Imalgo Limited

Lower Farm Care Home with Nursing

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

Overall summary

This inspection was undertaken by three inspectors on 3 March 2015 and was unannounced.

Lower Farm Care Home with Nursing provides accommodation and nursing care for a maximum of 46 people with varying healthcare and support needs. At the time of our inspection there were 37 people living in the home.

The home had a registered manager in post, although CQC had been notified of their absence, for which the deputy manager was covering. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered

Summary of findings

providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The deputy manager and nurses were knowledgeable about when a request for a DoLS would be required following changes in case law.

Staff had a good understanding with regard to identifying abuse and knew the reporting procedure, if they suspected people were experiencing abuse. Staff had also received appropriate training in respect of protecting people.

Everyone living in the home confirmed that they felt safe and relatives also confirmed that they had no concerns about their family members' safety.

Appropriate police checks were undertaken and suitable references were obtained to ensure new staff were suitable to work in the home.

There were insufficient qualified nurses on duty and staffing levels were not matched to the demand for the care and support of the highly dependent people living in the home. Ideas for better deployment of staff had not been considered by the provider. Care staff did not receive regular supervisions and appraisals.

Identified risks to people's safety and welfare were not being managed appropriately because, where risks had been identified, some reviews of those risks were out of date.

The nurses were proficient with regard to the safe handling and administration of medication.

People's individual dietary needs were catered for in line with their care plans and people were supported to have sufficient quantities to eat and drink.

People had access to external healthcare professionals, as needed. However, some people's care and review records were not being kept up to date. People's care plans were not always effective or reflective of people's current needs and there was a lack of clear and accessible guidance regarding people's needs for new, temporary or agency staff.

The care staff were kind, skilled and supported people in a courteous manner, Staff also consistently respected people's dignity. However, they did not have the time to offer individual or personalised care, due to the high level of people's needs.

People living in the home and their relatives were included in the 'pre-admission' assessment and care planning process. However, people's care plans were not user friendly and not truly 'person centred'.

People living in the home and their relatives knew how to make a complaint and there was information displayed around the home telling people how and who to complain to. However, this required updating. Some staff felt unable to question practice and contribute ideas for improvement.

There was a lack of clear and visible leadership, particularly whilst the manager was absent from the home.

Although people's concerns were dealt with, the systems used to monitor the quality of the service did not pick up concerns on a regular basis.

CQC had not been officially notified of incidents within the home that were required to be reported.

We found that the provider was in breach of six regulations.

You can see the action we have told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

There were insufficient qualified nurses on duty and staffing levels were not matched to the demand for the care and support of the highly dependent people living in the home.

Medications were not always safely managed because some record keeping and monitoring was incomplete.

People felt safe living in the home and staff had a good understanding with regard to identifying abuse and knew the reporting procedure, if they suspected people were experiencing abuse.

Is the service effective?

Requires improvement

The service was not consistently effective.

Care staff did not receive formal supervisions or appraisals.

People's care plans were not always effective or reflective of people's current needs and there was a lack of clear and accessible guidance regarding people's needs for new, temporary or agency staff.

People had access to external healthcare professionals, as needed.

People's individual dietary needs were catered for in line with their care plans and people were supported to have sufficient quantities to eat and drink.

Is the service caring?

Requires improvement

The service was not consistently caring.

People could not be assured that they would receive end of life care and treatment that was appropriate or in accordance with their wishes.

The care staff were kind, skilled and supported people in a courteous manner. Staff also consistently respected people's dignity.

People's relatives and other visitors were made welcome in the home.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People's care plans were not 'person centred' and care records were not always being completed appropriately.

People's individual wants, needs and choices were not consistently met by the staff supporting them.

People living in the home said that they could always talk to the staff if they were unhappy about anything.

Summary of findings

Is the service well-led?

The service was not consistently well-led.

Not all staff were enabled to question practice and make suggestions to improve the service people received. Nursing staff had regular meetings but care and domestic staff were not included in meetings regarding the home.

Quality monitoring systems did not adequately assess and manage risks to people and take into account the way people's records were maintained.

The registered persons had failed to notify the Care Quality Commission of specific events they are required to tell us about.

Requires improvement

Lower Farm Care Home with Nursing

Detailed findings

Background to this inspection

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

The inspection took place on 3 March 2015 and was unannounced. The inspection team consisted of three inspectors.

Before our inspection we looked at all the information we had available about the home. This included the report from our last inspection and notifications made to us.

