted them opened. We then saw them brush their hair, again without asking if they wanted this done. Pop music was playing on the person's radio/CD player quite loudly. The CD player was out of reach and the person could not switch it off or change the volume if they wanted to. We asked if it was their choice to listen to it. A nurse asked the person if they would like the music changed and the person responded "If you like". The nurse showed us CDs that the person enjoyed listening to and then changed the radio to one of the CD's.

We received mixed feedback from people about the care and support they received; however a number of positive comments were made. Where people had concerns about the quality of care provided, they felt this was due to low staffing levels rather than the abilities and approach of individual staff members. One relative said that when she

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Is the service caring?

had arrived that day after lunch, her relative who required support in her chair with pillows and cushions had not been properly supported and was falling over to one side and very uncomfortable. She went and found staff who said they would come and do it when they were free but it took a little while though her relative was fine afterwards. One person told us that the staff were mostly good, but at times they could be pushy not sensitive and gentle with their handling. Another person also said the; "staff can be pushy if they're short staffed". Another relative said "people are always clean here, the food is really good, and some of the staff go the extra mile, an example being they will get down face-to-face when they are talking to residents, and the home has really improved in the last month".

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other staff we observed and spoke with treated people with compassion and kindness. For example staff told us; "I like being able to help people and make them happy", "It's really important to listen to people; more important than speaking really" and "I think of the people here like my grandparents and I treat them how I would like to be treated". One staff member told us "I love the rapport I can build up with the elderly people. We can really get to know them". Some staff told us they did not feel they had enough time to spend with people. One told us; "I wish we had more time to do nice things with people, like doing the ladies' nails" and "There are plenty of activities for people, but some don't want to mix and do group things so we need to make sure they get that 1:1 time".

Staff gave good examples of how they gained people's consent for example before assisting a person to wash Staff told us; "It's important to listen to what people say and to give them choice" and "Lots of people here can make their own choices, so I encourage independence and respect people's wishes". Another member of staff told us "I always ask first before I do anything. Usually people will be quite happy for you to assist them with hygiene for example, but you should never just go ahead and do it".

Requires Improvement

Is the service responsive?

Our findings

We found that pre-admission assessments were undertaken to gather information about a person's individual needs prior to their admission. These assessments were a pro forma document which covered a number of areas such as mobility, activities, continence etc. In the care plans we looked at some of these assessments were fully complete and others were lacking in any detail. We found that this corresponded with the quality of information within the eventual care plan. The quality of person centred information was not consistent within the care plans and we found that they had not been reviewed on a monthly basis in line with the provider's procedures; the plans we saw had been reviewed every one to three months. Some care plans were written in the first person, others were not.

A life history document that was intended to give staff more information about the person and to aid person centred care was also not complete in a number of care plans. We were told by the manager that some attempts were made to gather information about a person's individual needs on admission to the service about people's preferred activities and their wishes for how they wanted to be cared for; however this was not in place in all files that we viewed. The manager said efforts had been made to obtain more information from the people themselves and from their relatives. There had been limited success and very little had been added to the information in people's care records.

We saw that people had been involved in their care planning. For example we saw a bed rails assessment had been signed by the person using the service. We also saw that each care plan contained an individual preference list. This was used to inform staff of the individual person's preferences for when to get up, when to go to bed, where they would like to eat their meals etc. However we found that these lists were not always fully complete and that one person who had moved into the home during January 2015 had not yet had this list completed by staff. This meant that the person's choices might not be known to or considered by staff.

We received mixed feedback from relatives about whether they had been included or involved in care planning. Some relatives told us that they had not been consulted by staff on their views and opinions, while other relatives confirmed that they had been involved in decision making, for example in relation to the use of bed rails. We found that the level of involvement of relative and other representatives was inconsistent. This meant that where people were unable to express their opinions about the care they wanted, there was a risk that important information about their care would be overlooked.

A nurse told us that care staff were able to access the care plans, but when we spoke with care staff, not all of them had read the plans of the people they were caring for. One nurse told us "The plans should be reviewed at least monthly; some of them weren't before, but this has improved". We saw there was a care summary in people's files that was kept in their room. It was not clear how this was reviewed and amended if a person's care needs changed when care plans were not always reviewed as often as they should be.

There was an activity coordinator in place and care staff undertook activities with people as time allowed. Some people's care plans identified activities that were suitable for the individual concerned; however recordings were not made on a regular basis in people's care files to monitor the suitability and provision of activities for people. This meant it could not be monitored and confirmed if people's social needs were being met. One person also said that when there were entertainments going on in the afternoon that their afternoon drinks were missed out. Other people told us that there were no activities on the weekends or many trips outside of the home unless you wished to go shopping with a member of staff. People said they wished to go out of the home and socialise in the community. We asked the manager about his and were told that 'outings' were limited due to the cost involved but that people could go out into the community with staff.

We also spoke with the staff about providing people with person centred care that met their needs with regard to their activities and companionship. The majority of staff told us that they did not have time to do this and relied on the activities coordinator.

All the above information amounted to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were given choices in their daily routines which helped ensure that their views were listened to and that they were involved in planning their own

Requires Improvement

Is the service responsive?

support as far as they were able. We spoke with people about the choices they had around their care one person said that when they had their meals she had a choice of having it in her own room or in the dining room.

We also found that people's individual bedrooms were well furnished and people were encouraged to personalise their rooms with photographs and memorabilia from home. This helped ensure that people's rooms were arranged in accordance with the person's wishes and preferences.

People in the home and their relatives confirmed with us that their views and opinions were sought through a yearly survey and through resident and relative meetings; this gave people opportunity to express their opinions and raise any concerns that they may have and as a means of keeping them up to date with developments in the home.

