Bupa Care Homes (AKW) Limited

Millfield Nursing and Residential Home

Inspection report

Bury Road
Heywood
Rochdale
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Ratings

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

Overall summary

Millfield Nursing and Residential Home is situated close to Heywood town centre. The home is able to accommodate up to 92 people. There are four separate units provided over two floors. A passenger lift services both floors and there is level access to the entrance. There is ample parking to the front of the building for visitors. The home is accessible to all local amenities, with easy access to the local bus network which runs between Bury and Rochdale. At the time of our inspection there were 62 people living at the home.

This was an unannounced inspection carried out on the 14 October 2014.

At the time of the inspection the home did not have a registered manager. A new manager had been appointed who intended to submit an application to register with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission 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.

We carried out a routine inspection in June 2013. All areas we assessed at that time met the regulations. Wee inspected the home again in October 2013 due to concerns that had been raised about the care and welfare of people who lived at Millfield Nursing and Residential Home. However, we did not find any evidence to support the concerns raised and the provider was meeting regulations.

At this inspection we spent time observing care and support in communal areas, spoke to people in private, and looked at care and management records.

Although people told us they felt safe living at the home, staff had not received specific areas of training and support enabling them to develop the knowledge and skills needed. Staff levels were not sufficient throughout the day to meet the current and changing needs of people.

Prior to our inspection we had been told that people were being woken in the mornings and dressed ready for when day staff commenced their shift. We found this had been occurring and raised this with the manager. Following our inspection the manager told us they had spoken with all staff about this poor practice and night visits were planned to check this practice had stopped.

We found people did not always receive their medicines as prescribed. Arrangements for the disposal of medicines was not adequate and at risk of being abused.

Audits and checks were in place to monitor and review the service provided. Where improvements were needed, plans had been put in place and were monitored by managers to check this was done so that people received a safe and effective service.

Staff told us that clear leadership and support was needed to improve morale within the home. Visitors and staff spoken with were happy with the recent appointment of the new manager.

Staff were able to demonstrate their understanding of the safeguarding and whistle blowing procedures in order to safeguard the health and welfare of people who used the service. Managers were aware of their responsibilities with regards to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). We saw systems to protect those people who potentially lacked capacity to make decisions for themselves were in place. A programme of staff training and development was provided to help staff understand how to promote and protect the rights of people.

Thorough systems were in place with regards to the recruitment of new staff, safety checks to the building and emergency procedures, which helped to keep people safe.

People and their visitors told us they had been involved in the planning of their care and support so their individual needs and wishes were taken into consideration. Care records contained enough information to show how people were to be supported and cared for. Records showed that people had access to all health care professionals ensuring their health and well-being was maintained. Suitable equipment and aids were provided to meet the assessed needs of people and promote their independence.

People and their visitors spoke positively about the care and support provided. We saw staff respected people's privacy and dignity and interactions were pleasant and friendly. People said they were able to see their friends and families when they wished. There were no restrictions on when people could visit the home. All the visitors we spoke with told us they were made welcome by the staff in the home. People told us they had opportunities to take part in activities both in and away from the home.

People were offered a varied and nutritious diet. We saw the lunchtime experience was not well organised and did not provide people with a relaxed sociable occasion.

Systems were in place for the reporting and responding to any complaints or concerns raised with the provider.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to sufficient numbers of staff to support people and the training, professional development, medication management ` and support of staff in carrying out their role You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. Staffing levels were not always sufficient to meet people's current and changing needs.

Staff knew how to recognise and respond to abuse. We found that safeguarding procedures were available to guide staff and relevant training was provided so staff understood how to safeguard the people they supported.

We saw up to date and detailed records in relation to the recruitment of new staff, servicing certificates and fire safety checks were in place so that people were protected against the risk of harm.

People spoken with said they received their prescribed medication when they needed it. However we found improvements needed to be made to some aspects of the way medicines were managed in the service.

Is the service effective?

Requires Improvement

The service was not always effective. Further staff training and development was needed to support staff in the safe and effective delivery of people's care.

Appropriate systems were in place to promote and protect the rights of people, particularly where they lacked the mental capacity. Training was provided for staff to help them understand that if a person is to be deprived of their liberty, they will need special protection to make sure that they are looked after properly and are kept safe.

People were provided with adequate nutrition and hydration. People's health needs were monitored and they were able to access a range of health care services.

Is the service caring?

Requires Improvement

The service was not always caring. We found a number of people were woken and got up in the mornings. This did not demonstrate people were supported in a dignified way.

People said they were happy with the care and support they received. People told us they had choices with regard to daily living activities and that they could choose what to do and where they spent their time. We saw and people told us they were able to see their visitors at any time.

We found the staff had a good understanding of the needs of people they supported. We saw staff interacted well with people offering reassurance and encouragement where needed.

