Abbey Ravenscroft Park Limited

Abbey Ravenscroft Park 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

Summary of findings

Overall summary

This inspection took place on 2 and 3 March 2016 and was unannounced. When we last inspected on 8 April 2015 we found the service was not meeting three legal requirements with regard to medicines, staff supervision and care records. At the current visit we found that these issues had been addressed.

The Abbey Ravenscroft Park Nursing Home is registered to provide accommodation, nursing and personal care for up to 67 older people. At the time of the inspection there were 57 people living at the home. The home had a registered manager in place. 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.

We found improvements in the management of medicines, staff supervision and recording in care plans as required at the previous inspection. However we found a number of new issues which required improvement.

We were concerned to find insufficiently rigorous recruitment systems in place for new staff, to ensure the protection of people living at the home. We also found that staff were not fully trained in the Mental Capacity Act 2005, and people who were unable to make decisions for themselves, were not always sufficiently protected by the procedures specified in this Act. Although quality assurance systems were in place, they were not sufficiently thorough so as to identify and address a number of significant shortfalls that were found during this inspection.

Staff had some knowledge of people's preferences regarding their care and support needs, but care plans were not always sufficiently personalised to record people's specific care needs and choices, and risk assessments did not always include clear actions to minimise the risk of harm. Staff were clear about the procedures for reporting abuse.

The home was kept clean and hygienic, and people were provided with a choice of food, and were supported to eat when needed. People had a range of activities available to them, and access to health and social care professionals. When people made complaints they were addressed appropriately.

At this inspection there were three breaches of regulations relating to staff recruitment, mental capacity and quality assurance, and one recommendation relating to care records. You can see what action we told the provider to take at the back of the full version of the report.

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 always safe. Recruitment procedures were not sufficiently rigorous to ensure that only fit and proper staff were employed at the home. There were sufficient staff employed to meet people's needs.

Assessments were in place to minimise risks to people, and there were improvements in the management of medicines in the home, although there were further areas for improvement found.

Staff knew the correct procedures to follow if they suspected that abuse had occurred.

The home was clean and hygienic.

Is the service effective?

Requires Improvement

The service was not always effective. Staff supervision frequency had improved, however there remained some variation in the frequency provided to ensure they had the support and monitoring needed to care for people effectively.

Staff understood people's right to make choices about their care. However they were not aware of people who were subject to a Deprivation of Liberty Safeguard in order to ensure that their rights were protected accordingly, and best interest decisions were not recorded for people whenever needed.

People received a choice of meals and staff supported them to meet their nutritional needs.

People's health care needs were monitored. People were referred to the GP and other health care professionals as required.

Is the service caring?

Good

The service was caring. Staff were caring and knowledgeable about the people they supported.

There was consultation in place for people and their

representatives about their care and support, and efforts were made to meet their social and spiritual needs.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans were in place outlining people's care and support needs, however these were not always sufficiently detailed to include people's preferences.

Staff were aware of people's support needs, their interests and preferences. A range of activities were available for people including occasional trips out of the home.

People using the service and their relatives were able to give feedback on the service and use the complaints system.

Is the service well-led?

Requires Improvement

The service was not always well-led. The home had systems for assessing and monitoring the quality of the service, however these did not always pick up shortfalls so that these could be addressed without delay.

People found the management team approachable. However there were insufficiently regular meetings with people using the service and their relatives, and staff working at the home, to ensure their involvement in the running of the home.

Abbey Ravenscroft Park 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 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.

At the previous inspection of the home on 8 April 2015 we found that the provider was not meeting three legal requirements with regard to medicines, staff supervision and care records.

Prior to the current inspection we reviewed the information we had about the service. This included information sent to us by the provider for rectifying the breaches identified at the last visit and notifications of incidents that had occurred. We also spoke with a health and social care professional about their views of the quality of care in the home.

This inspection took place on 2 and 3 March 2016 and was unannounced. The inspection was carried out by three inspectors (one of whom was a pharmacist inspector), a specialist professional advisor who was a nurse with knowledge of older people's needs, 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.

