London Residential Health Care Limited

Summerlea House Nursing Home

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced inspection of this home on 5 January 2015. Summerlea House Nursing Home provides accommodation and nursing care for up to 76 older people. The home is a large, purpose built property and accommodation is arranged over three floors although only two were in use. The second floor houses the Rosemead Unit . This is a specialist unit which accommodates up to 16 people who live with dementia. Two passenger lifts are in place to assist people to move between the floors. The accommodation provided is a mixture of single bedrooms and shared rooms for two people. There were 61 people living at the home at the time of our inspection, 11 of whom lived in the Rosemead Unit.

The service had a registered manager. A registered manager is a person who has registered with the care Quality Commission to manage the service. Like

Summary of findings

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.

Following an inspection in September 2014, the registered provider was found to be in breach of the regulations relating to the care and welfare of people, meeting people's nutritional needs, the cleanliness and infection control processes in the home, assessing and monitoring the quality of the service provided, and the quality of the records kept in the service. The registered provider sent us an action plan stating they would be compliant with these regulations by October 2014. The registered provider had addressed some areas of concern, whilst others were continuing to be monitored or further actions implemented.

People said they felt safe at the home. Relatives had no concerns about the safety of people although they felt more senior staff were required at the home at weekends. The home was clean and tidy and the kitchen area had been deep cleaned.

Staff had been trained and had an understanding of the risks of abuse against people. They said they were confident to report any concerns of abuse they may have through the appropriate channels. However the registered manager and staff had not identified several incidents of concern which should have been reported to the local authority and CQC. We reported these incidents to the local authority.

Although recruitment and training processes meant people were cared for by staff who had the skills to meet their needs, there were not sufficient staff to meet the needs of people who lived with dementia. A lack of nursing staff present in the home meant people did not always receive care which was led by nurses.

People were supported by nursing staff to take their medicines. However there was a lack of policy and procedures in place to ensure medicines were administered safely and effectively when they were not required regularly. Staff had not ensured the correct processes were followed when a person received their medicines covertly.

Staff gave people a choice of nutritious food and drink. New menus had been implemented following consultation with people and feedback was being monitored by the registered manager.

Staff at the home had not been guided by the principles of the Mental Capacity Act 2005 (MCA) when working with people who lacked the capacity to make decisions. The registered manager and staff had not always sought people's consent to their care. The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. This is relevant where people may need to have their freedom restricted in their best interests with authorisation from a local authority to do so. The registered manager and staff did not have a good understanding of when DoLS should be implemented.

People had access to health and social care professionals as they were required. External professionals were well received by staff who welcomed advice and support.

People said staff were caring and supportive. Staff knew people at the home well. However, people who lived with dementia did not always receive support which was meaningful and in line with their needs.

Individualised plans of care provided information about people's needs, however these lacked detail. Some people told us they were able to participate in activities, however for people who lived with dementia there was a lack of stimulating and meaningful activity.

People were provided with opportunities to express their views on the service through quality assurance surveys and through discussions with the manager and staff. Meetings were held with people and their relatives/ representatives to allow them to express their views.

Whilst a programme of audits was completed by the registered manager and the registered provider to ensure the welfare and safety of people, they had not identified the lack of mental capacity assessments or medicines policies in place to ensure the safety of people. Incidents and accidents were not recorded, reported and investigated thoroughly. This meant people were at risk of further harm following these events. The registered manager had not always identified any learning from these and shared this with staff to prevent recurrence of these issues.

Summary of findings

People who worked and lived at the home felt able to express any concerns they had and these were responded to. The registered manager worked to promote an open and honest culture of communication in the home, however this was not always reflected in the comments we received from people and relatives.

We found a number of breaches of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010. These correspond with the Regulations of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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 always safe.

There were not sufficient staff available to meet people's needs. Safeguarding policies and procedures in place were not always followed to ensure the safety of people.

Medicines were stored safely and administered by registered nurses. However, appropriate policies and procedures were not in place to ensure people received their medicines safely and effectively.

Risk assessments were in place to ensure people were safe in the home.

The home was clean and tidy and processes were in place to ensure people were protected from the risk of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

The requirements of the Mental Capacity Act 2005 (MCA) were not followed. Mental capacity assessments were not completed and decisions made on behalf of people were not made in accordance with legislation. The requirements of Deprivation of Liberty Safeguards (DoLS) had not been assessed or actioned for people who lived within a locked unit.

