Cotswold Spa Retirement Hotels Limited

Willow Lodge 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?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 26 and 27 November 2015 with the first day of the inspection unannounced. A previous inspection undertaken in March 2014 found no breaches of legal requirements.

Willow Lodge is a purpose built care home in the North Shields area of North Tyneside. It is registered to provide accommodation for up to 48 people. At the time of the inspection there were 32 people living at the home, some of who were living with dementia. Accommodation is provided over two floors with more residential needs catered for on the lower level and nursing needs supported on the upper floor, although not exclusively so.

The home's currently identified registered manager had recently left the home. A new manager had been appointed and she was in the process of registering with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered

Summary of findings

providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff were aware of the need to safeguard people from abuse and had a good understanding of potential abusive situations. They told us they had received training in relation to this area and were able to describe the action they would take if they had any concerns. Records showed that any safeguarding issues had been dealt with appropriately and relevant authorities notified. Staff were also aware of the registered provider's whistleblowing policy and told us they would immediately raise any concerns they had about care.

On the first day of the inspection there were transient odours in some areas of the home. The treatment room areas (where medicines are stored and some dressings changed), some parts of the kitchen and food trolleys were in need of cleaning. On the second day of our inspection we saw action had been taken and both treatment rooms had been thoroughly cleaned and food trolleys were much improved.

Checks on fire and other safety systems had not taken place for a period of around three months. This was because the previous maintenance man had left the home and no interim system had been put in place to ensure that safety systems were checked. A new maintenance man had recently been appointed and was starting to address this issue.

People's views of staffing were mixed, with some people telling us there were enough staff and others suggesting they had to wait for assistance. There was one nurse and six care workers on duty during the inspection. However, only two staff were rostered to support the ground floor, with at least three people in this floor requiring help from two staff at time throughout the day. We also observed period of 20 minutes or more when lounge areas were not observed or checked. Suitable recruitment procedures and checks were in place to ensure staff had the right skills to support people at the home.

We found some issues related to the safe management and administration of medicines. Some people's medicines were signed for before they had been given and people were not always given sufficient time to understand what was being asked of them during medicine administration. Poor ordering systems meant there was both under and over stocking of medicines.

People and relatives told us they felt staff had the right skills to support them. Staff confirmed they had access to a range of training, although highlighted the reliance on ELearning to maintain training levels. Staff also told us regular supervision took place and they received annual appraisals. A small number of staff were still in the process of updating their training and were due to receive supervision and appraisals in the near future.

People had mixed views regarding the meals provided at the home. Some people told us they were very good, whilst others said the quality was variable. We spent time observing lunches at the home and noted the food to be bland and unappetising. People who required a special diet did not always get a choice of meal. People who required assistance were not always supported with their meals in a dignified and appropriate way. Staff often talked over people whilst they were helping them and did not engage in conversation with people during support, neglecting the social aspect of the meal experience. People's weight and dietary intake were regularly monitored and reviewed.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 (MCA). These safeguards aim to make sure people are looked after in a way that does not inappropriately restrict their freedom. Staff understood the concept of acting in people's best interests and the need to ensure people made decisions about their care. The registered manager confirmed applications had been made to the local authority to ensure appropriate authorisation and safeguards were in place for those people who met the threshold for DoLS, in line with the MCA.

People we spoke with and their relatives told us they were happy with the care provided. We observed staff treated people patiently and appropriately. Staff were able to demonstrate an understanding of people's particular needs. People's health and wellbeing was monitored, with ready access to general practitioners, dentists, opticians and other health professionals. Staff

Summary of findings

were able to explain how they maintained people's dignity during the provision of personal care and demonstrated supporting people with dignity and respect throughout the inspection.

Care plans reflected people's individual needs and were reviewed to reflect changes in people's care. Care plans also reflected advice from visiting professionals such as occupational therapists or speech and language therapists. Some activities were offered for people to participate in but people also had the opportunity to spend time on their own or in their rooms pursuing their own interests.

People and relatives told us they would speak to the manager if they wished to raise a complaint. We saw from records complaints had been dealt with appropriately and a response offered to the person who made the original complaint.

