Interhaze Limited

The Spinney Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 13 October 2016 and was unannounced.

The Spinney Care Home provides accommodation for up to 26 older adults who require personal care for physical health needs or dementia. 24 people were living at the home at the time of our inspection.

We last inspected the home in June 2015 and found improvements needed to be made to the number of staff on shift at night and that risks were not always managed effectively in regards to people's nutritional needs. At this inspection we found some improvements had been made but further improvements were still required.

There was a registered manager in post however they were absent from the home due to extended leave. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was an interim manager in post who was overseeing the day to day running of the home.

People told us they received their medicines when they needed them. However we saw that medicines were not always stored safely and it was not always recorded when people had received their medicines.

People felt safe using the service and there were processes to minimise risks to people's safety. These included procedures to manage identified risks with people's care.

Care workers understood how to protect people from the risk of abuse and keep people safe.

Care workers' suitability and character was checked during the recruitment process to make sure they were suitable to work with people who used the service.

Environmental checks were completed to ensure that the home was safe for people who lived there, however we found that some areas were not always locked securely and could pose a risk to people.

Analysis of incidents and accidents were carried out to minimise the likelihood of them happening again.

Care workers received an induction when they started working for the service and completed regular training to support them in meeting people's needs effectively. People told us care workers had the right skills to provide the care and support they required.

The provider and interim manager understood their responsibilities and the requirements of the Mental Capacity Act and the Deprivation of Liberty Safeguards.

Staff were kind and caring when providing personal care. However, staff interaction with people was mostly when supporting them with care tasks. We saw limited engagement between staff and people at any other time of the day.

People were supported in a way that promoted their privacy and dignity.

Group activities were offered by care staff however activities did not reflect people's individual preferences.

Care plans and assessments contained information that supported staff to meet people's needs; however some had not been updated when there had been a change in people's condition. People and their relatives were not consistently involved in the planning of care being provided.

People received food and drink that met their nutritional needs however people were not always aware that alternative meals were available if they did not want a meal that had been offered.

The interim manager completed quality checks of the care provided however these checks had not identified some of the issues we had raised.

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.
People felt safe. Staff understood what action to take if they had any concerns about people's safety or well-being. People received their medicines as prescribed Medicines were not always stored safely. Medicine records did not always accurately reflect when medicines had been given to people.. Staff were available at the times people needed them.

Is the service effective?

Good

The service was effective.
Staff had received training and on-going support to deliver effective care. Procedures were in place to act in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People were supported with their nutritional needs. People were referred to a range of healthcare professionals as required.

Is the service caring?

Good

The service was caring.
Staff members interacted with people in a caring and respectful way but did not always have time to engage with people outside of delivering care. People's privacy and dignity was respected. People were supported to be as independent as they wanted to be.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.
People were not always supported to pursue their hobbies and interests. Care and support was not always provided in a way people preferred. People were not always aware that there were alternative meals available. People and their relatives were not consistently involved in the planning and review of care provided.

Is the service well-led?

Requires Improvement

The service was not consistently well led.
Staff felt supported and able to share their views and opinions about the service. People and relatives thought that recent

redecoration of the home had been an improvement. The provider and management team had systems in place to monitor the quality and safety of service provided but audits were not sufficiently robust.

The Spinney Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 13 October 2016 and was unannounced. The inspection was carried out by two inspectors and an expert by experience. An expert-by-experience is someone who has knowledge and experience of using, or caring for someone, who uses this type of service.

We reviewed the information we held about the service. We looked at information received about the home and the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We spoke with local authority commissioners who funded the care for some people at the home. They told us they had identified some areas for improvement and were due to revisit the service to review the action the provider had taken in relation to these.

During our visit we spoke with five people who lived at the home, three relatives, six care staff and a member of the kitchen staff. We also spoke with the interim manager and the provider.

We observed staff interactions with people and the support they delivered in the lounges and dining area.