Staff had received the training the registered provider had identified as required to meet the needs of people.

People received support to ensure they had sufficient food to eat and drink.

Is the service caring?

Requires Improvement

The service was not always caring.

People, relatives and professionals said staff had a caring attitude.

However, for people who lived with dementia interactions with staff were not always meaningful in line with their needs.

Staff knew most people well and involved them and their relatives in the planning of their care though this was not always clearly documented.

Is the service responsive?

Inadequate

The service was not responsive to people's needs.

Care plans for people lacked clarity, were incomplete and were not always specific to people's needs. We were not assured they reflected people's wishes.

The communication and recording of changes in people's needs and behaviours that may challenge was not thorough or individualised.

Summary of findings

A complaints process was in place and people knew how to access this.

Is the service well-led?

Inadequate

The service was not well led.

A lack of robust audits in the service meant concerns we had identified had not been identified by the provider.

Incidents and accidents were not investigated, recorded and reported in line with requirements. Learning was not identified and acted upon to ensure the safety and welfare of people.

The registered manager was available, but had a lack of visible presence in the home. Relatives did not always feel assured the manager responded in a timely way to their concerns.

A lack of nursing leadership meant, whilst people received care, we could not be sure this was in line with their clinical needs.

Summerlea House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 5 January 2015 and was unannounced. The inspection team consisted of one inspector, a specialist advisor in the nursing care of older people who live with dementia, and an expert by experience in the care of older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home, including previous inspection reports. We reviewed notifications of incidents the registered manager had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law. There were some serious incidents which should have been reported to us which had not been done so.

We spoke with ten people who lived at the home and two visiting relatives to gain their views of the home. We observed care and support being delivered by staff in communal areas of the home and in the Rosemead Unit. Staff in this locked unit supported people who were living with the advanced stages of dementia. We spoke with nine members of staff, including registered nurses, care staff, kitchen staff and cleaning staff. We interviewed a registered nurse, the registered manager and a carer. The operations support manager for the registered provider was also present.

We looked at the care plans and associated records for 14 people, eight of whom lived in the Rosemead Unit. We looked at a range of records relating to the management of the service including records of complaints, accidents and incidents, quality assurance documents, four staff files and policies and procedures.

Following our visit we spoke with a further five relatives to obtain their views of the home. We requested information from nine health and social care professionals who supported some of the people who lived at Summerlea House Nursing Home, five of whom responded.

Requires Improvement

Is the service safe?

Our findings

People felt safe at the home. One person told us, "I know the staff well and feel safe with them around." Relatives said they felt their loved ones were safe but that sometimes there was not sufficient senior staff or kitchen staff present at the home, particularly at the weekend.

At our inspection in September 2014 the provider had not ensured care and treatment was always planned and delivered in a way which was intended to ensure people's safety and welfare. Care records and risk assessments in place did not reflect people's needs in relation to specific health conditions. At this inspection, risk assessments were in place for people who had specific health needs. For example, for one person who had a blood disorder a risk assessment identified the risks this may pose to the person. Information was available for staff on how to monitor for and reduce these risks. For another person, a specialist health care professional had provided guidance and information for staff on how to reduce the risks associated with Parkinson's disease. This was clearly documented in their care records and personalised to ensure staff had clear information on how to support the person.

The provider's policy on safeguarding adults from abuse dated October 2014 gave guidance for staff on how to report any potential abuse. A copy of the local authority multi-agency policy and procedures for safeguarding adults at risk was available for staff to view. Records showed 28 of 36 care staff and 10 of 11 registered nurses had completed training in the safeguarding of adults. They had knowledge of the types of abuse they may witness and how to report this.

However, two incidents of serious injuries to people had not been raised as an alert with the local authority. Nor had they been investigated and followed up to ensure the safety and welfare of the people. We reported these incidents to the local authority for investigation under their safeguarding protocol. We found some people's records included evidence of injuries such as bruising and skin tears, which had not been reported. This meant that people were not fully protected from the risk of potential or actual abuse

The lack of recognition and reporting of such safeguarding incidents to the local authority was a breach in Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored securely and were always administered by a registered nurse. There were no gaps in the recordings of medicines given on the medicines administration records (MAR). One person was found to have hidden a medicine from staff and disposed of this on the floor. A member of ancillary staff who found the medicine reported this to the registered nurse on duty and this was then recorded appropriately in the person's MAR sheet and incident book.