Audits and checks on the home and the environment had ceased to be carried out after September 2015. Where audit processes were in place, they had failed to pick up on some of the issues we identified, such as the lack of safety checks and the cleanliness of aspects of the home.

Staff felt supported and were positive and enthusiastic about the recently appointed manager's impact on care and the running of the home. Staff felt the new manager listened to their views or concerns. The new manager told us she was looking to ensure people were at the centre of the home and care was personalised.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to Person centred care, Safe care and treatment, Staffing and Good governance. You can see what action we told the provider to take at the back 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 safe.

Medicines were not always managed or administered safely and effectively. Monitoring of medicines stocks was ineffective. Some areas of the home, including clinic rooms and food trolleys were not effectively cleaned. There were gaps in the monitoring of safety equipment and systems at the home.

Staff had undertaken training, had knowledge of safeguarding issues and in recognising potential abuse. People and their relatives told us they felt safe at the home. Accidents and incidents were monitored and recorded appropriately.

Risk assessments had been undertaken in relation to people's individual needs. Proper recruitment processes were in place to ensure appropriately skilled and experienced staff worked at the home.

Is the service effective?

Requires improvement

Not all aspects of the service were effective.

We observed a range of food and drink was available at the home and specialist diets were supported. However, the presentation of the food was bland and unappetising. Staff supporting people with meals did not always engage with them and promote the social aspects of the meals time, or spoke to other staff over their heads, whilst providing care.

There was evidence that applications had been made to the local authority to in relation to the Deprivation of Liberty Safeguards (DoLS). People's consent to care had been sought or relatives had been involved in determining decisions in people's best interests.

Staff told us, and records confirmed a range of training had been provided although this relied heavily on ELearning. The majority of staff received regular supervision and annual appraisals.

Is the service caring?

Good

The service was caring.

People and their relatives told us they were happy with the care they received and were well supported by staff. With the exception of the dining experience, we observed staff supporting people appropriately and recognising them as individuals.

People's wellbeing was supported, with access to general practitioners and other health professionals. Staff were aware of people's needs and responded appropriately to support them when confused or distressed.

Summary of findings

People told us care was provided whilst maintaining their dignity and respecting their right to privacy. People were supported to have a good end of life experience.

Is the service responsive?

Good

The service was responsive.

Care plans were in place that contained details of people's individual needs and plans were updated as people's needs changed. Information about people's individual likes or dislikes was recorded in their records.

A range of support and activities were offered, although the manager wished to increase this. People told us they could participate in activities or follow their own interests.

People and their relatives were aware of how to raise any complaints or concerns. Records showed complaints were dealt with effectively and appropriately.

Is the service well-led?

Requires improvement

No all aspects of the service were well led.

Audits and checks on the service had ceased in September 2015 and had not been updated since then. Where audits had been undertaken, both in the home or by the regional manager, they had not always identified shortfalls or ensured actions were followed up.

Staff talked positively about the support they had already received from the new manager and said there was good teamwork in the home. Staff, people and their relatives said it was early days but felt the manager was approachable.

The manager was not currently registered with the CQC. She said she was looking to further develop the home to make care more person centred. Daily records were up to date and contained good detail.

Willow Lodge 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 26 and 27 November 2015 with the first day of the inspection unannounced.

The inspection team consisted of two adult social care inspectors and a pharmacy inspector.

Provider Information Return (PIR) was not requested prior to the inspection.This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed recent information we held about the home, in particular notifications about incidents, accidents, safeguarding matters and any deaths. We contacted the local Healthwatch group, the local authority contracts team, the local authority safeguarding adults team and the local Clinical Commissioning Group. We used their comments to support our planning of the inspection.

We spoke with four people who used the service to obtain their views on the care and support they received. We also spoke with three relatives who were visiting the home on the days of our inspection. We talked with the recently appointed manager, the deputy manager, two nurses, three care workers, a member of the domestic staff and the handyman.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We observed care and support being delivered in communal areas, including lounges and dining rooms, looked in the kitchen areas, the laundry, treatment rooms, bath/shower rooms and toilet areas. We checked people's individual accommodation. We reviewed a range of documents and records including; five care records for people who used the service, seven medicine administration records; five records of staff employed at the home, duty rotas, complaints records, accidents and incident records, minutes of staff meetings, minutes of meetings of people who used the service or their relatives and a range of other quality audits and management records

Requires improvement

Is the service safe?