Notifications are changes, events or incidents that providers must tell us about by law. We also spoke with a representative from the Clinical Commissioning Group (CCG), who was familiar with the service

During our inspection we met and spoke with eight people living in the home. We also spoke with four relatives, the provider, deputy manager, three care staff, four domestic staff and the cook.

As some people were not able to tell us in detail about their care, 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 looked at care records for five people and a random selection of the medication records and nutritional records for a number of people living in the home. We also looked at records that related to the management of the service.

Requires improvement

Is the service safe?

Our findings

Staffing levels were not matched to the demand for the care and support of the highly dependent people living in the home. We were told that all but three to four people required two staff for all care tasks and two care staff told us that they had spent six hours helping seven people with their personal care. This meant that people were often not receiving assistance for areas such as washing and dressing until nearly lunch time. In addition, on the day of this inspection, no staff were available to support people with their social stimulation, which meant that some people were left alone while staff completed care tasks for others.

The provider had identified the need for two qualified nurses to be on duty for each shift, in order to meet people's needs appropriately. However, the registered manager was on long term absence from the home and the deputy manager was frequently being required to cover their managerial duties, whilst still being counted as one of the two nurses on duty. Discussions with one of the directors and the deputy manager as well as the nurse on duty and staff, confirmed that having only one dedicated nurse on shift was currently a common occurrence.

This meant that, although people were still having their nursing needs met, nurses were working under pressure and nursing care tasks were not being carried out in a timely fashion. In addition, reviews of care plans and other documentation that nurses were required to complete were not always being completed and in many cases were out of date. Therefore, although we had no evidence that tasks were not being done, records did not reflect up to date information so we could not be sure that people were receiving the correct care at the correct time.

The deputy manager told us that both they and the manager, assessed individuals to determine their levels of dependency and that most people were assessed as 'high dependency', such as increased nursing needs or requiring two members of staff to support them with their personal care requirements. However, from discussions with a nurse and the care staff, together with our observations, we identified that these dependency assessments were ineffective. This was because staffing levels were not being increased or adjusted, which resulted in people having to wait for aspects of their personal care needs to be met.

These matters were a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us that they were finding it very difficult to find and recruit trained or qualified staff. They also explained that they had been using recruitment agencies to try and find suitable staff, particularly qualified nurses.

We saw that agency staff were being used regularly and that, where possible, attempts were made to use the same agency and staff, to help enable consistency of care for the people living in the home.

Care plans were in place for each person living in the home. However, although the nursing staff were trying to improve those plans, following guidance from the Clinical Commissioning Group's (CCG) quality monitoring officer, the majority of care plans were out of date.

Where risks had been identified, reviews of those risks were found to be out of date. For example, a person who should be weighed monthly was found to have lost weight in December 2014 and there was no record of them having been weighed since.

Not all records showed that people with pressure concerns were being closely monitored as some records were not up to date. This meant we could not be assured that identified risks to people's safety and welfare were being managed appropriately.

The nurse on duty told us that the main medication rounds were usually carried out at 8am, 1pm, 5pm and 10pm. We were also told that there was never less than two nurses to cover one floor each and that the morning round usually took around one hour to complete.

The nurse on duty and the deputy manager both told us that there was no 'protected time' when carrying out the medication rounds and that nurses often got interrupted by care staff. This meant that the risk of errors or omissions was increased because the nurses were not able to concentrate fully on the safe administration of people's medication.

We observed one nurse and saw that, when uninterrupted, they demonstrated proficiency with regard to the safe handling and administration of medication. For example, checking people's records against the relevant medicine

Requires improvement

Is the service safe?

and securing the medicine trolley before leaving it unattended. The nurse also spoke with people in a friendly manner and treated them with respect and dignity when administering their medicine.

We looked at a selection of Medication Administration Records (MAR) charts and saw that these records were in order and no issues were identified. Disposals of medicines were recorded appropriately and we noted that where these were not returned to the pharmacist, they were collected by an appropriate disposals contractor.

However, we noted that the receipt of some medication had not been recorded and the temperatures for the medication fridge were not being monitored and recorded on a daily basis as required.

People told us they felt safe in the home. One person said, "They are all good. I feel I am looked after well, I live in a safe home and my family are happy with my care". Another said, "Totally safe". And a third person told us, "I feel quite safe here – all the staff are very good."

