Barchester Healthcare Homes Limited

Mount Vale

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 12 and 13 April 2016 and was unannounced. The service was last inspected in March 2015, when the service was found to be in breach of one regulation, because staff had not received the required level of training and supervision.

Mount Vale is registered to provide nursing and personal care for up to 65 people, including people living with dementia and old age. At the time of our inspection 48 people lived at the service.

The registered provider is Barchester Healthcare Homes Limited. The service did not have a registered manager at the time of this inspection visit, but there was a permanent manager in post and they completed their registration shortly after our visit. 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.

Staff were aware of the different types of abuse and how to report concerns within the home. However, not all staff were sufficiently familiar with the provider's internal whistleblowing processes or the wider safeguarding processes that could be accessed if needed.

Staff were recruited safely, with the required checks completed before staff started work. There had been difficulties maintaining staffing, with times when staffing levels and consistency of staff deployment had not been maintained at optimum levels. New staff had now been recruited and agency staff were used to cover when necessary.

Medicines were administered safely and as prescribed. The service's premises and equipment were maintained and in safe working order.

Although people were not clinically dehydrated, some people had dry mouths and there was confusion around the effective assessment and monitoring of fluid intake levels. Arrangements were in place to monitor people's nutritional wellbeing. A variety of meals and snacks were provided and special diets were catered for.

Staff were provided with a range of training to provide the knowledge and skills they needed. Staff felt supported and arrangements for the formal supervision and support of staff had improved with the employment of a permanent registered manager to oversee and monitor these arrangements.

People had access to healthcare professionals when needed. Staff were aware of their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards authorisations had been sought where appropriate to do so.

We received positive feedback from two health care professionals, who told us the service had worked well with them and involved them appropriately in people's care.

We found that there was a lack of consistency in the quality of care provided. This was particularly the case on the unit for people living with dementia, where people sometimes did not receive person centred care that met their individual needs. Some care plans we viewed would benefit from including more person centred information, to help staff provide better person centred care.

A complaints procedure was in place. However we found that complaints had not always been investigated or responded to promptly and in accordance with the provider's complaints procedures.

Activities and social events regularly took place, with a programme of activities available to people. However, we found that the activities provided could be developed further, in response to people's individual needs and preferences.

There had been a history of management changes and temporary management arrangements at the home, which had impacted on its leadership. However, the service now had a permanent registered manager and people we spoke with were positive about their impact so far.

Audits and checks were completed, to help the service continually improve. However, we found that these systems had not always been effective at bringing about the required improvements.

We identified breaches of regulation around person centred care, receiving and acting on complaints and good governance. You can see the action we took in the full version of this inspection 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.

Staff were aware of the different types of abuse and how to report concerns. Not all staff were sufficiently familiar with the provider's internal whistleblowing processes or the wider safeguarding processes that were available.

Staff were recruited safely. Staffing levels and consistency of staff deployment had not always been maintained at optimum levels, although actions had been taken to address these difficulties.

Medicines were administered safely and as prescribed.

Arrangements were in place to ensure the premises and equipment were maintained in a safe condition.

Is the service effective?

Requires Improvement

The service was not always effective.

Although not clinically dehydrated, some people had dry mouths and there was confusion around the effective assessment and monitoring of fluid intake levels. A variety of meals and snacks were provided and special diets were catered for.

Staff were provided with a range of training to provide the knowledge and skills they needed. Arrangements for the supervision and support of staff had improved since the last inspection.

People had access to healthcare professionals when needed.

Staff were aware of their responsibilities under the Mental Capacity Act and DoLS authorisations had been sought where appropriate to do so.

Is the service caring?

Requires Improvement

The service was not always caring.

Most individual staff were caring in their approach, but there was

inconsistency between different staff and the quality of their interactions when supporting people living with dementia.

Staff maintained people's privacy and dignity and people were able to have visitors when they wanted.

Arrangements were in place to provide end of life care, with support from appropriate medical professionals.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was a lack of consistency in the quality of care provided, with people sometimes not receiving person centred care that met their individual needs.

Complaints had not always been responded to promptly and in accordance with the provider's complaints procedures.

Activities and social events regularly took place, but could be developed further in response to individual needs and preferences.

Is the service well-led?

Requires Improvement

The service was not always well led.

There had been a history of management changes and temporary management arrangements, but the service now had a permanent registered manager.

The unit for people living with dementia did not have effective leadership. Areas identified as needing improvement had not been addressed by the provider.