Our findings

We looked at the systems in place for managing medicines at the home. We found appropriate arrangements for the safe handling of medicines were not always in place. We observed how medicines were administered on both floors of the home. On one floor, medicines were dealt with appropriately. However, our observation on the other floor of the home identified a shortfall in the safe and hygienic administration. Medicine administration records (MARs) were signed before the items had been administered. When people then refused their medicines this meant records had to be altered and became illegible. Several people's medicines were also dispensed together, meaning there was a risk people may receive the wrong medicines. The staff member administering the medicines did not spend time with each individual, explaining the importance and reason for the medicines. This meant two people refused their medicines because they were not clear what was being asked of them.

We found medicines were not always ordered effectively resulting in some items being over stocked and other items not being available. Some pain relief medicines, previously prescribed for specific individuals had been removed from their named packets and were being kept for general use. This is both unsafe and illegal and may result in people receiving inappropriate medicines. Some people were receiving their medicines through the use of skin patches. One person did not have an effective record of when the patches were given, meaning it was not clear they had received their medicine. We also found one person had patches applied to the same skin areas more frequently than was recommended.

Some people were prescribed "as required" medicines. "As required" medicines are those given only when needed, such as for pain relief. Although there were plans in place related to the administration of these medicines, it was not always clear this information had been reviewed and was up to date. Some people had topical creams kept in their rooms. There were no risk assessments in place to ensure this was safe and records of when they were applied were not always complete. This meant we could not be sure that these items had been applied and used safely.

We noted records of safety checks carried out on the home, such as on fire safety equipment, water temperatures and other equipment had a gap of two or three months when they had not been recorded as being carried out. The manager told us the previous maintenance man had left the home and a new one had only recently been appointed. We saw this was documented in staff meetings. However, no alternative arrangements had been put in place to ensure safety checks could continue during the transition period. This meant there were no safety checks on the operation and equipment of the home for a significant period, potentially putting people and staff at risk. The new maintenance man told us he was currently working through the required checks and we noted that records had recently restarted.

On the first day of our inspection we found some issues related to the cleanliness of the home. Clinic rooms, where medicines and dressings were stored, were in need of effective cleaning. Some areas of the kitchen were also in need of cleaning and we found staff used part of a storage room as a rest area, sitting next to the storage for dried good and pans and utensils. Trolleys used to transport food and drink had wheels that were encrusted with dried food. We brought these issues to the attention of the manager and noted the clinic rooms and the trolleys had been thoroughly cleaned overnight. People we spoke with told us they felt the home was generally kept clean and tidy. Comments included. "The place is kept clean. They clean my room regularly" and "The clothes are laundered nicely and the room is kept clean. It is all very good. You can't expect perfection." Other areas we checked, including toilet areas, showers and bathrooms were generally clean and tidy.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12. Safe care and treatment.

The manager told us there were currently 49 staff working at the home including eight nurses, three of whom were bank staff but worked regular hours at the home, 26 care staff (eight of whom worked regular nights), six domestic staff, and additional support staff such as kitchen staff, a handyman and administrative support.

Some people told us they felt there could be more staff around on the lower floor of the home. One person told us, "I think they work very hard. I think they could do with more, I really do." A relative told us, "I don't always think there is enough staff. There is not always someone to come and sort things out straight away." However, another

Requires improvement

Is the service safe?

relative said, "I think there are enough staff around when I visit. I have never been concerned that staff are not available. They are always around and have time for a chat."