The registered provider did not have a policy in place for the administration of 'as required' (PRN) medicines. A registered nurse told us these medicines were given to people as they requested them and people were asked at every medicines round if they required these. However, the lack of guidance for staff on the administration of these medicines could lead to inconsistency and unsafe practice. For example, one person had three prescribed medicines for pain relief on their MAR sheet, two of which contained paracetamol. There was no guidance for staff on how these medicines should be administered to ensure the person did not exceed the daily safe amount of paracetamol. There was no care plan or record with the MAR sheet to show the criteria for use of each medicine. Two other people were prescribed PRN medicines to reduce their agitation. The records did not contain guidance about the people's specific behaviours which would indicate the need to administer this medicine. When medicines were administered to support a person who had become agitated there were no clear records as to the effect this medicine had had.

Two further people had been prescribed a PRN night sedative. There was no care plan in place to indicate when this should be given to help people sleep, or how effective it had been when given. There was no clear guidance to ensure the people received the medicine as necessary and to ensure this administration did not become custom and practice by default. This meant people were at risk of receiving medicine when they did not need it, or of not receiving it when they did.

The registered provider had a policy in place for the administration of covert medicines, dated October 2014. Medicines given covertly are given in such a way as to

Is the service safe?

disguise the medicines to allow staff to administer them to a person who may not wish to have these but who has been assessed as lacking capacity to make their own decision in this specific area. This policy clearly set out guidance for staff to follow and ensure the involvement of a multidisciplinary team of people, including the person and their relatives in making this decision. Staff had not followed this policy. For example, for one person their pre-admission assessment identified their medicines had been administered covertly before their admission to the home. A medicines care plan dated 15 September 2014 stated, "Crush pills and administer covertly." There was no information to show this had been agreed with the person, relevant health and care professionals, their GP or a pharmacist or if it was safe to crush and administer medicines together. This meant these people were receiving medicines covertly without the appropriate procedures being followed to ensure their safety.

The lack of guidance for staff on the administration of PRN medicines and the lack of adherence to safe practice and the provider's own policy for the administration of covert medicines was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us how they ensured staffing numbers reflected the needs of people across the home. Whilst records showed the number of staff on duty were in line with their assessment, we saw nursing and care staffing levels were not sufficient to meet the needs of people within the Rosemead Unit of the home. People in this unit required a high level of support with all activities of daily living and close supervision to ensure their safety. We noted three periods of ten minutes and one period of 30 minutes where there were no staff available to supervise and support people in the lounge area, as they were busy supporting people with needs in other areas of the unit. People were not safe when staff were unavailable to supervise and support them. One staff member said, "It is really difficult to get everything done and we are under pressure every day, the worst bit is that we just are not able to do the things we want to for people and the things they deserve." Another member of staff told us, "I hate just doing the basics".

Whilst a registered nurse was available in the home at all times to support the needs of the people on the Rosemead Unit, there was a lack of clinical presence in this unit which supported people with complex needs. One relative told us they often visited to find no care staff present in the lounge area. They said, "The care staff are just fire fighting there [on the Rosemead Unit] all the time as there are not enough of them to meet the complex needs of these people." The registered manager told us they had not identified the need for a constant presence of a registered nurse in this unit as the care needs of the people living there could be met by the care staff available. It was apparent to us that the number of nursing and care staff available reflected the number of people living there and not necessarily their needs. The registered manager had employed a senior registered nurse to work one day at the weekend, and told us when this person was not available at the weekend the registered nursing staff were the senior people at the weekends. This meant there was a lack of presence of senior staff in the home at some times.

The lack of appropriate staffing levels to meet the needs of people who lived with dementia was 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.

At our inspection in September 2014 systems were not in place to reduce the risk of the spread of infection in the home. Improvements had been made in the cleanliness of the kitchen area of the home at this inspection. The registered manager had completed a robust audit of the infection control practices at the home and any actions identified from this audit had been completed. In most areas of the home slings for use with hoists for the moving and handling of people were allocated to individuals. Cleaning materials were available for all pieces of equipment after use. Staff were seen to use this equipment following most episodes of use, however we observed one occasion where staff returned a hoist to a storage space without cleaning the equipment. Care plans gave information for staff on how to manage specific risks of infection control for most people. For example, two people who had a health condition which required close monitoring had effective infection control measures in place.

Requires Improvement

Is the service safe?