Care records were not always maintained to a suitable standard, with gaps and omissions apparent.

Mount Vale

Detailed findings

Background to this inspection

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

This inspection took place on 12 and 13 April 2016 and was unannounced. The inspection team consisted of two inspectors and a specialist professional advisor (SPA). The SPA for this inspection was a qualified nurse who attended on the first day of the inspection. They had experience of managing care services and working with people living with a dementia.

Before the inspection we reviewed all of the information we held about the service. We looked at notifications we had received from the service. Notifications are information about changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also reviewed any complaints, concerns or other information that had been shared with us.

We asked the local authority (LA) and clinical commissioning group (CCG) commissioning teams for feedback about the service. We contacted Healthwatch. Healthwatch represents the views of local people in how their health and social care services are provided. We also requested feedback from a selection of health and social care professionals who work with the service.

The registered provider had completed and submitted a provider information return (PIR) in March 2016. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed this information before our visit.

During the inspection we spoke with eight people who used the service and five relatives. We also left posters in the home to let people know about the inspection, so that people could contact us if they wanted to.

We spent time observing how people spent their time and the interactions between people and care staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us

understand the experience of people who could not talk with us.

We spoke with the home manager, deputy manager, four nurses, six care staff and the activities coordinator. We also left our contact details with care staff so they could get in touch if they wanted to. We met and spoke with the Barchester Healthcare area clinical development nurse and regional director.

During the inspection we reviewed a range of records. This included eight people's care records, including care planning documentation and medication records. We also looked at staff recruitment and training records, records relating to the management of the home and a variety of policies and procedures.

Requires Improvement

Is the service safe?

Our findings

We looked at the arrangements that were in place for managing allegations or suspicions of abuse and managing concerns. There had been safeguarding concerns raised about the care provided to an individual at Mount Vale. These concerns were subject to an on-going investigation at the time of our visit. CQC will continue to be part of this safeguarding process and consider its regulatory response accordingly.

Staff we spoke with had completed training on recognising and reporting abuse and safeguarding adults. They were aware of the need to report concerns to their manager and felt confident that the new manager would respond appropriately. Staff we spoke with told us that they had not experienced or witnessed any abusive practices by other staff at Mount Vale. They also told us that they had been encouraged to report anything they were unhappy about by the home's management. One staff member described their approach to safeguarding by telling us, "You have to think how you would like your mum or dad to be treated."

Some staff we spoke with were aware of the role of outside agencies in the safeguarding process and that they could make alerts directly if needed, but other staff were not as aware of this as we would expect. Staff were also aware that they could report concerns to senior staff within Barchester Healthcare if they needed to [whistle blowing]. However, staff were not clear about how they would actually do this when questioned, although the manager informed us that information on Barchester's Whistleblowing telephone line was situated in the staff room and easily accessible to all staff.

It is recommended that action is taken to ensure that staff are fully aware of Barchester Healthcare's internal whistle blowing processes and the wider external safeguarding process, including how staff can raise concerns directly with external agencies if needed.

During our visit we looked at the recruitment records for four staff. We found that staff were recruited safely, with records showed that a thorough recruitment process had been followed. This included application forms, interviewing prospective staff, obtaining written references and a Disclosure and Barring Service (DBS) check before staff commenced work. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, helping employers make safer recruiting decisions. Proof of identification, employment histories and nursing pin numbers had been obtained.

We spoke with the registered manager about staffing levels and the staffing of the home. The registered provider used a staffing tool to calculate staffing levels. The registered manager explained that the staffing tool was primarily based on the actual dependencies of current residents. However, the numbers of staff actually provided on the unit for people living with dementia were above the number calculated by the tool, due to environmental factors and the layout of the building.

The nursing unit benefited from a stable staff team and a unit manager who had been in post for a long time. The dementia care unit had experienced staffing difficulties, which had resulted in agency staff and staff who normally worked on the general nursing unit covering shifts. This meant there had been a period

when achieving staffing continuity and providing strong leadership on the unit had been problematic. New staff had now been recruited so that a more stable staff team was in place, but at the time of our visit the unit for people living with dementia still needed to recruit an additional nurse and unit manager before it would be fully staffed. The registered manager described the home's agency nurse usage at the time of our inspection as "minimal, although variable." For example, in the eight weeks before our inspection the home used agency nurses for between 12 - 49 hours per week, with some weeks none used at all. They had not routinely needed to use agency care staff. They also explained how agency staff had been pre-booked, to help provide staffing consistency where possible.

