Caring Homes Healthcare Group Limited

Moorlands Nursing Home

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 25 and 30 November 2015. It was unannounced. There were 30 people living at Moorlands Nursing Home when we visited. People cared for were mainly older people who needed nursing care. People had a range of care and treatment needs, including stroke, heart conditions, breathing difficulties, diabetes and arthritis. Many people needed support with all of their personal care, eating and drinking and mobility needs. Some of the people were living with dementia. The home also cared for people at the end of their lives.

Moorlands was a large house, which had been extended. Accommodation was provided over two floors, with a passenger lift in-between. There were sitting rooms and a dining room on the ground floor. Moorlands Nursing Home was situated in its own grounds. The provider for Moorlands Nursing Home was Caring Homes Healthcare Group Limited, who provide a range of services across the United Kingdom.

Moorlands Nursing Home did not have a registered manager in post when we inspected. The previous registered manager had left their post and a new manager had been appointed. This new manager came

Summary of findings

in post on 19 October 2015. They confirmed they would be applying for registration as manager with the CQC. 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.

The home was inspected on 17 December 2014 and was judged to be inadequate. At that inspection, issues were identified relating to consent for care and treatment, assessments and monitoring of the quality of the service, staff support and staffing. A further inspection was performed on 30 January 2015 to review progress towards making improvements in service provision. We found improvements had been progressed and the outcome areas reviewed were judged to be requiring improvement.

At this inspection, improvements had been made but some areas still required further improvement. Some people's risks were not effectively managed. This included the care and treatment of people who were at risk of pressure damage, dehydration and the management of people's diabetes. Some staff were unaware of the degree of people's risk in these areas and the actions they should take to reduce them. Care plans did not clearly set out actions staff needed to take. They also did not follow relevant national guidelines on the care and treatment of people.

Where people were living with dementia, staff did not fully assess the extent of people's behaviours which may challenge either themselves or others. Care plans were not drawn up to direct staff on how these people needed to be supported when they showed such behaviours. People's individual needs for activities were not consistently assessed and the care plans for people were limited. The new manager and activities worker were taking action to develop and address such areas.

Where people needed medicines to be given in a disguised way (known as covert medication), systems for ensuring the consent of relevant persons were unclear and inconsistent. The new manager had taken action to ensure all other areas relating to consent to people's care and treatment complied with the Mental Capacity Act (2005). They had also taken action to refer people to the local authority where they were at risk of being deprived of their liberties (DoLS).

Some areas of management had not yet been addressed by the new manager. This included ensuring effective deployment of staff to meet people's needs. Also certain records, including records relating to people's medicines and the monitoring of meeting people's care and treatment needs were not in place, or did not accurately reflect what staff told us about.

Many people felt complaints and concerns had not been effectively managed in the past. They reported, now the new manager was in post, they were confident if they raised issues action would be taken to address their concerns. The new manager had ensured records of complaints and concerns raised by people were now fully documented.

The new manager had taken action to reduce risks to people by ensuring they had appropriate risk assessments. The systems for audit of accidents identified factors to reduce risk to people, and the new manager had taken action where relevant. They had also ordered relevant equipment such as new beds and pressure relieving equipment, to further reduce people's risk.

Staff were caring and supported people in a kindly way, ensuring they offered them choice. Staff showed respect to the people they were caring for, including people from diverse backgrounds. These systems also ensured people who were at the end of their lives were supported in the way they wanted.

People were able to choose where they ate their meals and what they ate. People were assessed for nutritional risk and action were taken to reduce such risks. Staff provided people with support where they needed assistance with their meals.

The new manager had reviewed systems for staff support and training. They had developed a revised training programme. They had also set up systems for regular supervision of staff so they were supported in their roles. All staff had been trained in safeguarding adults from risk of abuse and were aware of actions they needed to take to ensure people were supported if they had been identified as being at risk of abuse.