There was sufficient kitchen staff working to ensure people received the support they required with the preparation and delivery of meals. The registered manager told us there had been issues about the availability of staff due to sickness and absence but that this had been addressed.

The registered provider had safe and efficient methods of recruiting staff. Recruitment records included proof of identity, two references and an application form. Criminal Record Bureau (CRB) checks and Disclosure and Barring Service (DBS) checks were in place for all staff. These help employers make safer recruitment decisions to minimise the risk of unsuitable people working with people who use care and support services. Staff did not start work until all recruitment checks had been completed.

Personal evacuation plans were available in all people's records and an emergency evacuation box containing essential resources was available to be taken out of the home to ensure the safety and welfare of people in the event of an emergency leading to evacuation of the home

Requires Improvement

Is the service effective?

Our findings

Staff knew people well and people were happy with the care they received. People said staff helped them to be as independent as they could be and would help when it was required. One person said, "They do whatever I ask them to and this helps me to do what I want." Relatives said staff met the needs of their loved ones. Health and social care professionals said the home worked well with them to ensure they met the needs of people; however they had concerns about the effectiveness of the care for people who lived with dementia.

In September 2014 the provider had not ensured people were protected from the risks of inadequate nutrition and hydration. At this inspection, we noted that the registered manager had taken steps to ensure people were protected from the risk of inadequate nutrition and hydration. People and their relatives said they had been involved in the planning of new menus to be introduced at the home the week following our inspection. This had taken some considerable time to implement and so people had yet to see a change in the variety of foods available to them. However, people told us they were generally happy with the food they received. A nutritional screening tool was being used to assess people's need for support with dietary and fluid intake. Staff had identified the need to involve the GP or dietician and these had been actioned. Food and fluid charts had been maintained for people who required these following assessment.

Where people had capacity to consent to their treatment, staff sought their consent before care or treatment was offered. However, people who lacked capacity to make decisions about their care and welfare had not been assessed and supported to ensure their needs were met in line with their wishes or best interests. The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interests decision should be made involving people who know the person well and other professionals, where relevant.

Records showed, and staff told us, they had received training in the use of the MCA and Deprivation of Liberty Safeguards (DoLS). Staff told us people on the Rosemead Unit lacked the capacity to make decisions. However, no capacity assessments had been completed for people to identify what decisions they may be able to make. There was no information available as to who would be able to support people to make a decision and who else should be involved in this process.

Some care plans had been agreed by relatives on behalf of their loved one, but there was no evidence to show that these representatives had the legal right to agree to this care. For example, a communication care plan dated May 2014 for one person stated, "[Person] has full ability to make choices." However some of their care plans had been signed by a relative.

The Rosemead Unit had a coded lock entrance which restricted access to and from this area. The code for this access was known to staff but not visible for other people to use. The registered manager told us they had discussed this with the local authority in relation to the DoLS, however no further actions had been taken. DoLS require providers to submit applications to a supervisory body for the authority to legally deprive people of their liberty such as in the case of a locked area of their home. There was no information in people's care records to show they had been consulted about the use of the locked door on this unit. There was no information available in care records to advise staff what they should do if a person wished to leave this area. We found therefore that there were restrictions on people that did not consider their ability to make individual decisions for themselves as required by the MCA.

The above issues regarding the absence of proper capacity assessments are a breach of Regulation 18 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. We made a referral to the local authority safeguarding team to raise concerns about the lack of assessment of people's mental capacity at the home.

The main areas of the home were well maintained and had undergone significant refurbishment since our last inspection. People's rooms were bright and fresh and communal areas welcoming with easy to access areas. However, further adaptations were required in the Rosemead unit to meet the needs of people who lived with dementia, such as the use of colour and large signage to encourage people's independence.

An induction plan was completed for new staff when they commenced work at the home. A programme of training

Requires Improvement

Is the service effective?

was available to all staff to ensure they had the skills the registered provider had identified as required to meet the needs of people. The registered manager monitored this programme to ensure all staff completed training and refresher updates in accordance with the registered provider's policy. Registered nurses were supported to attend training to support their continuing professional development, however they had not had any training in the leadership of staff.

There was a system in place to support staff development through the use of one-to-one sessions of supervision and appraisal by the manager. This ensured staff received information on the service as well as offering the opportunity for staff to discuss any concerns or learning needs they had.

People had regular access to external health and social care professionals as they were required.