We looked at staff rotas and observed how staffing levels worked. Before our visit we had received concerns about staffing levels, including that staff had not always be available to provide the care people needed. During our visit people who lived at the home told us staff were usually available and responded to calls for assistance reasonably promptly, although response times could vary if staff were busy. Staff we spoke with felt that improvements had been made and current staffing levels were safe, although they could be busy at times. However, we saw occasions when staff did not respond promptly to people who would have benefitted from additional support. For example, when someone wanted support to visit the downstairs of the home for a break away from the unit for people living with dementia, or when a person who had just come to live at the home was disorientated and trying to leave.

Rotas showed that the downstairs and upstairs units were staffed separately, with staff tending to work on one unit or the other so that they got to know the people they were caring for and the way the units worked. Staff rotas showed that staffing levels were usually maintained at the levels assessed as necessary, but there had been times when staffing levels had not been maintained at these levels. For example, on Friday 1 April 2016 there had been times when only four staff were on duty on the unit for people living with dementia [the rotas showed that usual staff numbers on this unit were between five or six]. Ancillary support from domestic, maintenance and administrative staff was provided in addition to care staff numbers. The registered manager was supernumerary and supported by a deputy, who also had supernumerary management hours allocated each week. When we asked about the times when staffing levels could not be maintained we were told that the deputy manager could provide additional support to care staff if and when needed. Overall, at the time of our visit we found that the registered provider and manager had taken action to employ sufficient staff and maintain safe staffing levels.

We looked at the arrangements that were in place to ensure the safe management, storage and administration of medicines. Medicines were administered by nurses. We saw that medicines were stored safely and securely within the treatment rooms and while medicines were being administered. During our observations medicines were given to people safely and as prescribed by their doctor. Appropriate arrangements for the storage of controlled drugs [medicines that have special storage requirements, because of the risk of them being misused] were in place. The medicine administration records we looked at, including the controlled drug register, had been completed correctly. The registered manager and clinical lead nurse showed us the regular checks and audits that were completed to ensure that medicines had been administered correctly. Feedback from a healthcare professional included that staff informed them of medication errors, so that they could give appropriate advice, and that errors were relatively rare. They told us, "The service at Mount Vale Care Home has always seemed safe and patients appear to be well looked after."

The care records we looked at included risk assessments, which had been completed to identify any risks associated with delivering each individual person's care. For example, risk assessment and risk management plans were in place to help identify individual risk factors, such as safe manual handling, falls, nutrition, and maintaining skin integrity.

Arrangements were in place to keep premises and equipment safe and maintained to a suitable standard. A maintenance person was employed and described the systems in place to ensure maintenance tasks were identified and completed in a timely way. A schedule of regular maintenance checks was in place, with records confirming these had taken place. Up to date servicing and inspection certificates were available for fire equipment, manual handling equipment, electrical installations, Legionella testing and gas appliances. The service had achieved a five star food hygiene rating [the best available] during March 2016. Our observations showed that the service was clean and well maintained, with communal areas furnished comfortably and pleasantly decorated.

An external contractor had completed a fire risk assessment in May 2015. A 'traffic light' system was in place to identify the support individuals would need to safely evacuate the building in an emergency and records were available to show that multiple fire drills had taken place during 2016. A business continuity plan was in place and provided staff with information and guidance on what to do in different emergency scenarios. It included useful contact numbers for use in emergency situations. During our inspection the fire alarm sounded. Staff responded by going to the meeting points and it was quickly identified that it was a false alarm.

Requires Improvement

Is the service effective?

Our findings

Before our inspection concerns had been raised about the support people received with eating and drinking. During our visit we identified that several people appeared to have dry mouths and when we asked one person if they wanted a drink they used the word, "Parched," to describe how they were feeling. We looked at a selection of these people's care plans and fluid intake charts to see if they had received sufficient to drink.

We saw that people had been assessed as needing a minimum fluid intake during a 24 hour period, but that fluid intake records did not evidence that these intake levels had always been achieved. We asked the registered provider to look into this during our inspection, to ensure that people were safe and hydrated. The provider reviewed and updated each individual's assessed intake levels [which in some cases were identified as unrealistic for the individual concerned], and had the people concerned reviewed by their doctor. It was confirmed that there was no clinical signs of dehydration and that the doctor was satisfied with the fluid intake levels achieved for these individuals. However, our findings raised questions about the clinical and governance arrangements in place and why these issues had not been identified and clarified sooner.