The manager told us there were four care workers on the upper floor and two on the lower floor, where people had less complex needs. She said a care worker from the upper floor could be summoned to support the staff on the ground floor. However, staff said that at times, particularly during breaks and at busy periods this was not always possible. We saw a number of people living on the ground floor still required the support of two carers for some care delivery. One staff member told us, "Some people downstairs require two staff to help them. Sometimes you have to wait for the senior to be free or for someone to come downstairs. You can waste time waiting." We also sat in the lounge area on the lower floor. Whilst staff did check the area when passing the door there were occasional periods of 20 minutes when there were no staff in the lounge or checking the area. This meant there was a risk to people living at the home because regular checks in their safety were not maintained. We spoke to the manager about this and she agreed to review the situation.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18(1). Staffing.

People told us they felt safe living at the home. Comments from people and their relatives included, "Safe? Oh yes. The girls look after me"; "The girls are lovely. Yes, yes, I feel very safe with them" and "It's a safe environment, she is well looked after and is quite happy here."

Staff confirmed they had received training in relation to the safeguarding of adults and records supported this. Staff were able to describe circumstances that may indicate potential abuse occurring and said they would immediately report any concerns to the manager or deputy manager. They were also aware they could raise issues with the local safeguarding adults team. The manager maintained a safeguarding file and we saw any concerns were recorded and all relevant authorities appropriately contacted. Staff were aware of the provider's whistleblowing policy and how to report concerns.

Risk assessments were in place in people's individual care plans and these had been regularly reviewed and up dated. These included risks associated with the use of items such as bed rails and risk associated with falls. People had personal emergency evacuation plans (PEEPs) in their care records, detailing how they should be supported in the event of a fire or other untoward event. Risk assessments were also in place for the wider environment of the home. These included risks linked to use of equipment in the laundry area, the home's kitchen and the control of substances hazardous to health (COSHH).

Staff personal files indicated an appropriate recruitment procedure had been followed. We saw evidence of an application being made, references being taken up and Disclosure and Barring Service (DBS) checks being made. DBS checks ensure staff working at the home have not been subject to any actions that would bar them from working with elderly or vulnerable people. Staff told us they were required to wait for checks to be completed prior to starting work at the home. Registration of the nursing staff was checked on a regular basis, to ensure it was up to date. All nursing staff are required to be registered with the Nursing and Midwifery Council (NMC). This verified the registered provider had appropriate recruitment and vetting processes in place. Staff who had recently started working at the home confirmed they had received an induction and an opportunity to shadow experienced staff.

Requires improvement

Is the service effective?

Our findings

People told us there was a range of food and snacks available at the home. One relative told us that since their family member had come to live at the home they had put on weight and now seemed more alert. A person told us, "The food is great. I get too much of it. I can't eat it all." However, another person said, "The food varies. Sometimes it is good and sometimes it is disappointing; it varies."

Staff supporting people with their meals did not always give their full attention to the individual, either talking with other staff over their heads whilst supporting people, or simply helping people without engaging in any social interaction. Some people were given their meal but were not supported by being directed to the utensils on the table or being prompted that the meal was in front of them. This meant they were not supported to be able to start their meal, meaning food became cold, or they were not given encouragement to eat an effective diet.

People's weights were monitored regularly and there was no one with any significant weight loss noted. A choice of meals was available for both lunch and tea time. We noted that whilst the food was hot, it did not always look appetising, with constituent parts of the meal of a similar colour, such as chicken fricassee, cauliflower cheese, omelette, apple crumble and custard. On one occasion a person was having salad with their meal. We observed the salad was simply placed on top of the hot food, which did not enhance the appearance of the meal overall. The home had two dining rooms and we spent time observing how people were supported over a lunch time. In one dining room people were offered a choice of tea, coffee or juice with their meals. In the other dining room, people were simply offered juice with no alternative. This meant the dining experience was not provided in such a way that met people's individual needs.

One relative, whose family member had their meal in their room, told us, "She needs to have a pureed diet, so they sit with her and help her with that. I've no criticism of that at all." We spoke with the manager about how staff engaged with people during meal times and she said she would speak to staff about the social aspects of meals in the home.

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

People told us they felt staff had the right skills to support them. One person commented, "They are very efficient. They check on me to make sure I am alright." Relatives told us, "(Name) has not had a pressure sore since she has been here and she is always kept clean" and "I am really pleased with the care (name) receives and the support staff have offered us. The staff are aware of (name's) needs."