During the inspection we spoke with twenty people using the service, six relatives of people using the service, and a health care professional visiting people living at the home. We spoke with four nurses, seven care assistants, the director, registered manager, deputy manager, administrator, chef, a domestic worker, and an activities coordinator on duty. We looked at the care plans, risk assessments, and daily records relating to 16 of the 57 people who were living at the service. We looked at nine staff files (including recruitment records for three nurses and six care assistants), the last month of staff duty rosters, accident and incident records, selected policies and procedures and two financial records, and 19 medicines administration charts for people using the service.

Requires Improvement

Is the service safe?

Our findings

People told us that they or their relatives felt safe at the service. When asked if the home was safe, one person told us, ""Yes it is, otherwise I wouldn't live here," and another person said, "It is very safe here." One person told us that they had once waited a long time after ringing for assistance after a fall, noting, "They were busy with someone else. Otherwise it's all been good so far." Another person said, "I've had residents walk into my room," but noted that staff guided these people out when called.

At the previous inspection in April 2015 we found that the medicines requiring refrigeration were not stored securely and there was insufficient monitoring of the storage temperature of medicines. We found that these issues had been addressed at our current inspection. We also found that a significant number of people were prescribed as and when (PRN) medicines for anxiety or challenging behaviour without written protocols in place to ensure that they were not given more frequently than necessary. At the current visit we found some PRN protocols in place, however these were not in place for all people prescribed medicines for behaviour that challenged the service. We brought this to the attention of the registered manager, who advised that these had been produced for all people, however some of these had been archived by accident alongside previous medicines administration records (MAR). She undertook to ensure that these were retrieved and reviewed without delay.

People told us that they were given their medicines on time. One person said, "After 9 am and same again in the evenings they are very good with that". Another person noted, "I'm not sure what they are for but they come in the morning and afternoon to give us some." A relative told us, "We have been here when they talked about the medication and explained everything."

Medicines were stored securely in locked cabinets within locked clinical rooms. Medicines were also stored in locked medicines trolleys, attached to the wall when not in use. In one instance, the medicines trolley had been moved to the communal lounge area as the ambient temperature of the clinical room on that floor was too high. The temperature of the area where the medicines trolley had been moved to was being monitored appropriately. All refrigerators for medicines were kept locked. Storage temperatures were taken each day; however the staff at the home were advised to seek training on how to reset the thermometers correctly.

Medicines for the home were delivered on a monthly basis with most medicines dispensed into blister packs. Each compartment of each blister pack was labelled with the date, time, contents for that compartment, and the name of the person. Registered nurses were responsible for the administration of medicines. Records included relevant information such as photographs, swallowing ability, compliance, thickening requirements and any allergies or reactions. We observed that people were given PRN pain relief as needed, and there was a robust system in place to record refusal of medicines.

Prescribed medicines were in stock for people living at this service; however there was one person who had missed doses of Olanzapine tablets because they had been returned to the pharmacy in error. Running balances were not kept for medicines that were not dispensed in the monitored dosage system, which

meant that the nurses did not always know when a medicine was due to run out, and instead relied on the pharmacy to supply enough medicines each month.

We found gaps in MAR charts for 11 of the 19 people's records inspected, which may have indicated missed doses of medicines. Staff could not confirm whether or not these people received the medicines. Topical creams were administered by care staff as they assisted people with personal care. Although there were some topical MAR charts in use, they were not always fully completed and did not always indicate where the creams should be applied, whether they had been offered to people, or whether people had refused to have them. In one case we observed a nurse signing for morning medicines before giving them to the client. The client then refused to take the medicines. Later that day, the nurse said that the client was eventually persuaded to take the medicines at around midday; however the documentation on the MAR chart did not make it clear that the medicine had been given later than prescribed.

Controlled drugs (CD) were stored in locked CD cabinets and balance checks for each floor of the home were completed twice a day by two registered nurses. Random checks of several CDs were carried out and we found that the quantity in stock matched the quantity recorded in the CD registers. There were appropriate systems in place for the disposal of medicines no longer required.