We reviewed the care plans of five people. We also looked at other records such as medication records, recruitment files, complaints records and quality assurance records including meeting notes.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in June 2015, we found that due to staff vacancies, the provider's staffing levels were not always maintained at night. We checked to see if improvements had been made.

At this inspection we found the provider had taken some actions to improve and maintain safe staffing levels. They had recruited permanent care staff to the home and because of this agency staff were no longer needed. This promoted continuity of care for people who lived at the home. One member of staff commented, "We definitely have enough staff to keep people safe."
The provider told us that following their last inspection, they had reassessed the level of care that people who lived at the home required in order to meet their needs. They had identified that a number of people had been assessed as requiring nursing care, therefore they had moved out of the home. The provider told us they used a dependency tool to determine the number of staff required to care for people, based on the level of people's care needs. This indicated the minimum levels of staff that were required to support people. We saw that at night it had been assessed that a minimum of two members of care staff were required to be on shift. Rotas showed that although occasionally there were three members of staff, on the majority of nights there were two members of staff available to support people. A number of people living in the home required two care workers to support them with their care needs and we expressed our concern to the interim manager and provider that if there were two members of staff on shift and one person required support there would not be any members of staff available to support other people in the home. The interim manager explained that he or a team leader was always on call at night and able to go to the home to support the workers if this was required in an emergency. We asked the provider about the practicality of this to support people's routine night care needs and the provider stated they would continue to review the levels of night staff.

We asked people if they used their call bell at night to request support, one person told us "They [care staff] are normally pretty quick to respond." Another person told us "They have responded very quickly even at night when I use the buzzer." We reviewed accident and incident records and saw that there was not an increase in incidents at night which indicated that people were safe. The manager and provider assured us that they would ensure people were supported by sufficient staff at night and that they would continue to review staffing levels to ensure they met people's needs.

People told us they received their medicines when they needed them however we found shortfalls in the administration, recording and management of medicines. Medicines were not always stored safely. We checked people's medicines and found that one medicine which had to be kept in a refrigerator were not kept there. This caused a risk that the medicine being administered was not effective or safe to use. One medicine was instructed to be disposed of 28 days after opening and the pharmacy label showed that it had been dispensed on 6 September 2016. Staff had not recorded the date of opening and were unable to tell us when it had been opened. A care worker responsible for administrating medicines told us "I don't use date's opened on medicines." This meant the medicine had potentially been opened for longer than recommended, which could have made it unsafe or ineffective to use.

Each person had a medicines administration record (MAR) which showed when medicines had been given. We saw that the MARs were not always completed correctly. When people had medicines at multiple times during the day the MAR chart had been completed with the details of the times that the medicines were due to be given following the prescriber's guidance. However the MAR did not have details of the actual time the medicines were administered. We were told that the morning medication round began at 8am and we observed that it was not completed at 9.45am. A further medication round began at midday. We saw instructions that one person needed a four hour gap between doses of their medications. We asked a member of staff who was responsible for administering medication what time they had last received it, they were unable to tell us. This meant the time between doses may not have been adhered to and could increase the risks to a person's health.

Some medicines needed to be given at certain times before meals however there were no arrangements in place to ensure these instructions were followed. Some people had medicines prescribed on an 'as required' basis (PRN), for example, pain relief drugs. However, medicine plans to inform staff of when and why people might need these, were not consistently in place. A number of people were prescribed PRN pain relief but their records did not tell us how their pain levels were monitored or assessed by staff. This is important, especially for people who cannot communicate, to ensure they are kept free of pain and comfortable.

One person self- administered their own medicines and kept it in their room. We saw that these were kept out on a unit in the bedroom and were not stored securely. If another person who lived in the home took these medicines it could be harmful to them.

We discussed our concerns with the interim manager. During our visit the interim manager informed us that they had taken steps to address the issues we had identified. They told us they had created a list of medicines that required storage in the fridge in the medication room and had instructed staff who administered medicines to use 'date opened' labels. The medication which should have been stored in the refrigerator had been disposed of and replacements were now stored correctly. A meeting was held with staff who administered medicines to provide additional training about completing MARs accurately and to ensure they included times medicines were given. The provider had created new PRN protocols which included information about what the medicine was for and how staff could recognise if a person required it. The interim manager informed us, before we left the home that the person who kept their medicines in their bedroom had been provided with a lockable unit to keep them secure and to reduce the risks of another person accessing them. The actions taken by the interim manager reduced the risk of people being given medicines in an unsafe way.