Summary of findings

People were safely supported in taking their medicines. There were appropriate systems for storage of medicines. People who needed external professional support, such speech and language therapists (SALT), were referred in a timely way. Advice from external professionals, like the SALTs, was followed by staff when providing care and treatment.

The new manager had ensured all of the home was well-maintained and clean. They had set up systems for regular audit of facilities and services. They had an action plan which showed the areas they had addressed and areas which they needed to address, with dates for completion of actions.

During the inspection we found two breaches 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 the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

There were inconsistent systems to ensure people were assessed for risk and actions taken where risk was identified.

People were protected from risk of abuse.

People's medicines were managed in a safe way.

There were sufficient staff, who had been suitably recruited, were in post.

Is the service effective?

Requires improvement

The service was not always effective.

The home did not have full systems to ensure all people were assessed where relevant in accordance with the Mental Capacity Act (2005). Relevant referrals were made where people were at risk of being deprived of their liberties.

Staff were supported by training and supervision to provide people with the care and treatment they needed.

The home liaised effectively with external professions.

People could choose where they ate their meals. Where people needed it, they received the support they needed with eating their meals.

Is the service caring?

Good

The service was caring.

Staff cared for people in a kindly and supportive way.

Staff respected people, ensuring their individual needs were met and their

privacy and dignity maintained.

Where people were at the end of their lives, care was provided in a in a sensitive and caring way.

Is the service responsive?

Requires improvement

The service was not always responsive.

Some people's care and treatment needs were not always responded to in the way they needed and their care plans did not fully reflect all their needs.

Activities provision was being further developed, to ensure it was more person-centred.

The new manager had ensured people's complaints and concerns were acted upon.

Summary of findings

Is the service well-led?

The service was not always well led.

The service did not have a registered manager in post.

The management of staff deployment was not always appropriate and record-keeping was not always consistent.

The new manager had identified a wide range of actions which needed to be addressed, they had made considerable progress in the short time they had been in post.

Requires improvement

Moorlands 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 25 and 30 November 2015. It was unannounced. The inspection was undertaken by three inspectors. One inspector inspected on 25 November 2015, the other on 30 November 2015. The lead inspector inspected both days.

Before our inspection we reviewed the information we held about the home, including previous inspection reports. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met with 22 people who lived at Moorlands Nursing Home and observed their care, including a lunchtime meal, medicines administration and activities. We spoke with six people's relatives and visitors. We inspected the home, including people's bedrooms, sitting rooms, the dining room and bathrooms. We spoke with 16 of the staff, including registered nurses, care workers, domestic workers, the activities worker and the chefs. We met with the new manager, the area manager and clinical peripatetic manager. We also spoke with a visiting GP.

We 'pathway tracked' six of the people living at the home. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed records. These included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Requires improvement

Is the service safe?

Our findings

People said they felt safe at the home. One person told us "I feel safe with the staff, they're very caring," another that they felt "Absolutely safe." A person said they felt especially safe at night because there were staff available to help them. One person said staff came "Quickly" when they rang their bell and another "I ring my bell and they come." A person's relative said "Definitely yes," their relative was safe in the home, and another said they felt their relative was "Safe now" because of the actions taken by the new manager.

Many of the people were assessed as being at high risk of pressure damage. The new manager told us they had identified that the incidence of pressure wounds was higher than they would have anticipated. We discussed people's risk with staff. Some of the staff we spoke with were not aware of certain people's high risk of pressure damage. Staff were also not aware of actions to take to reduce risk of pressure damage as per guidelines from the National Institute for Health and Care Excellence (NICE). These set out that pressure wounds, once developed take an extended period to heal, can be painful and may be a source of infection. Therefore the emphasis must always be on their prevention.