We saw evidence that covert administration (medicines disguised in food) for people had been agreed with their next of kin, GP and a pharmacist. However the covert administration agreement form was not clear regarding administration instructions for the medicines. Medicines that needed to be given covertly included a modified release capsule which should not be opened and enteric-coated Aspirin tablets, which should not be crushed. The deputy manager undertook to review these formulation choices with the GP.

We were told that the deputy manager conducted audits of the MAR charts and the pharmacy staff undertook an annual medicines audit. However we did not see any evidence of this. There did not appear to be a system in place for reporting medicines errors. None had been recorded recently, and yet we observed medicines out of stock and gaps in recording on the first day of our inspection. We were also concerned to find that new nursing staff, who were routinely administering medicines, had not yet been assessed for medicines competency. We brought all these issues to the attention of the registered manager who undertook to address them without delay.

We found that recruitment procedures were not always sufficiently rigorous to ensure staff were suitable to work with people. Files of new staff did not always include a recent (or portable) disclosure and barring check prior to commencing work, and two written references. We found that two staff members had only one written reference on file, and two staff members did not have a completed satisfactory disclosure and barring check prior to commencing work at the home. We also found some gaps in people's employment histories which had not been explored with them at interview.

The above information was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service, relatives and staff members indicated that there were enough staff available. People told us "The staff I've seen are all good and help me with whatever I need," "Yes they are always busy but there are a lot of them," "I've never had any issue with staff not coming when we need them." A relative said, "When we come here there are always the same staff members which we find reassuring as they know how to look after them."

The staffing numbers observed on the day were noted to be consistent with the rota, and adequate for the

care provided. Four nurses worked in the day time (three at weekends) alongside fourteen care staff. At night there were two/three nurses and five/six care staff covering the home (eight staff in total). The registered manager advised that the home was fully staffed, with one new nurse and two care staff recruited recently.

People and their relatives told us that they could raise any safeguarding concerns with staff or the management. Staff showed an understanding of the service's policy regarding how they should respond to safeguarding concerns. They had received training in safeguarding adults and knew who they should report to if they had concerns that somebody was being abused. They were aware of the different types of abuse that people might experience. We saw evidence that incidents were reported appropriately. However staff were less clear about the service's whistle blowing policy. We looked at records of finances maintained for safekeeping for two people living at the home, and found these to be appropriate.

Assessments were in place to ensure that risks to people were minimised. There were detailed risk assessments for identified risks including falls, pressure ulcers, weight loss and moving and handling. These were reviewed monthly or more often when needed, including a record of changes to the level of risk and actions identified to address them. Nurses had knowledge of general first aid and emergency provisions within the home such as the presence of resuscitation equipment. Appropriate safety checks were in place for the home including fire safety, gas, and electrical safety certificates.

Access to the building was secure, with windows and doors safely closed/locked. We observed staff moving and handling people appropriately. Transfers were carried out competently and safely, with minimal distress to people. However we found that several people with dementia or confusion walking around the home were at risk of entering people's rooms (which were not locked) and accessing personal items (which could easily have included prescribed topical creams and razors which were not stored out of sight). We brought this to the attention of the registered manager who undertook to review the home's risk assessment in this area.

People told us that the service was clean and we found a high standard of cleanliness and infection control throughout the home during the inspection visit. Cleaning charts were kept which showed that there were clear systems in place to ensure that all areas were cleaned regularly, including carpets and equipment such as wheelchairs. However one relative was unhappy with the standard of cleanliness of their family member's room and we observed that this did need improving, and passed this on to management to address. We observed that staff wore disposable blue aprons and hair nets during meal times to ensure infection control.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection in April 2015 we found that staff received insufficient supervision sessions and appraisals to support them in their role. Following the inspection the provider sent us an action plan about how they were going to address this breach. We found an improvement in the frequency of supervision provided to staff at our current inspection.

People spoke positively about the staff that supported them. When asked if they were happy with staff support, they told us, "Yes it was part of the reason why I chose this place," "Staff always know how to help me," and "Staff are really good." They noted, "Staff are very good and aware of what I need," "I know that if I needed to ask for anything I would get it," "Staff are there when you need them but not in the way all the time," and "The staff are easy to talk to, but can be very busy."