We also saw occasions when communication and coordination between staff was not as good as it should be. For example, on the unit for people living with dementia we observed that staff did not always know who had received their meal. We overheard one staff member saying to another that one person had already had their breakfast so did not need help eating. A short while later a different staff member came and assisted the same person to eat their breakfast. This confusion between staff increased the risk of people not receiving the nutrition and hydration support they needed.

We recommend that the registered manager and provider takes action to improve how staff respond to people's nutrition and hydration needs.

We received positive feedback about the quality of food provided, with people telling us they received a choice of regular meals and snacks. For example, one person who used the service told us, "I think the food here is very good indeed. I am a vegetarian and they go out of their way to accommodate me." A relative told us, "The food is good, the food is lovely." Menus showed that a choice of meals was provided and our observations showed that the food looked appetising. During our visit we saw people being assisted with meals and drinks, with drinks being made available throughout the day.

The care records we looked at included nutritional risk assessments. These assessments included regular weight and body mass index monitoring, helping to identify anyone who was at risk due to poor nutrition or weight loss. The computer system provided nutritional monitoring information and we saw evidence of the involvement of the doctor, dietician and speech and language therapy team where there were concerns about nutritional wellbeing. We looked at the specialist care one person was receiving with their nutrition. A dietician had been involved and we spoke with them during our visit. They were happy with the nutritional care provided to the person and did not have any concerns following their review of the person's nutritional

care and support.

People who used the service told us they had access to doctors and other health and social care professionals when needed. For example, one person who lived at the home told us that it was, "Good, nursing care is good and medical back up is there when it is needed." We saw evidence in care records that the service liaised with relevant health care professionals. For example, visits by doctors and other relevant professionals were recorded in people's care records. A healthcare professional told us, "They [staff] are adept at passing messages onto me from other health care teams and family members. They also seek help from my team outside of my routine review, if needed, due to urgent medical problems. They also inform me of changes to patient's behaviour and condition which could possibly be due to a medical issue."

At our last inspection we found that staff had not been provided with adequate training and supervision and the provider was required to make improvements. During this inspection we looked at the training and support arrangements that were in place. We received positive feedback about the approach of individual staff. One person told us, "They [the staff] go out of their way to do as much as they can for you." A relative told us, "Staff are brilliant, especially [name of staff member]. All the staff are lovely." A healthcare professional told us, "The staff appear to be competent at all times. Communication also seems to be well maintained."

Staff we spoke with told us that they had access to regular training and spoke highly of the training staff who supported the home. The staff we spoke with told us they were up to date with the training they required and had been able to access specific training when needed for example, on palliative care and other medical conditions. Monthly training plans were available and showed training was planned on dementia, safeguarding, mental capacity, fire, moving and handling, infection control and customer care. The training system provided up to date training that the registered manager could monitor, to ensure that staff had completed the required training. The registered manager was aware of the new care certificate training for staff and able to explain and show us how this was being implemented as part of induction training. The Care Certificate is a recognised qualification which aims to provide new workers with the introductory skills, values and knowledge to provide safe and compassionate care.

The staff we spoke with had received supervision and appraisals of their performance. Staff told us that they felt supported by nursing staff and the registered manager, and could seek support when needed. The supervision records we looked at showed that staff had received formal supervision sessions during 2016. The registered manager acknowledged that formal staff supervision had not always been as frequent as they would like in the past, particularly on the unit for people living with dementia where there had been changes in staff and unit management. However, arrangements were now in place to ensure staff received supervision and to monitor that that this took place, with a staff supervision record available to monitor progress.

The Mental Capacity Act 2005 (MCA) 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The service had in place a policy outlining the principles of the MCA and how people should be supported with decision making. Training on the MCA was provided to staff, although when we spoke to staff regarding the MCA and DoLS their knowledge and confidence varied. The registered manager had undertaken training on the MCA and was able to describe the main principles of the Act and how to apply for authorisations when someone was being deprived of their liberty. At the time of our visit 17 people had DoLS authorisations in place. The manager had applied for DoLS authorisations for five others, who were awaiting assessment by the authorising body.

Requires Improvement

Is the service caring?