Summary of findings

Is the service responsive?

Good 

The service was responsive in meeting people's needs. People and their relatives were involved in the assessment and planning of their care so that their needs, wishes and preferences were considered. This helped staff plan and deliver the care and support people wanted and needed.

Opportunities for some people to take part in a range of activities both in and away from the home were provided. We were told the increased staffing would help provide more flexibility in support and opportunities offered to people.

People were aware of the home's complaints procedure and were aware of who they could speak with if they needed. A record of any complaints received and action taken were maintained.

Is the service well-led?

Requires Improvement 

The service was not always well led. No registered manager was in place. The new manager had yet to register with the Care Quality Commission and establish themselves in the role so they could provide clear leadership and support.

Systems were in place to regularly monitor and review the quality of the service and facilities provided. We were told the system was under review so that checks were more robust and helped to inform how the service was developed so people received a good quality service.

Millfield Nursing and Residential 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 checked 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 was an unannounced inspection and took place on the 14 October 2014. The inspection team comprised of two adult social care inspectors.

During the inspection we spent time speaking with six people who used the service, five relatives, seven nursing and care staff as well as kitchen and maintenance staff. We also spoke with the relief manager, newly appointed manager and regional manager.

During the inspection we observed how staff supported people in the communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also looked at eight people's care records, staff recruitment and training records as well as information about the management and conduct of the service.

Prior to our inspection we contacted the local authority commissioning and safeguarding teams to seek their views about the service. We were made aware of a number of concerns about people's care and support, which were being explored. We also considered information we held about the service such as notifications sent to us by the provider of any incidents or any events within the home.

We did not ask the provider to complete a Provider Information Return (PIR) prior to this 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.

Requires Improvement

Is the service safe?

Our findings

Prior to this inspection we had been informed by the provider of their decision to close the nursing dementia unit (Pilsworth unit) due to difficulties in recruiting nursing staff. Assisted by the funding authority, people living on the unit had found suitable accommodation elsewhere. During this inspection we found the unit was empty. We were told the provider was considering how the unit was to be used.

We looked at the staffing arrangements in place. Staff told us that since the closure of Pilsworth unit, staff had been redeployed to other units in the home. The manager and area manager told us there were still a number of staff vacancies across the service and that active recruitment was taking place to fill these vacancies. Agency nursing staff had been used due to current vacancies.

Staff spoken with on the nursing unit (Summit) told us there had been some improvement in the number of care staff on duty on the morning shifts. However we were told the numbers of care staff available reduced during the afternoon and evening shifts. Inspection of the staff rota confirmed what we had been told. From our observations and an inspection of care records it was evident that several of the people had intensive nursing needs. We were also aware that six of the people on the nursing unit were receiving 'end of life care'. Staff said it was accepted that the level of support was greater in the morning than during the afternoon or evening shift due to a lot of people needing two staff to assist them with tasks, such as bathing, assisting people to get out of bed and get dressed as well as practical tasks such as wound dressings and medication administration.

However we were told that peoples care needs were high and that a reduction in staffing levels made it difficult to provide the level of care and support some people needed at all times. Staff said there was not enough time to deal with other aspects of care that very ill people and their relatives required. One staff member told us that more 'end of life' care was being offered for people on the unit. This was confirmed by the managers. This would mean that, to ensure the intensive physical, psychological and social needs of people who require end of life care are met, more suitably skilled and experienced staff would need to be provided.

Staff spoken with on the residential unit (Hopwood) said that rotas were not always well planned. Annual leave was not always covered in advance, which meant at times shifts had not been covered or there was a reliance on agency staff. One staff member we spoke with had taken on a senior position on the unit two weeks prior to our inspection. They said they had received no information or handover into the needs of people. Another staff member said that due to the vacancies and numbers of new staff, this had placed additional pressure on the unit. An examination of rotas confirmed what we were told.

During the inspection we saw some people required the support of two staff and staff were kept busy assisting people with care tasks. This meant there were periods of time when people were not supervised. One person told us, "Staffing has been horrendous during the weekends". Adding, "They [the staff] do what they want, there's no leadership". Another person said, "Agency staff don't know the residents and communication is poor". The relative of one person told us, "There's not always enough staff". A second visitor added "There's not enough staff at night, sometimes they are short and on the bare minimum".

In contrast staff spoken with on the young disabled unit (Wham bar) did not express any issues. We were told this team had worked together for some time and supported each other. One staff member said, "I think the team works well."

We discussed our findings with the manager and area manager. There was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Sufficient numbers of staff were not provided at all times to meet people's needs.

We looked to see how the medication system was managed within the nursing unit. We checked the systems for the receipt, storage, administration and disposal of medicines. We also checked the medication administration records (MARs) of seven people.