Records showed staff had undertaken a range of training, including training on moving and handling, safe administration of medicines, fire safety and infection control. Most training deemed mandatory by the provider were sustained at above 90%, with only deprivation of liberty training falling below this mark. The manager showed us the home's training records which identified when staff had undertaken training, when the training had been completed and when an update on the training was required. A small number of staff, mainly domestic and kitchen staff still had training to complete. Staff told us they could access training, although commented that the current system relied heavily on ELearning.

Members of staff confirmed they had access to regular supervision and appraisals. We looked at staff supervision records and saw a range of issues had been discussed, including personal circumstances affecting work and clinical and care matters. We noted a small number of staff, predominantly domestic and kitchen staff were still in the process of having supervision and appraisals meetings arranged. Staff said they could discuss a range of issues in supervision sessions.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA, and whether any conditions on

Requires improvement

Is the service effective?

authorisations to deprive a person of their liberty were being met. The manager confirmed that applications and requests for assessment had been made to the local authority to consider restrictions for some people living at the home under the Deprivation of Liberty Safeguards (DoLS) and records confirmed this.

Records showed that consent was sought from people and that their capacity to consent is considered and the Mental Capacity Act (2005) (MCA) was applied appropriately. Staff we spoke with understood the concept of best interests decisions and supporting people when they were unable to make effective choices for themselves. Corporate records for these decisions included reference to best interests decisions, although it was not always clear from some documented records that the full process defined by the MCA had been completed.

People were able to make choices. People told us there was a choice of meals and that they could choose to sit in the lounges areas or stay in their own rooms. People also told us it was their choice to join in with activities or not. We saw that, where possible, people were encouraged to give their personal consent and agreement to care being delivered. Staff told us they would always ask people if they were happy with the care they were providing, or seek their permission before doing anything. People's care records contained consent forms, signed by people or with reference to relatives if people could not always give specific permission.

The handyman told us he had only recently taken up his post at the home and so was still assessing all that needed to be done. We noted some updating and refreshing of decoration was underway. The manager told us she had recently met with estates officers from the provider to map out a wider refurbishment of the home and had plans to develop the garden area when there was better weather in the spring and summer, including repairing the home's greenhouse and further developing the small vegetable patch to allow people to grow flowers and plants.

We saw people's wellbeing was monitored and maintained. People's care plans indicated they had access to general practitioners, opticians, dentists and other health professionals, when they required them. We noted a number of professionals were in and out of the home whilst we visiting, including community specialists and general practitioners. Staff told us no one at the home was currently accessing or using an advocacy service, although information about such services was available around the home.

Good

Is the service caring?

Our findings

People and their relatives told us staff were caring and supportive. Comments from people included, “The girls look after me. You can have a bit of a laugh with the girls. I have to keep them in order (that’s a joke). We have a laugh and a joke and I enjoy that” and “The girls are nice and overall I am happy with the care.” One relative when talking about the staff told us, “They are lovely with my mum and lovely with my dad (When he came to visit).”

We spent time observing how people and staff interacted in the lounge areas, in the dining rooms and more generally around the home. We saw staff had good relationships with people and, with the exception of the observed lunchtimes, were generally caring and showed concern. For example, one staff member thought a person looked cold and approached them and asked them if they were warm enough. They held their hand to see if they felt cold and then went and found both a cardigan and a blanket for them. The person said that this felt better. Staff told us they enjoyed caring for people and found their jobs very rewarding. One staff member told us, “I love the job. Knowing that I am caring and making a difference to the lives of people. That is really good.”

We saw staff supported people living with dementia in a thoughtful way that showed them respect and maintained their dignity. One person, who was becoming upset and distressed, was approached by staff in a calm and sensitive manner. They supported the person quietly and compassionately and reassured them about their concerns.

Because of the nature of their condition not everyone living at the home had been able to fully participate in the planning and reviewing of their care. Where people could speak with us they and their relatives told us they felt involved in their care. Relatives told us, “They keep me up to date with (name’s) needs and I feel I am involved in any decisions about the care” and “ They are good at keeping me appraised of things; keeping me up to date when I pop in.” Staff told us that no one living at the home had any particular religious or cultural needs.