Our findings

We looked at the arrangements in place to ensure that the approach of staff was caring and appropriate to the needs of the people using the service. Before our inspection concerns had been raised regarding the way certain staff treated people who lived at Mount Vale, particularly on the unit for people living with dementia. At the time of our visit this was subject to on-going investigations. We spoke with the registered manager about the actions taken in response to the concerns that had been raised, to ensure that staff were caring and respectful in their approach. They told us that group supervisions had been held to explore any concerns staff had and that staff had been asked to be extra vigilant and report any concerns. The manager confirmed that there had been no recent whistle blowing concerns raised by staff or reports of concern about the way people were being treated at the home as a result of these actions.

People we spoke with during the inspection were complimentary about individual staff and their approach. One person told us "The girls who look after me are pretty good, I've not come across anyone who was naughty [didn't treat them well]." Another person told us that they had, "Not had anyone be rude or unpleasant" and "They [staff] are very good and very caring." A relative told us, "Staff are lovely. They are really good with [name of relative]." A health care professional told us, "The staff are very caring, especially [name of three individual staff] downstairs. I have complete confidence that they make decisions with the patient's wellbeing as their highest priority."

We observed the care and support people received during our visit. Downstairs we saw staff interacting with people in positive, cheerful and proactive ways. For example, stopping to speak to people as they passed or sharing a joke. However, when we carried out observations on the unit for people living with dementia we saw times when there were limited interactions, with staff focused on physical tasks. For example, we observed a staff member assisting one person with a drink. They were patient and there was no rush. However, they made very little attempt to engage in conversation or positive interactions with the person while doing this task. We also observed an occasion when staff were gathered together eating toast, when they could have been spending time with people who used the service. Overall the culture on the unit for people living with dementia would benefit from becoming more person centred and caring, rather than task orientated. This further supported our findings, which are reported under the key question 'Is the service Responsive?', and the associated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Person-centred care.

During our visit we observed that staff ensured people's dignity and privacy was respected. We observed staff knocking on doors before entering and ensuring that care was carried out in private. Staff were able to describe to us how they helped to maintain people's privacy and dignity. For example, by giving people as much privacy as possible during care tasks and ensuring doors and curtains were closed. There was also a named "dignity champion," with one of the nurses taking on this role within the staff team.

We looked at the arrangements in place to support people in maintaining relationships. During our visit we observed people visiting throughout the day and people told us that there were no restrictions on visiting, with a number of relatives visiting regularly and staying for most of the day.

We looked at the arrangements in place to ensure that people were involved in decisions about their day to day lives. During our visit we saw people being offered choices around meals, drinks and where they spent their time. Information about people's wishes and preferences was included in their care plans, so that staff were aware of these, although we found the level of detail in people's care plans varied.

The service provided end of life care and the staff we spoke with had received training in this. A healthcare professional was very positive about the home's approach and told us, "Their [Mount Vale] end of life care is second to none for a care home in my experience." The local end of life/palliative care forum also met at Mount Vale and provided the opportunity for staff to discuss and develop best practice.

We looked at the arrangements that were in place for one person who was receiving end of life care. The person's care plan explained that they loved their animal companion and arrangements that had been made for the animal to visit them daily. We observed that facilities to enable these visits were available in the person's room. Staff were aware of the arrangements and confirmed that the visits took place. We saw that the person had been involved in discussions with their doctor and the home's staff, regarding their end of life care and treatment and what they wanted to happen. They told us that staff managed their pain relief well, responding when needed. This meant that support had been arranged in a way that supported the individual's wishes and facilitated what was important to them.

Requires Improvement

Is the service responsive?

Our findings

We looked at the arrangements in place to ensure that people received person-centred care, which had been appropriately assessed, planned and reviewed. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the individual person. We found that there was variation in the quality of person-centred care people received at Mount Vale, with differences apparent between the general nursing unit and the unit for people living with dementia. There was also marked differences between the quality of person centred care provided on the first and second day of the inspection, depending on the approach of the individual staff on duty. There was a lack of consistency.

During our visits we looked at the care plans and assessment records for six people. The care records all contained assessments, risk assessments and care plans covering key areas of care, such as nutrition, manual handling and skin integrity. The risk assessments had been reviewed regularly to ensure that risks to people's wellbeing were monitored. The care plans contained information about people's care needs, so that staff knew how to care for people. However, the person-centred detail available varied from person to person. Regular evaluations of people's care plans had been completed, to review their needs. However, in some cases information about changes to people's care had not been added to their care plans. This meant that staff could only be sure t they had a full picture of people's care needs if they read the care plan and all of the accompanying notes.