Staff told us that they felt well supported, and described good team work, and communication within the team. We found some variation in the frequency of individual staff supervision with some exceeding the frequency stated in the provider's policy of quarterly supervision, but others who had received less frequent supervision. However there was also group supervision in place for staff members. We were concerned at the lack of supervision sessions recorded for some of the new staff, and discussed this issue with the registered manager, who advised that it was an area that was being prioritised. We did observe that there had been a significant number of individual supervision in recent months prior to the inspection, and appraisals were in the process of being provided to staff members. Areas covered included people's strengths, areas for improvement, barriers to improvement, targets set and achieved, and training needs.

There was a low turnover of staff indicating that staff felt supported at the home. Induction training was in place for new staff, including shadowing more experienced workers, learning around the needs of the client group, and completing the national 'care certificate'. Staff were positive about the standard of training. Staff told us that they were supported to undertake national vocational qualifications in care. A mandatory training matrix was in place for the service, indicating which staff had undertaken each training course, or were due to do so or have refresher training in this area. This tool indicated that further dementia, syringe driver, and dysphagia (swallowing difficulties) training was required for nursing staff. Wound management training had already been organised for the nursing team to attend.

Staff told us that there was generally a weekly staff meeting on each unit of the home, however these meetings were not minuted. We saw records of quarterly meetings for the staff team including night staff meetings. Recent topics discussed included rota cover, activities and CQC compliance.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). This provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and

legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

People said they were able to make choices about their care, with the exception of one person who said that they were not always allowed to go to their bedroom when they chose. However most of the care staff and two of the nurses we spoke with did not have a clear knowledge of the DoLS requirements and the home's training matrix confirmed this gap in training. We found that significant progress had been made with undertaking DoLS applications since the previous inspection. However people's care plans did not always make it clear when they had a DoLS granted, and in three cases where DoLS had been approved with conditions, none of the staff including management, were aware that conditions were in place, so there was no recorded evidence that these conditions had been met. There were MCA assessments in place, however these were generic rather than decision specific, and few included a record of the best interest decisions made for people unable to consent.

The above is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The deputy manager was clear that best interest meetings needed to take place and said she had started to undertake these meetings for those people who had been assessed as lacking capacity. Staff did have an understanding of routinely seeking consent and giving choices when providing care. One staff member gave an example of offering a person a bath, saying "Try again if people refuse, they may change their mind." There were clear records of people's advanced wishes and 'do not attempt resuscitation' forms demonstrating people's choices and their relatives' wishes.

People were positive about the quality of food served in the home. They told us, "Dinner has a lot of options and I like all of it," "They come round at any time and ask me what I want to eat that day," "Food here is very good," "I like the food here," "It's not bad," "We get tea and biscuits at 10 am and 3 pm," and "I've never had an issue with getting a drink."

We observed breakfast and lunch on all floors during our inspection, with two main choices provided and specific dietary and soft lunch options available. One person was provided with their preferred cultural food, approximately twice a week. Food appeared appetising and people appear to enjoy it. Breakfast consisted of cereal, toast, bread and jam, and boiled eggs (care staff told us that a cooked breakfast was offered at weekends and twice during the week). There were two choices for lunch, and staff advised that alternatives could also be provided if neither option was chosen. At lunch time on one unit, we observed that all but two people were served their lunch, and the remaining two started becoming impatient, when their food was provided, one of these people refused to eat. We observed two staff noting that this person needed to be fed first, and they both decided to try again later. Some people were given clothing protectors during meal times, however in some cases these were put on approximately 20 minutes before their food or drink was served. Two staff were seen standing whilst 'feeding' service users. The pace and quantity of food per mouthful was appropriate to people's needs and no one was seen to be in distress or heard coughing/choking.

People appeared to have access to sufficient fluids throughout the day. We observed staff offering hot drinks at set times throughout the day and refilling cold drinks at other times. Staff were heard giving encouraged and reminders to people to have drinks. Menus included at least two choices for each meal, and vegetables of the day. There was a choice of meals beyond the published menu with acknowledgement of cultural needs as well as personal preferences. Dietary adjustment and supplements were evidenced in care plans, and medicines records. We observed some us of photo menus for people with dementia, to assist them in

making decisions.