People's care plans for risk of pressure damage were not clear and did not follow NICE guidelines on prevention of pressure damage. For example where a person sat out of bed all day, there were no instructions to inform staff of equipment to be used to prevent pressure damage and actions they were to take to reduce the person's risk. Two of the people who were assessed as being at very high risk sat out most of the day in chairs with no pressure relieving equipment on them. One of these people's pressure relieving cushions was placed by their chair throughout the day. People had movement position charts to show how often their position had been changed. These records showed people were not supported to change their positions regularly. For example one person's records showed they were not supported to change their position for a period of over five hours. This person's records showed they had recently developed pressure damage.

The home were also not following other guidelines to prevent people's risk of dehydration. The Royal College of Nursing (RCN) had produced guidelines on fluid intake for older people. These recommend "A conservative estimate for older adults is that daily intake of fluids should not be less than 1.6 litres per day." We saw staff accurately documented the amount of fluid people had drunk and totalled the amount every 24 hours. These totals showed people were drinking considerably less than 1.6litres a day. We asked staff about plans to support people to increase their fluid intake. Staff only reported they were told to "Push fluids" with no plans about how this was to be achieved. When we looked in people's records, their care plans did not show plans for how people were to be supported to drink more or if consideration had been given to referral to other agencies, due to their low fluid intake.

One of the people we met with was living with diabetes. Staff reported, and their records showed, they could experience high and low blood sugar levels. Such fluctuations can make a person unwell. When people's blood sugar levels fluctuate they may need intervention from staff to ensure their blood sugar levels were appropriately monitored, and relevant actions taken. We received differing reports from staff, including registered nurses, about how they supported the person if their blood sugar levels were unstable. The person did not have a care plans about actions staff were to take when they showed high or low blood sugar levels, to ensure consistency in approach by staff so risks to their health from unstable diabetes were reduced.

The home were not consistently ensuring relevant actions were taken to mitigate risks to people from pressure damage, dehydration and unstable diabetes. This is a breach of Regulation 12 of the HSCA Regulations 2014.

Many of the people needed support with moving. People had risk assessment in relation to this. All people who needed to be moved using a hoist had their own hoist sling. There was also full information in their records about the type and size of hoist sling they needed, to ensure their safety. All people's hoist slings were used only for them.

We saw staff supporting people to move. They did this in a safe way. For example a person was assisted to stand up from their chair by a member of staff. The member of staff described to the person how they should stand up safely and supported them in a safe way. The member of staff then remained with the person throughout the time they walked to the dining room, ensuring their safety and encouraging them.

Requires improvement

Is the service safe?

The provider had a full system for analysis of any accidents and incidents to people. This included identification of risk factors, such as time of day or place in the home where the accident had occurred. The new manager told us about a person who had recently sustained several falls. The staff had identified the person had an infection; this was being treated. Equipment had also been provided to reduce risk to the person while they were undergoing treatment. Their risk assessment had been revised.

All of the staff we met with confirmed they had received training in safeguarding people from abuse. They were also aware of their responsibilities in relation to protecting people from harm. Staff, including ancillary workers like the laundry worker, told us about the signs of abuse and how they could report any concerns they had about people's safety. A copy of the local multi-agency safeguarding procedures was available and staff had been given information about the provider's whistle-blowing policy.

All people who remained in their rooms were left with access to their call bells. Many people who remained in bed all the time had bed rails in place. The new manager said they had identified this as a risk to people's safety. They had ordered new beds so people could be safely supported, without the risks associated with use of bed rails. Where the older style bed rails were in use, they were correctly fitted to people's beds, so they did not present any additional risk.

Medicines were managed safely and consistently. Medicines were correctly stored. The room used for storage of medicines was secure, clean and tidy. Staff monitored the room temperature and the temperatures of the fridge used for storage of specific medicines. The records showed temperatures were within safe agreed limits.

The medicine trolleys were locked and secured to the wall when not in use. Access to the room was key-coded so only appropriate staff could enter. Each trolley had an antibacterial gel to maintain hand hygiene.