We found from walking round the home, that the environment was not always safe for people who lived there. We saw that a door to the attic was open with a pair of step ladders propped against the wall beside it. A member of staff was in the attic but the ladders were unattended and this area was accessible to people who lived in the home. We also saw a sluice room had a sign on it saying that the door was to be locked at all times. We found that this door was unlocked meaning people could gain access to an area which was not safe due to chemicals being stored there. We highlighted these risks to the interim manager because the ladders could pose an obstacle to people moving through the home and the open door to the attic could allow people to access an area that was not suitable for them. The manager immediately arranged for the ladders to be moved and the door to be shut and for the sluice to be locked. We checked the sluice room again and found that it had been locked. The interim manager informed us he would remind all staff that they have a responsibility to keep the environment safe and that hourly checks were to include checking that all doors which were to be kept locked were.

The interim manager told us that staff were always available in communal areas to ensure people were safe. We found that this was not always the case. Following breakfast we saw there were no staff members in the dining room, a person with dementia had walked into this area and we saw that the hot food trolley remained turned on and was hot to the touch. This meant that there was a risk of the person being burnt if they touched the equipment. We brought this to the manager's attention who assured us that staff would be present in all communal areas.

People told us they felt safe living at The Spinney, they said, "Yes, I am very safe." Another person told us "I haven't ever felt scared and I do feel very safe, I know the carers look out for me."

There was a procedure to identify and manage risks associated with people's care. Staff knew the risks and how these were managed. Risk assessments for falls, moving people, sore skin and nutrition were in place.

Professional healthcare advice had been followed by staff. For example, people identified as at risk of choking when eating or drinking had drinks thickened with a substance to reduce this risk. One person was provided with a pureed meal and we saw that staff supported them to eat their lunch in an unhurried way which reduced their risk of choking.

Staff had knowledge of adult safeguarding procedures and knew what to do if they suspected any type of abuse. Staff said they would refer their concerns to the manager and if necessary to someone more senior. One member of staff said, "If I had any concerns I would tell a team leader or the manager." Records showed that when any concerns were identified the interim manager had referred these to the local safeguarding service and sent the necessary notifications to inform us of the events. This helped to protect the people who lived in the home.

The provider's recruitment process minimised risks to people's safety because checks were made to ensure staff who worked for the service were of a suitable character. Staff told us and records confirmed, Disclosure and Barring Service (DBS) checks and references were in place before they started work. The DBS helps employers to make safe recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use services.

We saw there was an emergency evacuation file in the main reception area which included individual evacuation plans for people who lived in the home. This information would be required by emergency services if the home needed to be evacuated.

We asked about incidents and accidents in the home and what actions the provider took to reduce the likelihood of them happening again. The interim manager told us that information was recorded following any accidents or incidents by care workers and this was reviewed monthly by team leaders and the interim manager. The interim manager told us they analysed the information and put action plans in place to make improvements such as updating people's risk assessments or referring them to healthcare professionals for support. Records we saw showed that this had been done.

The interim manager was aware of how to ensure the home was kept safe for people who lived there. Maintenance checks such as water temperatures were completed regularly by the maintenance person. We saw that up to date safety certificates, such as gas tests were displayed in the main reception area.

Good

Is the service effective?

Our findings

People told us they thought staff had the correct knowledge to support them, one commented, "The carers have training every so often." Care staff told us, when they started working at the home, as part of their induction they worked alongside more senior and experienced staff. This meant they could observe them working and learn from them. Care staff told us that they felt they had sufficient training to provide support to people, however one staff member told us they would like to have more training about caring for people living with dementia.