Staff had an understanding of abuse and stated they would not jeopardise their professional status by delivering inappropriate or unsafe care. They knew who to report any concerns to and were aware of the safeguarding team and how to contact them if necessary. One staff member said they would not hesitate to blow the whistle if they had any concerns about the care and support provided for people in the home.

The provider, deputy manager and staff told us that appropriate police checks were undertaken and suitable references and proof of identity were also required, to ensure new staff were suitable to work in the home. Nurses told us their Personal Identification Numbers (PIN) were updated annually.

Requires improvement

Is the service effective?

Our findings

Two people, who were recorded as having capacity at the time of our inspection, had DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) forms in their folders that were out of date and inappropriate. There had been no involvement or consent to this decision from either individual.

For example, one person's care records stated, 'communicates well, has capacity and makes choices'. We saw that a DNACPR had been completed on this person's behalf in May 2013 and was stated as being 'ongoing'. There was no record of any discussion with the person for whom this DNACPR referred to and the decision had been made and signed for by a relative and a hospital surgeon.

Another person's care records also stated that they had capacity and communicated well. However, this person also had a completed DNACPR form in place that they had not been involved with. We noted that the decision for this person had been made by a relative and a doctor in 2012, at a time when their health had been poor. This person's health had since improved greatly and, as they were not of particularly advanced years, we could not be assured that this form truly reflected the person's own wishes.

These matters were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It was not clear how often the nursing staff had access to up to date information on current practices and the nurses we spoke with told us that they monitored each other's nursing competencies, particularly in areas such as 'end of life care' or palliative care. However, the manager and another nurse had recently failed to achieve the Gold Standards Framework (a model that enables good practice to be available to people nearing the end of their lives). This meant that we could not be assured that nursing competencies were being monitored appropriately.

Two members of care staff, who had worked in the home for a number of years told us that did not receive individual support or supervision and that they had not had an annual appraisal for a number of years. They said, "Just no time". The deputy manager confirmed that this was the case and that no 'time off rota' was allocated to individual staff.

Care and ancillary staff told us that they received suitable training to ensure they kept up to date. We noted that a number of training courses were scheduled for the coming month, in areas such as food hygiene, safeguarding and medication.

Care staff also told us that they were supported to undertake some distance learning and some staff had obtained level three in National Vocational Qualifications. We did not see any incorrect practices and only saw positive care and support being given. Staff were noted to be competent in their work, throughout the day of this inspection. One staff member demonstrated their skills whilst supporting a person with swallowing concerns. Another member of staff showed how they managed the hoisting equipment both confidently and carefully explaining to the person what was happening at each stage. This meant that people could be assured that they would be supported by staff who were competent in their roles.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS), and to report on what we find.

None of the care staff had completed formal DoLS training at the time of this inspection, although they were able to demonstrate a good level of understanding in respect of ensuring people were not deprived of their liberty unlawfully. We noted that formal training had been arranged for staff to attend on 10 March 2015. The nurses and care staff we spoke with were all aware of the Mental Capacity Act (MCA) and continually assessed people's capacity. We noted that two referrals had been made to the DoLS team for people who lacked capacity. We observed staff offering choices and giving explanations to people, with regard to what they were doing and why, particularly for people who appeared not to understand.

People we spoke with told us that the food was good. One relative told us, "The food is always superb here. The meat, vegetables and eggs are always fresh, Nothing is ever on the cheap and it is always beautifully presented". This person also said, "The food is wonderful, always beautifully

Is the service effective?

served – even pureed food is always done separately." One person said the meals were really good. They told us there was always a choice and if they did not like the choice they could have something different such as soup or an omelette.

The deputy manager told us that all foods were purchased fresh and cakes and puddings were all home baked.

We observed the mealtime process in the dining room and noted that meals were served following a choice offered to people at the start of each day. We saw that meal choices were displayed on a menu board for people to see in picture format. People's choice of meals and the amount of food consumed were logged in the dining room by staff, to monitor how much people were eating and help ensure people ate sufficient amounts. One person told us, "The food is very good but I have to be careful not to overdo it with my diet as I'm diabetic."

Food and drinks were offered to people regularly, although we saw that people could have food and drinks at any time throughout the day and night, as they wished. One person said, "I prefer to have my meals in my room – the staff bring them in on a trolley and the food is always very nice."

The deputy manager and the cook confirmed that people's individual dietary needs were catered for whenever needed, including cultural or religious requirements. The cook showed us information they had in the kitchen that described each person's dietary needs, including their likes, dislikes and preferences. For example, we saw that the dietary sheets showed who was vegetarian, who was diabetic and who required assistance or supervision. In addition, it also listed people's food types such as softened, pureed, finger food and thickened fluids, which we saw was provided as required. We also saw that staff followed this dietary guidance appropriately.