Registered Nurses administered medicines safely. They ensured people were encouraged in a kindly way to take their prescribed medicines. Registered nurses ensured the security of medicines while they were in communal areas, and the medicines trolley was locked when the registered nurse was not with it.

Each person's medicine administration record (MAR) had a profile sheet which was individual to the person. This included a photograph of the person and clearly indicated any allergies or specific instructions, for example, how to offer a person their medicines.

Most people had full instructions where they needed medicines to be administered on an 'as required' basis (PRN). We noticed a few occasions where such instructions were not in place. Staff told us they had identified this could be a risk to people so they were reviewing people's medicines with their GP; these occasions were addressed during the inspection.

Where people were prescribed skin creams, there were full instructions about where their skin creams were to be applied on their body, and the frequency. Staff completed records when they applied such creams to people's skin.

The home was clean throughout and smelt fresh. Difficult to clean areas like the undersides of bath hoists, hoist wheels and chassis were all visibly clean. Sluice rooms were clean, tidy and organised. The laundry was clean throughout, including behind and between the machines. The new manager said they had completed a full review of cleaning standards since they came in post as it was an area they had identified as needing action. They had also put in revised cleaning schedules.

People and staff said they thought there were enough staff on duty to meet people's needs. On two occasions we rang call bells for people who wished for assistance. On both occasions, staff responded to the call bell in under two minutes. The home rarely used agency staff and the new manager reported they had needed to use only one member of agency staff in the last six months.

People were kept safe by the provider's recruitment procedures, which helped to ensure only suitable staff were employed. We looked at staff files. They contained evidence of the applicant's past employment history, a face-to-face interview, details of qualifications and contract of employment. All staff files contained evidence of proof of identity, disclosure and barring checks (DBS) and written references.

Requires improvement

Is the service effective?

Our findings

People said their care was effective. One person told us "Staff know how to look after me." A person's relative told us the staff were "All trained to work here." We received positive comments about the meals. These included "The meals are lovely, "The food is very good, there's always plenty of it," and "I eat plenty – it's so good." People also said they got a choice for their meals. One person said if they did not like either choice, staff would give them a "Sandwich or something else." A visitor told us staff "Always bring something else if they don't like the meal."

Several of the people were being administered their medicines in a disguised way, known as covert administration of medicines. Information about best interest decisions in relation to covert medicine administration were not always in place or regularly reviewed. This included a person who had an instruction that certain medicines were to be given in soft food, juice, tea. A different person was documented as receiving all their medicines via a feeding tube. Two of the staff told us this person had capacity to make decisions about their care but two members of staff said the person did not. No mental capacity assessment had been completed for the person. Other people's information in relation to covert administration of medicines did not include relevant information on who was appointed by the court of protection to make decisions on the person's behalf.

Other areas in relation to the MCA and the Deprivation of Liberty Safeguards (DoLS) were effective and the new manager understood their responsibilities in relation to such matters. Staff had attended training in the MCA and DoLS and understood how the principles of the legislation applied in their work. The manager told us that they had arranged two further training sessions in December 2015 to embed staff knowledge of this area.

Staff understood the importance of consent and explained how they gained people's consent to their care on a day-to-day basis. The manager told us applications for DoLS authorisations had been submitted for eight people, due to restrictions involved in their care. The manager said further applications were in the process of being submitted for people who had restrictions placed on them.

Staff told us the new manager and new management team had made improvements in the home so they felt more supported in their roles, to ensure they could effectively care for people. Staff said they had received training in key areas including fire safety, infection control and hygiene and moving and handling people. They said training had mainly been in the form of e-learning. The home had a room where staff could access computer terminals to support them in e-learning. Staff said the new manager was planning to set up more face-to-face training sessions and they welcomed this approach. Nearly all the staff, including domestic workers said they had received 1:1 supervision from the new manager since the new manager had come in post.