People and their relatives told us they felt they were treated with dignity and respect. People said their privacy was respected and staff would knock on their door before entering. Relatives we spoke with confirmed this. We noted some people had expressed a preference to have their doors closed during the day, even though they were sitting in the rooms, rather than in the lounge areas. We saw that when staff entered the rooms, to offer the person medicines or clean the room, they confirmed the person still wished the door to be closed and shut it after them. Relatives also told us they could visit any time they liked and said they were always made to feel welcome. People’s likes, dislikes and preferences were recorded in their care plans. People’s preference for a male or female care worker was recorded.

The deputy manager told us about how people were supported with end of life care. This sometimes included supporting people to have their pets with them at this time.

Good

Is the service responsive?

Our findings

People told us staff responded to their requests for help. During our inspection we noted call bells did not ring for long periods before they were silenced. One person told us, "I get by one day at time, but the girls are always there for me." Another person told us, "I like showers. I can have one when I ask and if I tell them in advance they remember and sort it out for me." Relatives told us they felt the care provided was person centred and addressed people's needs, although one relative told us, "They generally do things well, although there sometimes things they could do better. They take things on board." One person told us what had impressed them was how staff had noted little details. She told us staff had noted she regularly had two visitors together and always ensured she had two chairs in her room.

We looked at four people's care records, including support plans about their care needs and choices. We saw two people's care plans provided consistent and up to date information about each individual. They were person centred and provided clear evidence that people's views and preferences were respected and taken into account when care was planned. Plans were very detailed and contained clear information about people's support needs. For example, one person had had a recent assessment by the speech and language team and their plan and risk assessments had been updated to reflect this.

The other two plans were in the process of being updated in the new care planning system paperwork. These were not as detailed and some areas required further work. However, we did note that good information was available within the daily records to show care was being delivered effectively. For example, a person's dietary intake was monitored, their use of an inhaler was recorded and the support offered when they became anxious.

Care records also contained a "This is me" document that provided good information about each individual and their preferences. For example, rising and retiring times, use of hearing aids, walking aids, ability to undertake some personal care tasks and use of assistive equipment such as a bed sensor mat. It also provided information about their previous life, interests and family.

The home had one activities co-ordinator employed, who worked part time. The manager said one her priorities for the home was to increase the number of hours available and ensure they were delivered at times that best suited people's needs. We saw a range of activities were advertised around the home. People confirmed activities and events took place at the home and that they could choose whether they wished to take part. One person told us how staff had worked very hard at trying to arrange for him to go on a trip out to places he used to visit when he was younger. He told us, "I did get offered to be taken out. They arranged everything. But then it was my fault. They helped get me all ready and then it was raining so I decided not to go." Another person told us, "There are activities, but I don't join in. I like my privacy. But that's my choice."

The manager told us she also wanted to improve the personalisation of people's rooms and personal space. She told us about a range of ideas to decorate or improve people's room based on their likes and interests and how she wanted to involve people in these events. For example, she told us about one person who loved poppies and how she was hoping to introduce poppy stickers into their room, to brighten it up for them and to provide an activity that was personal to them.

There was information around the home about how to make a complaint and raise any issues. Copies of the complaints procedure were also available in languages other than English. People told us they would raise any concerns with the staff or the home's manager. One person told us, "I've not made any complaints, but believe me I would if I needed to. But I'm quite content here." A relative told us, "I've brought on or two things up. They are taken on board at the time." The manager showed us the home's complaints records. We saw complaints had been responded to in an appropriate and timely manner. The provider's response template highlighted the duty of candour on the home and the manager to be open and honest regarding and accidents or events.

Requires improvement

Is the service well-led?

Our findings

At the time of our inspection the person registered with the CQC as the registered manager had recently left to take up another position. The provider had notified us of this but the registered manager had not formally applied to deregister. A new manager had been appointed to the home, who was in the process of registering with the CQC. This new manager was present on both days of the inspection and was supported by an manager from another of the provider's homes.