In addition, we noted that information was available regarding people's preferences in respect of drinks and included the drinking vessel people required. For example, a cup, beaker or sloping mug, which we saw was provided for people, accordingly.

One person with a swallowing concern was being monitored closely and staff told us that they ensured a member of staff was with this person at all times whilst eating and drinking, which we observed to be the case. Staff said they were waiting for further advice from the Speech and Language Therapy (SALT) team and that a referral had been made via the GP. Staff also explained that it could take six to eight weeks for a SALT referral to come through so, in the meantime, if people appeared to be having swallowing difficulties, the home would automatically thicken fluids and puree their food, to help maintain their safety until the SALT assessment had been completed.

The deputy manager and staff told us that the home received very good support from the local medical centre, as well as local hospices and cancer support networks.

We saw that people had access to external healthcare professionals, as needed. For example, One person told us they had regular access to their GP, saw a chiropodist regularly and that their glasses were updated when their prescription changed. In addition, evidence was seen of regular general health checks such as weight, urinalysis and blood pressure. We noted that appropriate action was taken and referrals were made, if any issues or concerns were identified.

Tissue viability assessments were completed for people living in the home. The deputy manager told us that there were currently three people being treated for pressure areas but added that not all pressure ulcers were acquired in the home. One relative told us, "[Name] had a pressure sore when they came out of hospital but was really well cared for when he came here".

We noted that another person had been identified as being at very high risk of acquiring pressure ulcers and we saw that full pressure area risk assessments were being carried out at least six monthly, in addition to regular daily checks. We also noted that this person had been provided with a pressure relieving mattress when the risk had first been identified and that staff followed the support guidance appropriately.

Requires improvement

Is the service caring?

Our findings

During the previous 12 months a high number of people had required palliative care upon admission to the home and, as a result, there had also been a high number of deaths in the home. The deputy manager told us that the service did not specifically intend to provide 'end of life' care and that care staff did not receive any specific training in this area. We were also told that the nurses only completed a half-day training course in 'end of life' care. In addition, the care plans we looked at lacked detail regarding people's end of life wishes. Therefore, we were not confident that people would receive end of life care that met their needs or in accordance with their wishes.

People living in the home told us the service was caring. For example one person said, "The staff are kind and look after me well. I am happy enough". One visitor we spoke with said, "I was a nurse and know good care. My [relative] is receiving good care".

Other visitors told us, "I absolutely can't fault the care here at all. [Name] is so well cared for and all the staff are so caring and so very good". "The house is always immaculately clean and there's never any bad smells." And, "The beds are changed every day and the laundry is always immaculate."

During our visit we saw that staff treated people kindly and compassionately and provided good quality care. We noted that many families had thanked staff for their kindness and cards of gratitude were seen in the home.

We also saw that people were supported to be involved in making decisions about their care and noted that staff listened when people expressed their views. For example, people we spoke with said the staff knew them well and helped them with their preferences. One person told us, "They get all the clothes out the wardrobe and then I decide what I want to wear. They help me with my jewellery and make up if I want".

People's care records also showed that they were involved with regard to the planning and delivery of their care. For example, having a bed bath and having their hair washed, was recorded as a choice and the person's involvement was evident.

Although there was no one living in the home with specific or diverse cultural or religious beliefs at the time of our inspection, the provider said the home would cater for people's individual needs as required. We noted that people's lifestyle choices, including the gender of staff that provided care for them was recorded and respected.

One person said, "I've been here a few weeks now and I'm quite happy with everything at the moment". Another person told us, "I can have a laugh and a bit of fun with the staff".

We saw that various equipment was available in order to help people maintain their independence, as well as ensuring their safety and comfort. For example, adapted cutlery and crockery, hoists and pressure relieving equipment.

People's dignity was consistently preserved during our inspection. For example, people had covers placed over their legs when their dignity could be compromised. One person required assistance to preserve their dignity whilst in their bedroom and we noted that a member of staff immediately shut the door and assisted the person appropriately. We observed that people's doors were knocked on before staff entered and the people we met and spoke with were cheerful, and appropriately dressed.

Requires improvement

Is the service responsive?