People's friends and relatives frequently visited. Visitors were welcome at any time and were able to join in any activities that took place. Information was displayed about the activities provided for people in various areas of the home; this included information about events such as outside entertainers coming in to the service.

There were systems in place to respond to people's complaints and we saw that the procedure for making a complaint was advertised in the home. We viewed examples of formal complaints that had been addressed by the provider and manager and saw that the concerns had been responded to. We did however find that an ongoing issue in relation to the time taken for staff to answer call bells had been repeatedly raised with the provider and manager over the previous eighteen months and that although the issue had been looked into and plans were being made to purchase equipment to audit the call bells, no actual action had been taken to resolve the issue which was still an ongoing concern.

Requires Improvement

Is the service well-led?

Our findings

There had been no registered manager in place at the home since December 2014. A new manager was in place and was undergoing the registration process with the Commission.

There were systems in place within the home to monitor quality and safety, however these had not been fully effective in ensuring consistent and good quality care was delivered throughout the service. We saw records of quality audits completed by the provider's representative and the manager which included areas monitored such as: health and safety, infection control, care plans and medicines. These audits were completed on a monthly, quarterly or annual basis according to the type of audit. All audits had been undertaken within the timescales set by the provider but had not identified all of the shortfalls in the service provision so that action could be taken to rectify these.

The home also reported on a monthly basis in relation to the number of pressure ulcers, information about people's nutrition and the number of infections. However there were no comments or actions recorded on the report to show whether any action was being taken in response to it to make any necessary improvements.

The last infection control audit did not find the poor practices we found in the laundry area of the home. The laundry area did not comply with the Department of Health's publication; The Code of Practice for health and adult social care on the prevention and control of infections (code of practice). We also identified that boxes had been ticked on the provider's infection control audit to confirm that bathrooms had pedal bins when in fact they all had flip top bins. The bins were replaced during the inspection however the audit evidenced that it had not been completed thoroughly. The last kitchen audit had been undertaken by the provider some six weeks prior to the inspection and detailed some of the concerns we had found. This audit however had not been shared with the manager of the home prior to our inspection and he was therefore unable to rectify the areas of concern promptly.

We asked the manager for the call bell audits for the last month. We were told that no formal audits took place. This was because there was no system in place to record the call bells. We asked how the manager ensured that staff were responding to call bells and that people were not waiting an inordinate amount of time for their call bells to be answered. We found that the manager and provider had failed to implement a system to effectively monitor call bell responses. There was no system in place to effectively assess the call bell responses to ensure that people were receiving care that ensured their safety and welfare

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All services registered with the Commission must notify the Commission about certain changes, events and incidents affecting their service or the people who use it. This also includes allegations of abuse and serious injuries to people. We found that the manager was not clear about the recording and informing processes for statutory notifications and had not responded appropriately in making statutory notifications to the Commission in relation to serious injuries and allegations of abuse. We found that two incidents we looked at constituted statutory notifications and none had been made; the manager stated that they were unaware that these incidents had required reporting to the Commission as statutory notifications.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. Customer satisfaction surveys were sent out to the people living in the home and their family and representatives. This survey received a good response and people living in the home raised a number of issues they wished to be addressed. The manager told us they had initiated actions as a result of the surveys. These actions were recorded as part of an auditable action plan; they did not however all have set timescales for completion. This meant that the provider was unable to ensure that the progress of actions were reviewed and met in a timely way.

"Residents meetings" were held at least quarterly for people living in the home. These meetings gave people an opportunity to discuss their concerns and raise issues. We saw records of the minutes from these meetings. People living in the home had raised various issues similar to those received in the feedback from the surveys. Similarly the

Requires Improvement

Is the service well-led?

actions were recorded as part of an auditable action plan; they did not however all have set timescales for completion. The manager was unable to answer if all actions had been followed up.

People living in the home told us that they generally felt that their views were taken into consideration. People did however express that they felt that they did not always receive feedback for requests they had made particularly in relation to activities.

Some of the people and relatives we spoke with also told us that they had never met the manager or knew that a new manager had been appointed. It was unclear why this was as there had been residents meetings and newsletters introducing the manager. People and relatives did comment that the manager rarely popped by people's bedrooms to say hello.

We spoke with staff about how well they felt able to raise concerns or issues. We received mixed comments including;

Members of staff told us there had been a staff meeting "a couple of months ago", but not all had attended. One told us "There have been lots of changes here; it's hard to keep up sometimes. One manager had everyone on food charts, then another took everyone off them, and now some are back on them". One told us "Personally, I don't think the manager is very approachable and they stay in their office a lot. They're not very visible". Another member of staff said that the manager was not approachable and spoke to staff rudely when something went wrong. Some staff told us they felt they could speak to the management team and one told us they had raised concerns in the past, and that these were taken seriously. Other staff told us "It's homely here and the team are supportive of each other" and "It feels like care is person centred here and not task oriented".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The home was not clean and people were at risk from poor hygiene practices. The administration and storage of people's medicines was not in line with best practice or secure

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Records relating to people's care and treatment were not fully completed to protect people from the risks of unsafe care People did not receive effective care that met their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Not all staff had received appropriate training to carry out their roles The provider had not ensured that staff performance and progress was monitored effectively. The provider had not ensured that statutory notifications had been made for notifiable incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

People were placed at risk due to the lack of effective quality and safety monitoring systems in relation to staffing.

Systems in place within the home to monitor quality and safety, were not fully effective in ensuring consistent and good quality care

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not always treated with dignity and respect.