People and their relatives told us they were aware of the new manager being in post. They said they had seen her around the home and she had introduced herself to them, but they had not had any detailed conversations with her at this point.

A range of audits and checks had historically been undertaken at the home. However, we found most audits, checks and meetings had ceased in September 2015. The manager told us she was unsure why these matters had not been continued on but it was her intention to reinstate the various audit processes and meetings. Review visits by the regional manager had not highlighted that these records were not in place. Similarly, the regional manager reviews had not highlighted that safety checks were not being undertaken because the previous maintenance man had left and no interim process had been put in place. One recent home review by the regional manager stated the home was "lovely and clean", although we found the clinical rooms and food trolleys were in need of effective cleaning.

Where audits and reviews were in place it was not always possible to ascertain if actions had been carried out. For example, some medicines record audits highlighted some signatures were missing, but it was not clear these had been followed up and the record rectified. Another check on medicines counted the remaining number of tablets left in boxes, to see if the amount tallied with those given. We found the checked number changed, even when there was no record of a medicine been given to a person. Similarly, in senior staff meetings the need to ensure that supervisions and appraisals were up to date had been highlighted, but the matter was not followed up until some months later. This meant management actions were identified but not always followed up to ensure there were proper processes in place.

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

Safety records, such as gas/electrical safety, Lifting Operations Lifting Equipment Regulations (LOLER) checks on equipment and portable appliance testing (PAT) of small electrical equipment were in place and up to date.

Staff told us there had been regular staff meetings and they felt they could raise issues. They told us the new manager had already held some meetings with staff to introduce herself and to outline some of her thoughts and ideas for taking the home forward. Staff told us they felt very positive about the future direction of the home and the ideas the new manager had. Comments from staff members included, "(New manager) seems fine so far. I've mostly worked weekends so not seen her a great deal, but she seems very approachable"; "She seems really nice. She's already said a few of the ideas for the home and they have made sense"; "A new energy has come with (manager). She is much more focused on the residents" and "The manager is an approachable person. She is very driven and has had lots of new ideas. It's a really exciting time."

Meetings with people who used the service or their relatives had been taking place but had also ceased to occur from September. The manager told us she was looking to reinstate and develop these.

Staff also told us they worked together well as a team and could raise issues or put forward ideas. One staff member told us, "We all work together and support each other. The communication is good and I can raise issues or make suggestions and be confident the senior staff will listen." A member of staff who had recently started working at the home told us, "I've really settled in. I've not seen anything that worries me. I find it more homely than where I previously worked. If I had to, I think I would put my mum and dad here." The deputy manager told us she felt the care workers were dedicated and hard working. She told us, "The care staff are fantastic. They do their upmost to make sure that every resident has time and receives care. The work hard, are enthusiastic and do their best."

Daily records relating to people's care and welfare were up to date and contained good detail. Care plans were regularly updated and all plans were being reviewed as new documentation was being brought in.

Requires improvement

Is the service well-led?

The new manager told us her overall aim was to have, “Happy staff, happy residents and happy relatives.” She said she wanted to ensure staff worked in a person centred way and wanted to increase information about people; their likes, dislikes and their life stories. She said, “If you know a person’s life story you won’t have a problem writing a care plan.” She said she felt there was a good team at the home and the range of nursing skills, both general nursing and mental health would complement each other to develop a holistic approach. She said being a nurse helped her in her manager role, allowing her to see both sides of a situation and bring both management and clinical skills to bear.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 9 (1)(a)(b)(c)(3)(b)(i). Person centred care. Care and treatment was not always provided in a way that was appropriate to the individual, met their needs or reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 (1)(2)(d)(g)(h). Safe care and treatment. Care and treatment was not provided in a safe way because risks related to the premises were not always assessed, medicines were not always managed effectively and risks associated with controlling infection were not managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17(1)(2)(a)(b)(d) Good governance. Systems and processes were not in place to assess, monitor and improve the quality and safety of the services provided.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18 (1). Staffing. There were not always sufficient numbers of suitably qualified, competent and skilled persons deployed to meet people's needs.