Our findings

Due to people's high levels of need and the limited numbers of staff available to support those needs, we could not be assured that people had the choices they preferred. For example, people's care plans reflected when the person would like to get up but with many people in bed and requiring two staff, some people were still receiving their first full personal care of the day at 1pm.

Staff told us that people's needs were met by responding to call bells and ancillary staff were noted providing some people with food or drinks upon request as care staff were busy. One person told us, "Staff usually answer the call bell quickly but it does depend on the time of day. Lunch time is always busy".

We noted that 22 of 37 people remained in their rooms during the lunch period at this inspection, some of whom also required full support with eating and drinking. Some of the remaining people who attended the dining room also required assistance at mealtimes. We saw that one person in their room, who was recorded as requiring support and encouragement with their meals, remained without staff support for approximately 10 minutes after having their meal taken to them.

The deputy manager told us that people's 'pre-admission' assessments were completed by the manager or the deputy and that each person and their family members were included throughout the whole process. However, we found that people's care plans were not sufficiently detailed or informative enough for staff to be considered 'person centred'.

For example, one person we met and spoke with was very hard of hearing and their care plan just said to speak slowly and clearly, which we saw that the staff did. However, we found that this was not always effective and we held a full conversation with the person by also writing some things down, which they acknowledged and appreciated.

It was particularly important to ensure effective communication with this person in respect of their choice of meals. This person was noted to be at high risk of poor nutrition and had lost 9kg in weight in less than three months. It was stated in their care records that staff should 'encourage' this person to eat, which we observed them doing verbally, but the notes frequently referred to the person's 'poor diet' and refusals. During this inspection, when the person's lunch was delivered, they stated that they didn't want it. We asked if they would like something else instead and, with the assistance of written questions, the person answered that they would like "soup", which was duly obtained from the kitchen. This meant that the person may be more inclined to eat if alternative choices were more clearly communicated

It was difficult to establish people's precise care needs and preferred routines from the information in their care plans. We also found that this information lacked consistency and we saw that it was recorded and stored in various areas of the home. This meant that people could not be assured that their individual wants, needs and choices would be met appropriately by the staff supporting them.

The deputy manager told us that people's care plans were in the process of being updated to a more 'user-friendly' and 'person centred' format. However, none of the people for whom we requested care plans, had yet had these revised formats completed. We also saw that there was a significant lack of clear and accessible guidance regarding people's needs for new, temporary or agency staff to follow. This meant that new staff were reliant on more experienced staff showing and telling them what people's individual support needs were and people could not be assured that these would be consistently met. This was of particular concern, given the high number of agency and new staff currently working in the home.

These matters were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we were assured by staff that people had their physical care needs met, the records to support this were not always being completed appropriately.

In respect of one person receiving oxygen therapy and who had a PEG (Percutaneous Endoscopic Gastrostomy) feeding tube in place for all their food and drink, we noted that their care and review records were not being kept up to date.

For example, a new PEG care plan began in August 2014 but had not been evaluated since. There was also no record of the PEG site being cleaned, flushed or a rotation of the tube between August 2014 and February 2015.

Requires improvement

Is the service responsive?

The care plan for the oxygen therapy stated that 'O2 stats must be monitored twice weekly with effect from July 2014 but the last recorded evaluation was August 2014. In addition, we noted instructions to wash and care for the nasal cannula every two weeks but the most recent entries were December 2014 and January 2015.

These matters were a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the care staff were kind, and competent and supported people in a courteous manner, they did not have the time to offer individual or personalised care, due to the high level of need in the home. Staff told us that they did not rush people or cut corners so people were given the care they required but not always at the time that they preferred. For example, although some people had indicated that they would like assistance with washing and dressing during the early part of the mornings, this was not always provided until late morning or even lunchtime.

People told us that they were supported with social stimulation and interests, such as art, quizzes and one-to-one interaction when the activities member of staff was on duty. However, on the day of our inspection, this staff member was not on duty and many people were sitting alone with little to do, as the care staff were busy supporting people with their personal care.

For example, we spent one hour observing three people in the downstairs lounge and, although the television was on, it was not wanted by one person who was facing the set. A second person in the room said they were not interested in the television and always read their bible. A third person remained asleep in their chair for the full hour of our observation. The only interaction during this time was by the maintenance man, who thought the television was broken, as it had since been turned off. After one hour, the provider arrived with a letter for one of the people but left straight away.