We found evidence that people living with dementia had not always received a good level of person centred care. For example, one person became distressed and frightened when being moved with a hoist. The person's care plan instructed staff to reassure and explain what was happening, but the care plan was not sufficiently detailed to ensure staff gave consistent care. Feedback from a health care professional indicated that staff had not always used the correct sling to move the person in a safe and comfortable way, although this had been dealt with immediately by the provider and had not resulted in any harm. We also saw that staff did not always provide reassurance in a way that was appropriate and effective for the person being moved. For example, we observed one member of staff approached a person with dementia and said, "I'm just going to move you." However they said this at the same time as they moved the chair back, which startled the person sitting in the chair. We saw a task orientated approach by some staff, with limited attempts to engage in meaningful interactions with people who used the service.

We saw that new admissions to the service had not been planned or managed in a person centred way. For example, during our visit two people were new to the service. Both showed signs of confusion and distress. No person centred arrangements had been made to help ease the admissions process. For example, there was no name or other identifiable feature on one person's bedroom door and their memory box [a display box for pictures or objects that are familiar to the person] was empty. This meant they had no way to identify their bedroom or orientate themselves to where it was. We saw another person who had recently come to live on the unit walking up and down the corridor knocking and opening doors to look inside. On several occasions when they saw visitors heading towards the entrance door they walked with them and tried to leave. During this time no staff intervened or attempted to divert the person's attention.

We found that the content of recording showed a lack of understanding of the conditions people were living with. For example, reference was made to people living with dementia as, "smirking" or "glaring." One record referred to a person as having, "appeared to have tripped over her own feet," when the person actually had a pre-existing medical condition that placed them at risk of falls.

We spoke with the registered provider and manager about the user experience on the unit for people living with dementia. They acknowledged that improvements in this area was one of the home's main priorities and that additional support was being provided to help achieve this.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Person-centred care.

However, we also saw some positive person centred care being arranged. For example, one person had difficulties maintaining a comfortable posture. This had been recognised by staff and during our inspection an occupational therapist visited to assess the person, with regard to their posture and being fitted for a new chair. On the second day of the inspection we saw examples of staff being very responsive to people's individual needs. For example, people who had been asleep and disengaged the day before, were enthusiastically joining in with a baking session and there was a very different atmosphere to the one we had seen the day before. On the general nursing unit observations of people's care during our visit and feedback received from people using the service, relatives, visiting professionals and staff was generally very positive.

We looked at the arrangements in place to manage complaints and concerns. Feedback we had received prior to the inspection indicated that some of the home's staff had not always welcomed concerns or feedback, resulting in some people feeling anxious about openly raising any issues with staff.

We spoke with the registered manager and deputy manager regarding complaints and looked at the complaint record. Two complaints had been received so far during 2016. One of these had been dealt with and resolved appropriately. The other had progressed to an internal investigation, but this had been significantly delayed and the complainants were still awaiting a response, over three months after initially raising their concerns. This complaint had not been responded to in line with the provider's own complaints procedure, which stated that complaints would be investigated and responded to within 28 days. The registered manager acknowledged that this needed to be resolved as soon as possible.

No other complaints had been recorded for the previous 12 months, despite us receiving information to suggest that concerns had been raised with the home's staff during this time. For example, relatives had raised concerns about care standards and held a meeting with senior staff in September 2015, but there was no record of their concerns actually being investigated. Another relative told us that they had raised concerns with staff about care standards during 2015, but in their experience raising the concerns had not resulted in sustained improvements. Overall complaints and concerns had not always been responded to effectively and in line with the provider's complaints procedure.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Receiving and acting on complaints.

We looked at the arrangements in place to help people take part in activities, maintain their interests and encourage participation in the local community. There was an activities coordinator employed by the service and a member of staff who provided additional support with activities on the unit for people living with dementia. An activities programme was displayed in the home and we saw that people had their own

copies of this during our visit. For example, one person showed us that they had an activities programme, and told us that the activities staff were very good and worked hard trying to encourage people to join in. Some people were happy with the activities provided, while others said they would like more to do and that more trips out would be welcome. Feedback received in a recent resident's meeting had also highlighted that people would like more trips out.

The activities we saw taking place during our visit varied in effectiveness. We saw some good examples of people enjoying being engaged in meaningful activities, such as baking. But we also saw long periods of time when some people had no social stimulation. We found that although activities regularly took place they could be developed further in response to individual needs and preferences.