Records showed people had access to a variety of specialist services including chiropody, dentistry, specialist nurses, and GP and community nurses. Health and social care professionals told us they were warmly welcomed at the home and staff responded to their professional advice.

Requires Improvement

Is the service caring?

Our findings

People felt they were well cared for at the home. Staff were kind and understood their needs. Relatives were very happy with the caring and supportive approach of staff to looking after their loved ones. One relative said, "This is such a caring home, my Mum is very happy here." Health and social care professionals said the registered manager and their staff were very kind and caring when supporting people and this was evident throughout the home.

People who did not live on the Rosemead Unit were able to move around other areas of the home as they wished. They spent time in the communal lounges or dining room of the home or in their own rooms. Each person was encouraged to personalise their room and several rooms were decorated with memorabilia of the person's life. Staff interacted in a kind and respectful way supporting people to maintain their independence. People enjoyed time in communal areas and staff encouraged people to interact.

However, in the Rosemead Unit, there were no memory areas or activities available to stimulate people who lived with dementia and encourage their engagement in activity. People on this unit did not have meaningful activities available to them. They sat in the communal lounge area with the television on and received no stimulation from staff who were attending to other people's care needs. One relative told us they often visited to find their loved one in the lounge area with no activity or stimulation other than the television. Staff responded to people's needs on the Rosemead Unit in a reactive manner, supporting them in a kind and helpful way when they showed signs of requiring help. However they did not engage and interact with these people in a meaningful way.

People and their relatives were involved in the planning of their care, however this was not always documented clearly. Relatives told us they spoke with staff regularly to update their loved one's care needs and could speak to staff at any time if they had a concern care needs had changed. Whilst daily records showed staff spoke with people and their relatives regularly to ensure their needs were met, this was not always reflected in their care plans.

People felt happy to express their wishes to staff and these were respected. Staff encouraged people to be independent in their daily routines, and respected their wishes. For example, one person had decided they did not wish to sit in the lounge, but would rather sit in their room listening to music. We saw staff supported this choice and regularly checked on them to see if they wished to join in activities in a communal area. Staff responded to people's calls quickly and efficiently.

Inadequate

Is the service responsive?

Our findings

People were able to raise any concerns they may have about the service with staff or the registered manager. Staff were very approachable and responded to any requests or concerns in a prompt and efficient manner. Relatives felt staff were approachable and responsive to any issues they may raise. Health and social care professionals said whilst staff reacted to the needs of people and called them whenever they were required, staff did not always act in a proactive and holistic way to meet the needs of people.

Each person had an individual plan of care. On admission to the home, information had been sought from people, their families and representatives to gather a history of their life and personal preferences. This information had helped to inform care plans for people which included mobility, dietary and nutritional needs, sleep routines, communication, continence and personal hygiene needs. Care plans were personalised and were reviewed by staff monthly or more frequently if required. A 'Resident of the day' scheme had been implemented to ensure each day of the month care records for a named person were reviewed, updated and agreed with the person or their relatives. This work had commenced since our last inspection and the registered manager told us this had improved the consistency in care records. Records showed people's needs were being reviewed monthly, however, in particular for people who lived with dementia on the Rosemead Unit, we found some care plans lacked sufficient clarity and information specific to their needs and abilities.

People who lived on the Rosemead Unit had cognitive impairment resulting from dementia. As this condition progresses people commonly display agitation and what can be regarded as aggressive behaviour. In order to provide appropriate support it is essential that behaviour is monitored. Staff did not record incidents of agitated behaviour over the time of our visit. They told us this was because, "This kind of thing [agitation or aggression] happens all the time and unless it is serious we often don't record it, if someone was hurt or two people were involved we would but sometimes it is so difficult because we are so busy." This meant people's care was not being adequately monitored, reviewed and adapted in line with their needs.

People who live with dementia can become less able to recognise pain and tell someone about it. Staff depend on appropriate tools to assess pain in addition to recognising signs of an individual's pain. There were no pain assessment tools in use in any area of the home. One member of staff dismissed a person's pain as acceptable as they had just had a surgical procedure which meant they were likely to have pain from this area. There was no attempt to assess the person's pain at the time or request further intervention from a nurse or other health care professional.