Food and fluid charts were in place for people on a reduced dietary intake, or where concerns about their nutrition were identified, to monitor the amount of food or drink they consumed. Where necessary we saw that people had been referred to the dietitian or speech and language therapist if they were having difficulties swallowing. Nutrition and hydration was monitored by monthly weight records, reporting by care staff, fluid balance charts and food diaries. Appropriate systems were in place for people who received food via a PEG tube (directly into their stomach).

People confirmed that they had access to health care professionals, and we saw this documented in their care records. People were registered with a GP, mostly a local GP but some people retained their GP from prior to staying at the home. Arrangements were made for people to be reviewed by a range of health and social care professionals including their GP, physiotherapist, chiropodist, occupational therapist, social worker, dentist and optician. We observed that instructions from health care professionals such as a tissue viability nurse (regarding pressure ulcer care) were followed by staff at the home. Clear records were maintained of the outcome of health care professional visits. Staff recognised that people's health care needs could change and demonstrated awareness of how these should be reported and effectively acted upon.

Good

Is the service caring?

Our findings

People told us that they felt well cared for, and that they were treated with dignity and respect. Comments included, "It's lovely here, they do their best," "Staff are good," "The staff always have time to talk and listen," "The staff are very busy but very good, I can always speak to one of them if I need to," and "I have been here two weeks and it is generally very good. Sometimes I have to wait a long time for things." Relatives were also positive about the caring nature of the home. One relative told us, "On my father's birthday we had a party with 20 family members. The staff here were very accommodating and they even bought him cake". Other relatives told us, "It's quite good here, I bring my daughter with me sometimes and she gets on well with the staff too," and "On the whole a very good home."

During the inspection people were observed to be treated with kindness, respect and compassion. During the course of the day staff were observed to be interactive with people and we noted good natured exchanges and communication. We saw staff being caring toward people living at the home. They spoke politely and were supportive to people. Staff demonstrated an understanding of dementia awareness and how to care for particular people. However, although staff were around at all times and most interactions were kind and positive, there was little time for social interaction beyond those relating to the immediate task at hand such as support with care needs, food and drink. Once people were seated in the lounge there was little interaction with them from staff, as they supported other people.

People confirmed that their privacy was respected, they told us, "Yes the staff always knock before they enter my room and they asked me if it'll be okay to go in my room when I'm not there." However one person told us, "All the doors are usually left open and residents just walk into my room. The staff do try and help." The staff were observed to respect people's need of privacy and knocked and waited for a response before entering any room.

We observed one person calling out for help, whilst staff appeared to chat in one lounge, and that on one unit people who required clothing protectors had these placed around their necks approximately 20 minutes before their meals were served, which impacted on their dignity. We also noted that two staff members stood as they supported people to eat. We brought these issues to the attention of management who undertook to address them without delay. However we noted good support from care staff seated next to people whilst supporting them with food. During mealtimes we saw that staff had a good awareness and familiarity with the client group. Support with moving and handling people was observed to be appropriate, with a lot of verbal interaction between the staff and individual being supported.

People told us that they were involved in producing their care plans, to ensure that their preferences were incorporated. Some of the care plans had been signed to indicate people's involvement including consent forms when needed. We found detailed information of some people's life histories, and their individual preferences recorded, with a clear indication that relatives had been involved. Staff reported that they knew people well and had a good understanding of personal histories and preferences. Staff told us, "Residents' likes and dislikes are important to us," and "The history of residents helps me with looking after them and gives me a chance to talk to them about their past." We observed that two people living at the home were

supported to have their pet cat in their shared room.

Staff understood people's needs with regards to their disabilities, race, sexual orientation and gender. Care records showed that staff supported people to practice their religion and attend community groups that reflected their cultural backgrounds. A religious service was available to people on a regular basis. The provider also held memorial services for family and friends periodically to celebrate the lives of people who had lived at the home.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection we found significant gaps in people's care records including pre-admission assessments, nutritional and skin integrity assessments and monitoring records for blood sugar levels and blood pressure. The provider sent an action plan indicating how these issues would be addressed, and we noted improvements during the current inspection.