The new manager told us they had identified that staff needed increased support to enable them to do their roles, both through training and supervision. The new manager had fully reviewed the training programme and had set up training sessions, and further sessions were in the process of being arranged. This included training staff in the principals of prevention of pressure damage. The new manager also told us they had identified that systems for staff supervision had lapsed. At the time of the inspection, a few weeks after their appointment, the new manager had met nearly all of the staff for 1:1 supervision. Once they had completed this process, they said they would be setting up systems for regular supervision of staff, to support them in their role.

People received the support they needed from external professionals. We met with a GP who visited the home regularly. They said the new management team had improved liaison with them when making referrals, and information from staff to enable them to treat people had improved. This included ensuring base-line observations and tests were performed before asking for GP support. One of the people needed support with swallowing safely. They had been regularly reviewed by a speech and language therapist (SALT) to ensure they received appropriate clinical advice. The person had full instructions in their records about how staff were to support them. Staff followed these instructions. We saw a care worker go and find a registered nurse to tell them they were concerned about a person who was more sleepy than they usually were. The registered nurse promptly came to see how the person was and to make an assessment of the person's nursing needs. The registered nurse was kindly and gentle in their approach to the person, listening to them and observing their general state to enable their assessment.

Requires improvement

Is the service effective?

People's nutritional needs had been assessed and any dietary needs were recorded in their care plans. We spoke with the two chefs on duty, who explained that people's individual dietary needs were communicated to kitchen staff by the care staff. We saw guidance around people's individual dietary needs was displayed in the kitchen. This included instructions for the preparation and consistency of soft and pureed diets. The chefs told us they regularly sought people's opinions about the food and it was clear they had a good awareness of people's individual needs and preferences about their meals. The chefs said they had been given training in the preparation of soft and pureed food and knew which people had needs relating to their religion or culture.

People told us they enjoyed the food provided. They said they could have alternatives to the menu if they wished. We met with a person who was having a late breakfast. They smiled at us and said "This marmalade sandwich is nice." Relatives told us they were able to join their family members for meals and that they found the food to be of good quality. The new manager told us that they had introduced measures to increase people's involvement in choosing what appeared on the menu. People said they had been asked for menu ideas at residents' meetings and relatives told us their opinions had been sought at a recent relatives' event. The manager reported they had introduced measures to improve people's dining experience, such as putting a printed menu and fresh flowers on each table.

We observed the lunchtime meal in the dining room and saw people enjoyed their meals and the environment in which they were served. Staff supported people to eat and drink in a way which ensured their comfort and maintained their dignity. Staff sat with the person they were supporting and made sure they provided support at a pace which was comfortable for the person. Staff promoted people's independence by encouraging them to do what they could for themselves. For example a member of staff supporting a person to eat said, "You have a try yourself and I'll give you a hand if you need one."

Some people chose to remain in their rooms to eat their meals. We saw a care worker sitting with a person who needed full support to eat their meal. They gave the person a small amount on their spoon each time, so they could swallow safely. They gave the person the time they needed to enjoy their meal and did not rush them in any way. The person's expression showed they were clearly enjoying their meal.

Good

Is the service caring?

Our findings

All of the people we spoke with commented on the caring nature of the staff. One person said "They're all very helpful," another "The staff are lovely, very kind." A person's relative said staff were "Caring, very good," another "Staff are always nice" to their relative, and another "I can't fault the staff." A relative told us "When we see staff with them, they're very kind and loving. They keep a close eye on them. They always take the trouble to help them look good. They always have co-ordinated outfits and their hair and nails are done."

We observed that staff were polite, friendly and helpful. Staff engaged positively with people and were attentive to their needs. We observed several occasions in which staff demonstrated a caring approach, such as placing an arm around someone's shoulder to comfort a person who became distressed or were in pain. Staff offered people choices in all aspects of their care and support. For example staff asked people whether they wished to stay in their wheelchairs to eat their lunch or to transfer to a dining chair. A member of staff brought a cardigan for a person who said they felt cold. The member of staff asked the person whether they wanted the cardigan placed around their shoulders or if they would like help to put it on.