A wide range of activities was available for people who lived in the main area of the home and they were encouraged to participate in activities such as games, films, entertainment and singing. People interacted with each other and were able to ask for support as they required it. On the Rosemead Unit, people were seen to be sitting without any stimulation or encouragement from each other or staff present in the room. Staff provided reactive support for people, however there was no other staff interaction with people in this area of the home. People who lived with dementia were not motivated or encouraged to be independent with their activities of living. Staff were task orientated in their approach to routines and activities for these people. A relative told us, whilst the staff were all lovely and very caring, sometimes they felt people on the unit [Rosemead] did not get the same care as those in the rest of the home. They said, "It feels as if ,because they have dementia, they are not worth it." Staff told us there were sometimes activities brought into the Unit for people to participate in. We did not see people engaged in any activity during our visit and the television remained on throughout our visit. Care plans for people who lived with dementia did not provide any information as to the activities people may enjoy or which may help to stimulate and engage them. They did not give clear information on how the person could be supported. Staff were not certain about how to best support people. For example, one member of staff spoke to people in a way which was loud and difficult to understand. People did not respond to their direction.

The lack of consistent and effective plans of care in place to meet the individual needs of people who lived with dementia was a breach in 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.

Relatives were involved in reviews of their loved one's care; however the person was not always included in this

Inadequate

Is the service responsive?

conversation. Few people knew about their care plan or what was in it; some were aware of reviews of their care. People did not always know if their care plans reflected their wishes although people told us they were happy they received the care they needed. This meant whilst the provider had sought the views of people, they could not always be assured care plans were a true reflection of people's wishes.

Daily records were maintained by staff to record the activities people had participated in during the day and the support and care they had required. They held information on all health and social care professionals visits. Information from the daily records had been used to update most people's care plans and records.

The registered manager held meetings for people, their relatives and also staff. They encouraged feedback about the care and support they received. Minutes of these meetings were displayed around the home in appropriate areas to ensure anyone who did not attend was informed of the outcome of these and any planned actions. Records showed the registered manager took action following any concerns which had been raised with them.

The provider had a complaints process in place which was clearly available for people. They had received no formal written complaints in the three months since our last inspection. Many compliments about staff and the service they provided had been received from people and their relatives. The registered manager shared this with staff.

People were happy to raise any concerns they had with staff or the management of the home and felt sure their concerns would be dealt with. The registered manager responded promptly and effectively to a concern raised during our visit. A relative told us of an issue they had raised and how it had been dealt with. They said, "I know who to speak to and the issue is always addressed." However, another relative shared less positive views about their experience of how concerns reported to the registered manager were not addressed promptly.

Inadequate

Is the service well-led?

Our findings

Some people knew the registered manager but did not understand their role or responsibilities. They said the registered manager was present but they did not know where or how they could speak with them. Relatives said the registered manager was available most of the time if they wished to speak with them during the week, however they, "Had an answer for everything," and they did not feel their concerns were always addressed in a timely way. One told us, "Things are very different when the manager is not around; there are not enough senior staff."

In our inspection of September 2014 records had not been maintained accurately and consistently to ensure they reflected the on-going needs of people. An effective audit system was not in place to monitor and evaluate people's needs. At this inspection, we noted that systems had been introduced to monitor and review care records monthly. An audit in place had identified learning needs in this area for registered nursing staff and further work was being completed to address this concern.

A programme of audits was completed by the registered manager and provider to measure if the service was safe and effective for people. These audits included; infection control, health and safety, medicines administration, care plans and environmental audits. The registered manager was working on an action plan with the local safeguarding authority which they had completed to assure the provider that all the identified actions were being taken to ensure the safety and welfare of people. However these audits had not identified the risks associated with the administration of medicines, the lack of safeguarding incident reporting, or the lack of mental capacity assessments in place for some people in relation to their ability to consent. The registered manager acknowledged this work needed to be completed at the time of our inspection

The registered manager monitored all information on incidents, accidents or areas of concern identified at the home. They collated information on these incidents on a monthly basis and reported this to the registered provider. However this system did not allow the identification of themes of incidents across the home. The effectiveness of this system was noted to be inadequate when the inspection team identified several incidents in care records which had not been recorded, investigated or reported appropriately. In the event of a person having frequent incidents there was a risk this would also not be identified in a prompt manner therefore putting people at risk of further harm. Care records had not been updated in line with incidents and with the outcomes of any investigations from these. The registered manager could not identify learning which had been shared following incidents and this did not ensure people's needs were safely met.