People told us that they were comfortable that the service responded to their needs, providing them with pain relief, and supporting them when they were unhappy. They told us, "I can ask for extra medication when I need it," and "The staff always listen to what I need," and "they all are very good and do listen." A nurse carrying out medicines administration told us, "I get to speak to and interact with every resident during the process and I am aware of the need to be aware of any change of presentation that may need a response." Another staff member told us, "We are aware of the care plans and know how to inform staff if there is any change."

Care that we observed was given in a personalised manner, reflecting the needs and wishes of the individual. Care records included a care and support plan and risk assessments, daily care records, monitoring charts and activity/social records. Care plans were in place to address people's identified needs, and were reviewed monthly or more frequently when a person's condition changed, to keep them up to date. People living at the home and their relatives confirmed that they were consulted about their care when they moved into the home and when their needs changed.

We found some variety in the level of detail included in people's care plans, with many seen lacking information about people's preferences and details such as how drinks should be thickened or wound care provided. Risk assessments mostly consisted of scoring each risk without a clear action plan to address them for example in supporting people to mobilise. One person's risk assessments for mobility, dexterity, diet, oral health, bowel and bladder control, speech, hearing, sight and foot care indicated that special assistance was required. However there was no indication of what the special assistance was. Care records did not include details of how to support people in each area, what they could do for themselves, or their personal preferences and choices. One record for a person, who was unable to use the call bell, indicated 'check frequently' but did not specify how often. We found that one care plan included inaccurate information about a person's continence needs, and some inappropriate use of language for example using the word "fits" to describe epileptic seizures.

We also found that admission assessments particularly for self-funding people, did not include detailed information about people's needs to ensure that the home was able to meet them. Monthly updates on people's care records were in most cases brief, and we found some missing updates and reviews for several months in 2015. The deputy manager had recently been assigned the role of overseeing care records, and described the auditing and recording system in place, and plans to ensure that monthly updates were more personalised and detailed, and ensure that accuracy of information.

Accidents were recorded appropriately however there was no record of actions taken as a result to avoid a

reoccurrence and the home was not routinely using body charts to record injuries and other skin markings for people living at the home, to ensure that these were monitored. □

Food and fluid charts for people at risk of poor nutrition or dehydration were well recorded and we were told that there was no one living at the home who required the daily total amounts of food and fluids to be completed.

People told us that they were satisfied with activities provided. One person said, "Twice a week someone comes down and we play games, bingo is on Fridays, someone also comes around and sings. They do quite a lot of other things I just don't go along to them." Others told us, "I like to go to bingo," and described, "a church service we try to attend," and "a nice Christmas party here."

The home offered a programme of activities on weekdays, with two activity co-ordinators employed, on Sundays a volunteer provided one to one sessions with people. A poetry session was held on the morning of our visit, and balloon tennis was also played with people who were sat at the dining room table that morning. People were actively engaged and seemed to enjoy this activity, although it both started and ended rather abruptly. However the lounge on Rose unit held little to occupy people and most people slept through the morning and afternoon, only waking to eat meals. Those people unable to mobilise without staff support were effectively unable to leave this area, other than when they were supported to use the toilet. The lounge's chairs were set out along the walls with the television at one end of the room, so that most people could not view it. It was left on all day without any sound. Instead music (appropriate to the age of people living at the home) was played. For those who could see the television this would have been quite confusing.

Activities recorded included one to one sessions, puppetry, arts and crafts, skittles, reminiscence, newspaper discussions, flower arranging, keep fit, barbeques, and entertainers including a children's ballet, singers, and instrumentalists. Occasional excursions out were arranged including trips to a garden centre with a zoo, Capel Manor, Brick Lane and bowling, in the last year. There were birthday parties, and parties to celebrate other events such as St Patrick's day. Management advised that a wedding was planned at the service, by family members of a person who lived there. Large key computers were available for people to use, and activities staff advised that they often supported people to use google earth to look at the area in which they lived, or grew up.