We were told that training was planned to provide staff with further skills and knowledge. The provider told us that the organisation had a training manager who was currently providing training to key members of staff which would enable them to deliver training to others. The provider told us, this would enable more training to be provided.

We saw that a training programme was available for staff which included training that the provider deemed essential for staff. This included areas such as health and safety, safeguarding, infection control and the mental capacity act. The staff training record was up to date. Staff told us "[Interim manager] tells me when training is coming up and shifts are arranged to allow us to attend."

We saw that staff had completed "React to Red" training. This is training offered by the local tissue viability team (nurses who reduce the risks of skin problems) with the aim of educating care staff about the dangers of pressure ulcers and the simple steps that can be taken to avoid them. Staff told us they were aware of how to recognise signs of skin problems. Records showed that no one in the home currently had any problems with their skin related to pressure area management.

Care staff told us they completed moving and handling training. We observed two care staff in the lounge area hoist a person from their wheelchair to an armchair. The care staff used the correct moving and handling techniques and they spoke to the person throughout so that the person was aware what was happening and to offer encouragement.

The interim manager informed us new staff undertook training in line with the Care Certificate during their induction. The Care Certificate assesses the fundamental skills, knowledge and behaviours of staff that are required to provide safe, effective and compassionate care to people. However records showed that this was not routinely completed. This was raised with the provider and the interim manager who agreed to further support staff to complete it.

Care staff told us they received supervision (one to one meetings with their manager) on a regular basis which helped them feel supported in their work. The interim manager told us supervision was carried out monthly and included observations of staff to check that they were competent at providing care and that they worked to the provider's training and procedures. . We saw a timetable which identified when staff were due to meet with their manager for their next supervisions sessions and annual appraisals.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. Mental capacity assessments were in place and reviewed regularly. Capacity assessments for individual decisions involved the person, their family and appropriate healthcare professionals. We found staff followed the principles of the Act when providing people with support and respected the right of people with capacity to make decisions about their care and treatment.

Staff knew they should gain people's consent before they provided care and support. We asked staff what they would do if a person refused support. They responded, "If the person has capacity we have to respect their choices, I might go back later and ask again. If the person does not have capacity you have to make a judgment about if providing the care would be in their best interest. If it isn't then you can't do it."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).The manager understood their responsibilities under the legislation. They had identified that some people could have some restrictions on their liberty and had submitted the appropriate applications to the authorising authority.

Some people had their food and fluid monitored to ensure they ate and drank enough to maintain their health and well-being. Records showed that one person was at risk of urinary tract infections and this risk was increased by not having sufficient fluids. We saw that this person was offered drinks throughout the day and the fluid charts completed during the week prior to our inspection visit showed they had sufficient to drink

People told us they were referred to health and social care professionals where a need to do so was identified. One person explained they had been concerned about their skin and had told a care worker who arranged a visit to the GP who had prescribed a cream. Another person told us that they required a type of mattress which would help relieve pressure points when they were in bed. The person told us that an occupational therapist had visited them and completed an assessment to determine what mattress would best meet their needs and it had been ordered for them. A relative praised how the home worked with other health professionals. They explained that their family member had lived at the home for a relatively short time and he had been referred to a physiotherapist. The relative explained that the physiotherapist had visited their family member and with their support the family member had been able to stand for the first time since before moving to the home.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring, however they went on to say staff were often very busy which limited their time to spend with people. One person told us, "The carers are lovely and they are like friends, I am always sad when they go. They always seem very busy dashing in and out but they stop and chat when they can." Another person told us "All the carers are very kind, friendly, they have always been alright with me, they treat me very well, they don't usually have time to stop and chat though as they seem quite busy." A third person said "They (care staff) are all very polite, respectful and well mannered. They all seem very busy and don't have much time to stop and chat, they are never rude though." Relatives told us "It's a fantastic place; the carers are lovely, easy to talk to." Another relative told us "The care staff are all lovely and caring, and they seem to know our relatives very well."