People said staff supported them in making choices. One person told us "I don't like mixing and they don't try and make me mix." A different person said "I like to keep to myself and this is respected." A person said "I could eat in the dining room if I wanted to but I don't want to, I prefer my own room, so they take me back for my meals." A person told us they liked to smoke cigarettes. They said they could go out and smoke whenever they wanted to, and staff did not place any restrictions on this. A person was being supported to come out of the dining room after their meal. The care worker who supported them explained to them what was happening as they appeared to be unsure. The care worker asked them where they would like to go next. They listened to what the person said and supported them to go where they wanted.

Staff ensured people's dignity. We met with a person whose relative told us liked to try to be independent with eating, and particularly enjoyed 'finger foods.' After mid-morning coffee, the person's clothes were covered in crumbs. By the time we next met with the person, before lunch, their clothing was neat and tidy and all signs of food debris had been removed. A relative told us about the laundry worker, describing them as "Caring and very polite." They said they appreciated the way the laundry worker cared for their relative's clothes to ensure the person's clothes were always correctly laundered and well maintained. They said the laundry worker also always contacted them about any matters which needed addressing so their relative was always well turned out, as they wished to be.

Staff were responsive to people. As a member of staff was leaving a person after supporting them, the person called the member of staff back and asked for something they wanted. The member of staff came back into the person's room and said "Of course" they would get the item the person wanted. A person changed their mind several times about what type of drink they would like when the drinks trolley came round. The member of staff remained cheerful and polite, making sure the person had the drink they had decided on.

Several people remained in or their rooms all of the time. People had a range of different music, television channels, or silence, according to what they preferred. A person from a particular ethnic minority lived in the home. They always had music playing which reflected their culture. Two members of staff said they spoke the person's language, so had been able to find out which music they liked to listen to, to meet the person's cultural preferences.

We heard someone calling out repeatedly. A care worker explained to us that the person could experience pain and had just been given pain relief by the registered nurse and was restless at that time. The care worker stayed with them, talking to them in a gentle and supportive manner until they became calmer, as the pain relief began work. We met with a different person who had difficulties with speaking verbally. Staff were polite and took their time with to them, putting an effort into understanding what they were asking for or how they wanted to be supported.

One person was at the end of their life. Staff supported them and their relatives in a sensitive way. The person's room was calm and their privacy and that of their family was respected. Staff actively tried to reduce any external noise in the corridor outside the room to maintain a peaceful atmosphere for the person and their relatives. The person's relatives could stay with them for as long as they wanted, and were also offered refreshments. Staff were readily available to support the person and their relatives but did not intrude, ensuring they allowed time for the

Good

Is the service caring?

person to be alone with their family. The new manager ensured they were available to support the person's family in a private area, away from the room, when this was needed.

Requires improvement

Is the service responsive?

Our findings

We received mixed comments from people and their relatives about the responsiveness of the home. A person who remained in bed all the time told us they "Don't really do anything other than watch the telly." A person's relative told us their relative had "Bed sores," which had "Not cleared up." Another person's relative told us staff looked after people's physical needs but did not support people's social and recreational needs. Other people said the service was improving. One person said they had not been involved in their care plan in the past but knew they would be now with the new manager. A person's relative said staff "Always" let them know about changes in their relative's condition. A different person's relative said they appreciated the way "I can come in at any time."

Some of the people we met with were living with dementia. One of these people told us "I don't feel safe." This was because they could see both children and men outside their room, particularly in the evenings. Staff were aware of what the person told us and described the person's reports as "Hallucinations." When we asked staff about these apparent hallucinations, they gave us differing replies about how often they occurred, their duration, and effect on the person. The person did not have any records to document what the person described to us or what staff reported. The person did not have a care plan about how they were to be supported when they saw these people, who were real to them. The person had not been referred to their GP about their symptoms during the past six months. We met another person who was confused as to time, place and person. Some staff said the person could become upset and show signs of agitation on occasion. There were no monitoring records to show the frequency of such occasions and how such matters affected the person. The person did not have a care plan about how they were to be supported when they showed such behaviours which may challenge others.