People told us that they knew how to make a complaint, and felt that the management team listened to any concerns they raised. All but two relatives were satisfied with the way their concerns were addressed. We discussed some of their concerns with the registered manager, who undertook to be more proactive at addressing concerns before they became complaints. There was a notice displayed in the home explaining how to make a complaint, and recent resident and relatives meetings had been held at which people had an opportunity to raise their concerns. Records were in place of all complaints received since the last inspection, including details of action taken to address them.

We recommend that the format of care records including risk assessments be reviewed to ensure that they contain sufficient qualitative information for supporting people in a person centred way.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us that they were generally happy with the way that the home was run and their day to day experiences of staff and management. One relative said, "We spoke to one of the managers before my [relative] came to here. She answered all my questions and knew a lot about her condition and how to look after her." Others told us, "Senior staff are nice and approachable. They take time to answer any of my questions," "The staff are great," "They do everything right and they make sure everyone is fed," and "They listen to the things we say and get on with it. Like when they moved in the bathroom floor was old and dirty, and they went and replaced it."

Staff spoken with were helpful, co-operative and described an open culture within the home. They told us that there were regular staff meetings and supervision sessions in place to discuss issues of compliance, address any shortfalls and receive feedback from managers. Staff said that they had opportunities and systems for raising concerns. However we found that there staff meetings, and meetings for people using the service and their relatives were not held on a regular basis.

At the most recent residents and relatives meeting in November 2015 issues discussed included the service's lifts, future plans to improve the environment, activities at weekends, complaints, staffing, key workers, laundry and care plans. However we noted that there had not been a previous meeting since September 2014, and then May 2014, so there had not been many opportunities for consultation within the last year. The registered manager advised that relatives attended the service on other occasions for social gatherings enabling information sharing and issues to be dealt with in an informal setting.

Staff meetings were also not held on a regular basis. The last meeting was in February 2016, at which topics covered included mealtimes, use of mobile phones, infection controls, staff sickness, and recruitment. However prior to this the last meeting was in July 2015, where issues discussed included the need for more training and activities.

A residents and visitors satisfaction survey was conducted in June 2015, with an action plan in place to address issues raised. The service improvement plan included changing the flooring on the first floor and ground floor carpets, appointing gardeners, and providing more trips out of the home. The manager advised that a new survey was being undertaken in 2016. However there were no recent surveys of staff views on the service.

There was a system of surveys and audits in place for the service, to ensure that areas for improvement were identified and addressed. A monthly quality assurance report was produced including details of complaints, compliments, safeguarding issues, accidents, and survey results. Care plan audits, tissue viability and infection control audits were undertaken on a monthly basis, and medicines, safeguarding procedures, recruitment, equipment, and the home environment were audited quarterly, health and safety was audited twice a year and food safety on an annual basis (most recently receiving a five star rating from the local authority). However we were concerned that care plan, medicines and recruitment audits did not pick up on the issues that we found during the inspection. It was of particular concern that no medicines errors had

been reported within the last year, despite us finding errors on the day of our inspection, indicating that errors were not identified or reported, so that learning could take place.

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

The quality care manager for the home usually undertook unannounced visits on a monthly basis. In recent months issues identified included the temperature of medicines stored on the first floor of the home, the need for bedroom audits to be undertaken, with an action plan put in place to address the issues raised.

There was a training plan in place for the service, to ensure that staff undertook all required training, and evidence of revalidation requirements for qualified staff with the registered manager needing to fulfil the requirements herself in 2017.

Plans were in place to extend the home over the summer months, providing a conservatory and improving the layout of lounge areas, whilst adding six more bedrooms for people using the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 11 HSCA RA Regulations 2014 Need for consent Insufficient staff training on the Mental Capacity Act 2005, and recording of mental capacity assessments, and best interest decisions made on people's behalf, placed people at risk of not being protected by the provisions of this Act. Regulation 11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were insufficiently rigorous quality assurance systems to identify areas requiring improvement, in particular with regard to care plans, recruitment and medicines administration, which placed people at risk of receiving unsafe care. Regulation 17(1)(2)ab

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People were not protected by sufficiently rigorous staff recruitment procedures to ensure that they were supported by fit and proper staff. Regulation 19(1)(2)(3)ab