We heard staff speaking kindly to people and saw they were respectful, however as staff were busy we saw little interaction with people outside of receiving support. We raised this with the interim manager who explained the home had recently employed new staff to fill vacancies and that with the higher number of permanent staff; their aim was to enable care staff to have more time to spend with people who lived in the home. The interim manager went on to explain that plans were in place for staff to spend more one to one time with people.

Care staff ensured people's privacy was protected, one person told us "They always respect my privacy, knock on my door and ask if they can come in, (they) close my door when need be." Staff told us that they were always respectful of people's dignity when assisting them and we saw that when a person was moved using a hoist, staff maintained their dignity by moving their clothing to ensure they did not expose themselves.

People were supported to be as independent as they wanted to be. One person told us, "I change my bed with help from the carers but I put all my own clothes away and clean my room, the carers would help me if I need them to." Another person said "The cleaner comes and hoovers my room every day but I like to be as independent as possible so I clean my own room, I wash and dress myself." A third person explained that they now required a higher level of support than previously "I have had help getting undressed at night recently and I used to hang my own clothes up but the girls do it for me, and they are always happy to help." A member of care staff explained "I'll always encourage a person to do things for themselves if they are able, but I'm there to assist them if they can't or if they are having a day when they need more help."

We observed staff usually communicated with people in a caring manner. . They bent down to speak with people who were sitting and used gentle reassuring tones when talking. However we observed that when staff moved a person in a wheelchair who had limited vision they did not communicate where they were going. We discussed this with the interim manager who after our inspection sent us minutes of a meeting with staff which included reminding them of being aware of how they communicate with people with sensory difficulties to ensure they knew what was happening.

People were encouraged to maintain relationships important to them and visitors were welcomed at the

home. Relatives we spoke with told us they were able to visit their family members when they wanted.People told us that staff were kind and caring, however they went on to say staff were often very busy which limited their time to spend with people. One person told us, "The carers are lovely and they are like friends, I am always sad when they go. They always seem very busy dashing in and out but they stop and chat when they can." Another person told us "All the carers are very kind, friendly, they have always been alright with me, they treat me very well, they don't usually have time to stop and chat though as they seem quite busy." A third person said "They (care staff) are all very polite, respectful and well mannered. They all seem very busy and don't have much time to stop and chat, they are never rude though." Relatives told us "It's a fantastic place; the carers are lovely, easy to talk to." Another relative told us "The care staff are all lovely and caring, and they seem to know our relatives very well."

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Requires Improvement

Is the service responsive?

Our findings

People had different experiences about the activities organised by the home. One person explained that the interim manager had arranged a party to celebrate their one hundredth birthday and a singer had attended which they had enjoyed. Another person said that they had enjoyed a reminiscence activity. However other people did not enjoy the activities offered. One person told us, "The activities are not very good. I am not interested in passing a ball around to each other." Another person told us "The activities here are a bit half hearted, most of the time we are just sitting in armchairs around the room, not talking or doing anything." During our inspection we saw two members of staff in the lounge encouraging two people to play skittles and throwing and catching a ball.

We saw that group activities were arranged in the home but there were no individualised plans for people based on their preferences. We saw an activity folder had an activity listed for each day for example bingo, singing games, baking and newspaper. After each activity people who had taken part were listed. The interim manager told us that different activities were organised each month however records showed that the same activities had been offered for April, June and September. There was no analysis completed by the interim manager of the provider to find out if people enjoyed the activities on offer or to gain their feedback about what activities they would like to do. People living with dementia often have difficulty participating in group activities and can benefit from one to one activities that are tailored to meet their individual needs. We looked at people's care plans to see how they were supported with individual activities. We saw that individual activities were limited; one activity recorded for a person was that they "went outside for a cigarette." We raised this with the interim manager who informed us that the person was a "very private individual" and that when they go outside it gave them the opportunity for social interaction with others which they enjoyed. Three other care plans stated that one to one activities had occurred but did not provide details of what the activity was.