One person told us, "When the activities are on we have a good time". Another person said, "There's not much to do, I usually just watch TV." A third person said, "I sometimes join in with the painting sessions in the lounge and 'exer-set' (exercise sessions). [Activities staff] also does other activities. To be honest though, I'm often quite happy just watching TV." We also noted that another person we met and spoke with frequently left and re-entered the building as they wished and enjoyed spending time outside.

We were told that the activities coordinator usually worked in the home every week-day morning and a private physiotherapist/occupational therapist attended two days per week to support people. In addition, the provider told us that people would be supported with their religious beliefs. For example, we noted that the 'Church of Nazarene' visited the home one Monday per month, the Church of England vicar visited one Sunday per month and a catholic nun visited every Sunday to spend time with people who wished to see her.

People living in the home said that they could always talk to the staff if they were unhappy about anything. One person said, "I've been here for years - the staff are all very good. They know when I'm in a bad mood and want to be left alone." "I've got no complaints whatsoever; I can soon say if I'm not happy – and I do! Sometimes I just prefer to be left on my own". Another person told us, "I've got everything I need thank you. I would talk to the staff if I had any problems or concerns but I've got nothing to complain about at the moment".

We saw that visitors were welcome to come and go as they wished. One regular visitor said that they were always made welcome and could talk to a staff member if they had any concerns. Another visitor told us, "The staff are friendly and know people's likes and dislikes. We have no complaints about the care provided".

Requires improvement

Is the service well-led?

Our findings

We were told that medication audits were carried out every three months but we noted that the last audit was dated October 2014. The nurse told us that audits did identify issues, which were then discussed in the nurses' staff meetings. However they also said that the audits had not been carried out recently due to a lack of time and the absence of the manager.

The nurses had also identified that care plans were in need of updating, with one nurse stating that people's care plans were, "Not good or reflective of current needs". However, action had not been taken to address this issue.

The concerns we identified during this inspection, regarding the staffing situation, had not been clearly recognised by the provider and therefore appropriate action had not been taken.

These matters were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider has a legal obligation to notify CQC of certain events affecting the health and welfare of people. We found that incidents such as DoLS applications, serious injuries and safeguarding concerns had not been reported to us as required.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

It was unclear how care staff were enabled to question practice and contribute ideas for improvement. Some staff said that the home was set in a certain way and fresh ideas were rarely considered. Staff also told us that the directors and management team were not receptive to change.

Although nursing staff had regular meetings and minutes were seen of those meetings, there were no records of care staff or domestics being included in any meetings regarding the home. Some staff had some positive ideas about how to be included in the development of the service but this had not been given consideration by the management team at the time of this inspection.

There was a lack of clear and visible leadership, particularly whilst the manager was absent from the home. Staff turnover was also of concern, particularly when we were informed that a further three nurses had recently handed in their notice. In addition, staff told us that considerable pressure was being applied by the provider, to admit people with very high needs, which significantly impacted on the care provision for everyone else. We also noted that, despite the high use of agency staff, permanent nurses were also being required to do high levels of overtime.

Staff spoken with told us that concerns would be dealt with and that the welfare of people was paramount. However, we saw that the systems used to monitor the quality of the service did not pick up concerns on a regular basis.

We noted that the home was in the process of dealing with a complaint during the time of this inspection. The deputy manager and one of the directors explained the concerns and what action they were taking to address the issues. We also noted there was information displayed around the home telling people how and who to complain to. However, the information on complaints in the Statement of Purpose/Service User Guide, supplied in each person's bedroom, was a number of years out of date and contained the incorrect name and address in respect of he Care Quality Commission.

The deputy manager told us that monthly reports were completed in respect of pressure ulcers and we saw three months of records that had been completed and were up to date. Audits we saw in the office included kitchen checks and cleaning schedules. We also saw servicing records for lifting equipment and fire safety equipment. All of these records were up to date.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's care plans were not 'person centred'. It was difficult to establish people's precise care needs and preferred routines from the information in the care plans. Regulation 9(1)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were insufficient qualified nurses on duty and staffing levels were not matched to the demand for the care and support of the highly dependent people living in the home. Regulation 18(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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Action we have told the provider to take

	Issues of consent were not fully understood and therefore DNCACPR forms were not reviewed and updated appropriately. Regulation 11(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's care and review records were not being kept up to date. Regulation 17(2)(b)(c) Quality monitoring systems did not identify the areas in need of improvement and action had not been taken in respect of these. Regulation 17(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered persons had failed to notify the Care Quality Commission of specific events they are required to tell us about. Regulation 18(1)(2)