Requires Improvement

Is the service well-led?

Our findings

We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. We found evidence that the provider's internal governance systems had not always been effective. For example, successive audits had been carried out on the unit for people living with dementia, to help identify areas for improvement in relation to the environment and peoples care experience. However, the recommendations from these audits had not been implemented. Our own findings during this inspection continued to mirror those of the provider's own internal audits, with no apparent improvements having been made.

We found that the unit for people living with dementia had not had effective unit management in place for some time, due to staffing changes. This had resulted in a lack of leadership and a failure to effectively make improvements and address issues affecting the unit. We also received feedback from relatives that the care provided to people living with dementia was perceived as being of a lesser standard than that provided to those living in the general nursing unit. For example, one relative told us, "Second class citizens up here [people living with dementia]." The manager explained that recruiting the right person as the unit manager for people living with dementia was one of their key priorities, so that the unit could benefit from the strong day to day leadership it needed.

Before this inspection we had received concerns about the standard of records maintained by the service. We found that some of the care records we looked at were inaccurate or incomplete and did not demonstrate that people had received the care they needed. For example, we saw inaccurate recording on fluid intake records, unexplained gaps on positional change records, entries that were difficult to read and amendments to care records that had not been signed or dated by the person making them. Where care plans had been evaluated we saw two examples where only a date and signature had been recorded, with no record of the outcome of the evaluation or what it meant for the individual person's care.

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

We looked at the arrangements in place for the management and leadership of the service. At the last inspection the impact of frequent management changes and the lack of a permanent manager had been raised as a concern by staff and people using the service. The home had four different registered managers between May 2011 and March 2016.

At the time of this inspection visit there was a new permanent manager in post, who had submitted an application and was in the process of registering with us. Since our visit the registration process has been successfully completed. A registered manager is a person who has registered with CQC to manage the service. Throughout our visit the manager provided the information and explanations we asked for. They told us they felt supported by the registered provider and had received support and supervision from senior

management. We saw records to confirm this. During the inspection the manager was supported by other senior staff, including the regional director and area clinical development nurse.

During our visit people using the service, relatives and staff were positive about the appointment of the new manager and the impact they were having on the service. Staff expressed the hope that the new manager would stay long-term and provide some management stability for the service. For example, one staff member told us, "The new manager is approachable, but not been here long. It's been difficult because they [different managers] all have different ways of doing things and you can't get close to them because they are going all the time." Another told us they had a, "Lot of faith now that things will get done," and that the home had, "Turned a corner." Feedback we received from other professionals working with the service included, "I feel that some management stability would be good for the home, as it would be good for any service."

Arrangements were in place to gather feedback from people who used the service and their relatives. The new manager had held resident and relative's meetings and we saw the records of these. The most recent meeting had covered what was being done to address staffing issues, a satisfaction survey that was being completed, how to raise concerns or complaints with the manager, and a questions and comments session. There was also a regular resident's catering committee meeting, where people using the service met with the chef and registered manager to discuss and improve catering arrangements. Satisfaction surveys had been completed with people who used the service, relatives and staff during 2015, and the 2016 survey was underway. The 2015 survey was based on 14 responses and showed a high satisfaction rate.

A range of staff meetings took place. We saw the records relating to recent staff meetings, which included monthly management meetings and daily 'stand up' meetings, intended to ensure that key information was passed between staff quickly and effectively.

The manager completed monthly management reports, which were submitted to senior management for oversight and review. These reports looked at the occurrence of pressure ulcers, safeguarding incidents, accidents and falls, infections and hospital admissions. The registered manager also showed us the records of regular checks that were completed on the premises and equipment, to ensure the service was safe and maintained in good order. Regular medication audits and checks had been completed.

Accidents and incidents were recorded. These were reviewed by the registered manager each month, to ensure that appropriate actions had been taken and to identify any trends or further actions that were needed. The registered manager was aware of notification requirements [events that the service is legally required to tell us about] and we had received appropriate notifications from 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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People care and treatment did not always meet their individual needs or reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints
Treatment of disease, disorder or injury	Complaints had not been investigated and necessary and proportionate action taken in response to any failure identified by the complaint or investigation. The provider had failed to operate an effective system for handling and responding to complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Effective systems to assess, monitor and improve the quality and safety of the service had not been operated. Care records were not always complete or accurate.