Life histories had been completed for people; however this information had not been used to plan meaningful activities for people. Staff demonstrated good knowledge about people's histories and their interests, one care staff member said "I know [Name] used to love dancing. I would love to take them and others to a show. I think they would enjoy that." The provider acknowledged this and following our inspection took steps to provide further training to staff so that individual activity plans could be created for people which reflected their interests.

The Spinney has a large, enclosed garden which was accessible from the lounge area. People told us that they had been able to go out to the garden during the summer but would like to use it more often. The provider told us that he was planning on placing paving slabs down over the winter which would allow people to use the garden independently.

Meals were not cooked on site and were provided from a central kitchen. People had mixed views about the meals. One person told us "The food is very good here, I had what I wanted for my breakfast and there are always choices for lunch and dinner." However other people told us that they did not receive a choice about the meals they received. One person said "I am not asked what I would like, they just bring a meal, and I

can't grumble about the food, I just get on with it."

We saw at lunchtime that although a menu was not on display in the dining room people were given the option of roast pork or salad for their meal. People were shown two plates of food to enable them to choose which they would prefer. We saw that when one person did not want either option they were offered a sandwich instead. One person was vegetarian and was given a salad for their lunch. We heard the person commenting about being cold. We spoke to the provider about the suitability of a salad as the vegetarian option in October when people may prefer a warm meal.

Following our inspection visit the provider spoke with the chef in the central kitchen to ensure that options were being provided to people that met their dietary requirements and preferences. We saw correspondence from the chef that showed multiple options were offered to people at each meal. The provider arranged for daily menus to be placed in the dining room and the interim manager arranged additional training for staff to ensure that they were aware of options available to people.

We looked at three people's care records. Some of the care plans and assessments contained detailed information, however some lacked important information. For example one person's health records stated that they had been prescribed a medicine in 2015. This medication was not mentioned in any other care plans or risk assessments and it was unclear if they were still receiving it. This had implications because if the person was receiving this type of medicine they needed regular blood tests to monitor the levels and it could have interactions with other medications and food. We raised this with the interim manager who confirmed the person was still receiving this medicine and updated the care records accordingly.

We found that some care plans had not been reviewed when people's needs changed. For example, one person's care plan had conflicting information as to whether they had capacity to self-medicate to reduce anxiety. The interim manager explained that this had been changed two weeks prior to our inspection visit because of a change in the person's capacity. They agreed to update the care plan immediately. Following our inspection the interim manager sent us copies of the care plan to confirm that this had been done.

Some people told us they had not been involved in formulating and reviewing their care plans. One person told us, "I have not been asked to be involved in any meeting or care plans." The provider told us that not all people had capacity to be involved in planning their care and staff would then involve family members to make decisions in the person's best interest. One relative told us, "We were involved in the care planning, it was last week."

We saw that in some people's care plans they had stated they preferred to have a bath rather than a shower. When we went into the bathroom and there were numerous pieces of equipment in it, such as walking aids, which would prevent people using the bath. A member of staff told us that they "never used the bathroom" and that "people are only offered showers." We fed back the information we had received from staff and the interim manager immediately arranged for all equipment to be moved out of the bathroom. The interim manager told us that staff had been instructed to offer people the choice of a bath or a shower. Following our inspection the provider provided us with copies of care records which showed a person was regularly offered a bath. Minutes of a team meeting following our inspection visit showed that staff had been instructed not to store equipment there and that people were to be offered a bath or a shower.

We observed a staff handover meeting between shifts. This enabled staff starting a shift to be informed of any changes in people's health so they could respond appropriately.

Information about how people could raise complaints was displayed in the entrance hall of the home. We

asked people if they knew how to make a complaint, one person told us, "If I had to make a complaint or had anything I was worried about I would speak to the boss (interim manager)." Relatives told us they felt confident to approach the interim manager to discuss any concerns but that they had not needed to.

The interim manager told us all formal complaints received were recorded so they were able to identify any emerging trends and take appropriate action. Eight complaints had been received in the 12 months prior to our inspection and the manager had followed the organisation's complaints policy to respond to them in the required time frame. No trends had been identified in the complaints.