The new manager had reviewed activities provision. They said work needed to be progressed to make activities more person-centred and diverse. Many people remained in their rooms all the time and did not go down into the communal areas of the home. People had care plans about their recreational needs, but these were brief, for example that they liked 'Knitting' or 'Watching television.' Care plans had not been developed further, to document for example which programmes the person liked to watch. Benefits of activities to people were not assessed. Although most interaction for people was with staff, staff confirmed they did not become involved with activities provision as they regarded this as the activities worker's area. One member of staff said "We need more carers to help with activities."

The home were not consistently ensuring people had person-centred care which was appropriate, met their needs and reflected their preferences in relation to their living with dementia and people's recreational activities. This is a breach of Regulation 9 of the HSCA Regulations 2014.

The activities worker told us they had adapted the activities they provided as people's needs had changed over time. They said more people spent the majority of their time in their bedrooms than in the past. As a result, the activities worker spent much of their time visiting people in their rooms. They said they were working on various activities to enable such peoples' participation. The activities worker said, "Sometimes they enjoy having their nails done, at other times they just want a cup of tea and a chat." The activities worker said the manager was sending them to meet with other activities workers within the provider's group of homes to exchange and develop ideas.

We asked people how they brought up issues of concern to them and if they knew how to raise a complaint. Nearly all the people we spoke with felt the new manager had made a big difference. Two people's relatives described complaints they had made in the past and said they felt previous managers, and the provider, had either not responded or not responded in a way to address the issues they were concerned about. They said this was not the case with the new manager.

A person said if they had any concerns now they would tell the new manager and they would "Sort it." Another person described an issue they had raised with the new manager about the care and treatment of their relative. They said the new manager had taken full action to ensure the person received the correct treatment and care, by the following day. Many of the relatives said they had brought up issues about deficiencies in the lift with the new manager. The new manager had taken full action and the lift was now safe and functioning correctly.

Requires improvement

Is the service responsive?

There were limited complaints records relating to the period before the manager came in post. Those which were there did not reflect what people told us about their past concerns and complaints. Since the new manager came in post a full record of issues raised with them was in place.

As well as taking action on issues of concern to people, the new manager had consulted with people, including by holding meetings for people and their relatives. They said they were also planning to make sure they introduced themselves to all people's relatives, particularly where they were not able to attend such meetings.

Requires improvement

Is the service well-led?

Our findings

People told us they thought that under the new manager, the home was well led. One person told us "Since new manager started it's going back up again," another "The new manager has lots of ideas, which she talked about at the meeting. We've seen some of them happen already. The whole place is looking a lot better," and another person told us "The new manager has made the whole home look much nicer." This was echoed by a GP who said the new manager and their team had made "Huge improvements."

Staff also reported on the improvements made by the new manager. One member of staff told us "Things have got much better since the new manager came. We're very happy with what the new manager is doing. Residents and relatives have a much nicer environment. The manager has introduced team meetings and supervision." Another member of staff reported "She's lovely, very supportive. There's been a lot of improvements since the new manager arrived. The team we have now is very good, very reliable. The support has improved. She's always got time to stop and listen."

The previous registered manager was no longer in post. They were in the process of being de-registered by the CQC at the time of our visit. The new manager came into post on 19 October 2015. They told us they would be applying with CQC to become the registered manager for the home. The new manager was supported by a new area manager and a peripatetic clinical support lead.