The lack of recording, reporting and learning from incidents and accidents and the ineffectiveness of audits completed was a breach in 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 registered manager is required by law to report all incidents of serious injury to a person to the Care Quality Commission without delay. The registered manager had failed to report two such incidents. This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered provider's head of care was not present on the day of our inspection. The registered manager told us this person was responsible for the clinical leadership of staff in the home. Care staff had a good understanding of their roles and responsibilities. However, nursing staff were not seen to interact with people throughout the home except during the administration of medicines. They completed administrative duties and other tasks away from people and their interaction with care staff was limited. They did not provide a clear leadership role in the home. The lack of clinical knowledge and information in care records showed nursing staff did not have a good understanding of the needs for clinical leadership in the home, particularly in the care of people who lived with dementia. A health care professional told us, "Although caring and kind the nursing staff often do not seem knowledgeable about medical conditions, particularly dementia." This meant people were at risk of not receiving care which met their needs as staff did not have always have effective leadership skills to assess and monitor the clinical needs of people.

The registered manager told us they promoted an open and honest working ethos. The statement of purpose for the home contained the 'Core Values' of the service which were based on the provider's resident's charter of rights.. Both were available to view in the home. Staff were aware of these and encouraged by the registered manager to

incorporate these in their daily work. For example, people's right to privacy and dignity and respect was a core value, we observed this was demonstrated in the home. An electronic noticeboard at the entrance to the home gave people information about the service and activities in the home. A staff duty board was to be erected in the hallway to identify staff on duty and their roles.

People said the registered manager was in their office during the week and had an open door policy where people were welcome to speak with them. They met with people, relatives and staff in their office to ensure they were aware of who they were and how they could communicate with them. However, people told us the registered manager was not visible to them and they did not see them around the home talking with them. One person told us, "I don't know who is the boss". Another said, "I don't know I would need to find out." Relatives told us they knew the registered manager and they could speak with them during the week if they wanted to. They told us the lack of senior staff at the weekend meant the home often felt disorganised with not enough people around and the carers, 'lacked guidance'.

Regular staff meetings were organised and the registered manager discussed topics such as policies and procedures, training, complaints and information for staff on people new to the home, CQC visits and other general feedback, as well as any other issues staff wished to discuss. Staff found these meetings useful, gained feedback from the registered manager about any issues within the service and actions were completed by the registered manager following these. The registered manager had implemented a schedule of 'Policy of the Week', whereby they provided access for staff to a particular policy and asked for confirmation each staff member had read and understood this. The registered provider was working to ensure staff recognised and understood these documents and the implications they had on their working role.

People and their relatives were asked for their views of the service and the quality of the care they received. This was requested in a questionnaire which the registered manager sent out and collated responses to. This had been sent out in November 2014 and the registered manager would collate information and ensure an action plan was created from these comments. A previous questionnaire had identified concerns with menu plans and this had been addressed.

Staff said they felt supported by the registered manager and head of care in their duties. Staff confirmed they received regular one to one supervision sessions. This was a time for them to discuss any concerns they may have, have an update on any matters about the home or people who lived there and review the training they had received or any further training they required. Staff had a good understanding of their role and how to report any concerns to senior staff or management. The structure of staffing supported an effective reporting of concerns by staff

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had failed to identify the possibility of abuse and report this accordingly. This was a breach of Regulation 11(1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use the service were not protected from the risks associated with the unsafe administration of medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 (f)(g) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered provider had not taken steps to obtain and act in accordance with the consent of service users. This was a breach of Regulation 18 (1)(a)(b)(2) 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.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered provider did not always ensure there were sufficient numbers of suitably qualified, skilled and experienced staff to meet the needs of people. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2010, which corresponds to Regulation 18 (1) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.**
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The registered provider had failed to report incidents of serious injury to a person to the Commission without delay.**

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People who use the services had not had their care planned and delivered in line with their individual needs and to ensure their safety and welfare. Regulation 9 (1)(a)(b)(i)(ii)(iii)**

The enforcement action we took:
A Warning Notice was served on the Provider and Registered Manager requiring them to be compliant with this Regulation by 10 April 2015. A further inspection will be carried out to ensure the provider has met the requirements of this notice in due course.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **Incidents and accidents were not reviewed and analysed to ensure people's safety and identify learning for the service. Regulation 10 (1)(a)(b)(2)(c)(i)**

The enforcement action we took:
A Warning Notice was served on the Provider and the Registered Manager requiring them to be compliant with this Regulation by 10 April 2015. A further inspection will be carried out to ensure the provider has met the requirements of this notice.