People told us they had decorated their rooms how they wanted them and some people had chosen to bring furniture with them from their previous home. Signs were not in place to assist people with dementia to recognise their bedroom and toilets or bathrooms. The interim manager explained that this was due to areas of the home being redecorated and showed us the signs which were due to be put on bathroom doors. The interim manager also explained that frames had been purchased so photographs and pictures people had chosen to help identify their rooms could be placed on their bedroom doors.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post who was currently on maternity leave and an interim manager was acting in their place. The interim manager was previously a team leader within the home and knew the staff and people who lived there well.

We asked people if they felt the home was well led. One person told us, "The home is always very clean and well looked after, you walk into room and they smell clean, not like some places." Relatives we spoke with were aware there was a new manager, one told us, "The manager is great." Another said "We have no complaints at all. The place has really improved with all the redecoration too."

There was a timetable indicating audits that needed to be carried out by the manager on a weekly and monthly basis. These included safe management and administration of medicines, falls analysis and skin damage. Checks of care plans were conducted and staff were consulted to see if they had any concerns about how people's care needs were being met. We saw that these checks were carried out, however some audits had not highlighted some of the issues we identified such as MAR charts not being completed correctly and care plans not always containing up to date information.

We spoke with the interim manager and the provider to share our concerns over our findings and they understood the issues we had identified and the challenges the home faced. The provider told us they were disappointed that the shortfalls had not been identified by themselves but they felt confident on being able to correct them. They immediately responded to our concerns by reviewing all the medicine records and met with staff who administered medicines to provide guidance on completing them correctly. The interim manager provided us with updated copies of care plans that had not been up to date and a plan was in place to check the other care plan's contained the correct information. The provider told us that he was providing training to managers in their other homes, to create a team who would visit each home to complete audits and checks similar to a CQC inspection to make sure they were meeting our regulations. The provider hoped that by having an external team visiting the homes, would enable them to identify any future issues so action could be taken to address them.

The interim manager was motivated to make improvements within the home. They told us they felt well supported by the provider to carry out their role. In addition they received support from an experienced registered manager from one of the provider's other homes. They told us they were committed to improving the service and said, "I want people to tell me if there are any problems so I can fix them."

The provider sent an annual quality assurance questionnaire to people who lived in the home, staff and relatives. In the most recent questionnaire six people living at the home had replied, all of which had provided positive feedback about the home including "I am happy here" and "Staff treat me with kindness and respect." However one suggested improvement, "Better use of the garden which in my opinion is sadly wasted." Plans were in place to address this.

Nine relatives responded to the survey and were all happy with the care provided. However it was identified

that not all relatives were aware that the home provided end of life care. The interim manager identified this and completed supervision with staff so that when they completed care plan reviews with people and relatives this could be explained and end of life wishes could be recorded.

Eight members of staff responded to the survey and whilst they all responded positively to working in the home, staff commented about wanting to have more staff available which would enable people to be offered more activities. However staff were aware that "the manager is working on this as a priority."

Relatives told us they received good communication from the home, one relative said, "I can pick up the phone anytime I want." The interim manager told us that a 'residents and relative' meeting was held every six months which enabled people to be involved in planning future events in the home. At the most recent meeting people had discussed wanting to go on more trips outside the home. This had been followed up at staff meetings where it had been reinforced with staff that people were to be offered the option of going for a daily walk outside the home. Staff confirmed that this was being offered more frequently now that new staff had been employed.

The provider and interim manager mostly understood their responsibilities and the requirements of their registration. For example they knew what statutory notifications they were required to submit to us and had completed the PIR which are required by Regulations. However it is a legal requirement that a copy of their ratings is displayed in the service and on their website. The last rating was not displayed at the time of our inspection visit. The interim manager was not aware of this requirement however agreed to display it immediately. The interim manager sent us evidence following our inspection that the rating was now displayed in the entrance hall. The provider explained that they were currently in the process of updating their website and this would be completed as a priority.