The new management team had been in post for a short period of time, so had not yet been able to take action on all areas which needed to be addressed. We received comments from people and observed the management systems for staff deployment did not consistently ensure effective support for people's needs. The majority of people did not leave their rooms, so staff were occupied with supporting people in their own rooms. This meant staff were not readily available to support people in other areas and times. One person's relative said they though there were not enough staff on duty, because they did not see them much, particularly at mealtimes. We saw a person walking unsteadily across the lounge, pushing a small table to support themself. There were no staff visible in the lounge to support the person. The person's care plan documented they had a history of falling and stated "I will sometimes get up from my chair unsupervised and walk without my frame. I have fallen when I have done this so need close observation and reminding to use my frame." On one of the inspection days at lunch time, people were being served dessert. There was only one member of staff visible in the dining room and this member of staff was assisting two people to eat at the same time. We discussed this with the new manager who said there were enough staff on duty but the previous management systems for deployment of staff meant they may not always be available to people when they needed. The new manager said they were planning to review how staff were deployed and supervised during the day.

Some people's records were not consistently completed in an appropriate way. For example, records showed us one person had their medicines via a feeding tube whereas staff told us they usually gave the person their medicines by mouth. This person had no records to show their feeding tube was regularly rotated, to ensure review of its safety. A person was prescribed eye drops. Their instructions only stated the drops were to be administered to their 'affected eye', with no further instructions such as which eye was being treated. A person chose to smoke. Staff reported differently about how often the person smoked. Staff said the person had asked for them to keep their cigarettes and they had used to record about when the person had been given a cigarette but this record had not been completed recently, they did not know why. Some staff said it was a useful record because the person could not recall when they last had a cigarette and wanted to know such information. The person's fire risk assessment had also not considered if their smoking presented any additional risk to themselves.

The new manager was aware there were areas which needed to be improved. Since they came in post, they had reviewed a wide range of areas and taken action to address people's needs and reduce risk. For example the management team had recognised that they did not have enough appropriate pressure relieving equipment to reduce people's risk of pressure damage. They had ordered new equipment, some of which had already been delivered. The new manager had reorganised the clinical room. A new medicines fridge had been delivered to replace the old one, medicines had been audited and over-stocked medicines disposed of safely. Medicines records were regularly audited and due to the audit, the incidence of non-completion of records had much improved.

Requires improvement

Is the service well-led?

The new management team had audited a wide range of other areas of service provision. This included the home environment, where carpets had been replaced, and a redecoration programme was nearly completed. New furniture had been provided, or was on order. The new manager had completed two audits of care and treatment at night. From these they had identified more snacks were needed for people when they woke up at night. They had reviewed the home's fire inspection of 24 June 2015, and all areas identified by the fire safety officer had now been addressed. They had set up regular staff meetings. Staff said the manager recognised and acknowledged their efforts and they now felt valued in their work.

Staff told us that the manager had improved the leadership of the service. They said the new manager spent time "On the floor" getting to know people and supporting staff. Staff told us the new manager was visible, approachable and welcomed their contributions to the development of the service. The management team had improved the availability of out-of-hours support for staff, this included providing a management on-call rota.

A member of staff summed up the improvements in the home saying "I've seen a lot of improvements since the new manager got here. She's nice to work alongside. She's very approachable and she's open to ideas. She's really trying to get to know us. Everyone's working together. When I first arrived there was not a good atmosphere but now I feel part of a team." A different member of staff described the improvements saying "It's good to have someone taking control. There's more responsibility and accountability. It helps that we've got someone in charge who is leading things. We've made a really good start in addressing some of the concerns."

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 9 HSCA (RA) Regulations 2014 Person-centred care **The provider was not ensuring people's care and treatment met their needs, was appropriate and reflected their preferences. This was because they were not carrying out relevant assessments of people's needs and designing care and treatment to meet people's dementia and activities needs.** Regulation 9(1)(a)(b)(c)(3)(a)(b)

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 **The provider was not providing safe care and treatment to people because they were not doing all that was possible to mitigate people's risk in relation to prevention of pressure damage, risk of dehydration and management of people's diabetes.** Regulation 12 (1)(2)(b)