The system for the receipt of medicines was safe. When a medicine was received into the home staff recorded the quantity received onto the MAR. Staff also recorded how much medicine had been brought forward from the previous month. This helped ensure that the medicines

Is the service safe?

could be accounted for as the stock of medicines could be checked against the amount recorded as given; thereby checking that people received their medicines as prescribed.

We found that medicines, including controlled drugs, were stored securely. The medicines in current use were kept in a locked trolley in a locked medicine room. We were told that the medicine keys were always kept with the nurse responsible for the management of medicines**.**

The MARs we looked at were filled in accurately and showed that staff documented on the MAR when a medicine had been given. One of the MARs we looked at however showed that the person was prescribed an antibiotic that was to be given three times a day over a 24 hour period. It was recorded on the MAR that the antibiotic was being given three times a day but staff were giving them too close together. Medicines may not be effective if they are given too close together.

The system for the disposal of medication was not as safe as it should have been. We saw that medicines no longer required were stored in a locked cupboard within the medicine room but the containers they were stored in were not secure, they had no lids. We saw that medicines had spilled out onto the cupboard floor. We also saw two domestic staff, at the request of the nurse on duty, start to remove the unsecured containers to another area of the home; ready for collection by the pharmacist. Failing to ensure the safe storage of medicines waiting to be disposed of increases the risk of these medicines being abused. There was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People living at the home did tell us they felt safe. One person said, “It was hard giving up my home but I feel safe being here”. Another person said “I no longer feel frightened.”

Four staff members we spoke with said they had received training in protecting vulnerable adults and that this was updated on a regular basis. The staff were able to clearly tell us what they would do if an incident occurred or an allegation was made to them. Staff were also familiar with the term ‘whistle blowing’ and their responsibility to report any concerns regarding poor practice. Whistleblowing takes place if a member of staff thinks there is something wrong at work but does not believe that the right action is being taken to put it right. Staff told us there was a helpline number if they needed to raise any issues.

Prior to our inspection we had been made aware of concerns which had been brought to the attention of the local authority safeguarding adult team in relation to the standard of care people received, staffing and access to health care support. Where necessary, investigations were being carried out by the local authority. The home was cooperating with these investigations.

We asked two people if they received their medicines on time. One person told us, “I get my medicines when I need them. I only have to ring the bell and they are there”. The other person told us, “I do it myself, they bring the stuff for my nebuliser when I need it, make sure it is on and leave me to it. I like it that way.”

We saw people’s care records contained risk assessments that identified if a person was at risk of harm from conditions such as pressure ulcers, poor nutrition and hydration, restricted mobility and the risk of falls. Staff wrote down what action they would need to take to reduce or eliminate any identified risk. Monitoring sheets were in place so that any changes in need could be identified and acted upon.

Maintenance staff told us what plans were in place in the event of an emergency. We were shown a ‘business contingency plan’. This provided staff with relevant information and emergency contact numbers for contractors should an emergency arise. A fire risk assessment had also been completed and reviewed annually. Maintenance staff told us where action had been identified, this had been completed. Fire evacuation procedures were also in place. Maintenance staff carried out regular fire drills with all staff to make sure staff knew what to do in the event of a fire. Personal emergency evacuation plans (PEEPs) had also been completed for everyone living at the home. This information was kept update and easily accessible in the reception area should an emergency arise.

The recruitment system was safe. This ensured that the people employed to work at the home were fit to do so and helped protect people against the risk of being cared for by unsuitable people. We looked at the recruitment files for five staff who worked at the home. The files contained a full

Requires Improvement

Is the service safe?

work history, evidence of the staff's identity and current address, two written references, a medical questionnaire and checks from the Disclosure and Barring Service (DBS). The provider told us how they checked that the nurses they employed had a current registration with the Nursing and Midwifery Council (NMC).

Requires Improvement

Is the service effective?

Our findings

We asked staff about the training and support they received. Staff said that some areas of training were compulsory and had to be updated regularly. These included areas such as; moving and handling, safeguarding adults, food hygiene, infection control and medication. We looked at the training records which confirmed staff had undertaken a range of training relevant to their role. The provider regularly monitored staff training to make sure this was reviewed and updated when needed. One of the care staff we spoke with told us they had completed, "More than enough training."

Two care staff we spoke with on the Wham bar unit told us about recent training they had completed. One care worker had attended training with the speech and language therapists around people's dietary needs, whilst another had completed catheter care. Both said this had been beneficial as this was relevant to the people they supported. In contrast, the relative of one person on the residential unit (Summit) told us they had spoken with staff on several occasions as their relatives catheter had not always been managed properly. The training records we looked at did not show any training had been provided in catheter care for staff on this unit. The area manager told us this type of training was not compulsory and staff were 'invited' to attend should they wish. We were told this was to be changed and additional training was to be included as part of the programme to be completed by all staff. Without relevant training in specific areas of care and support people were potentially placed at risk of not receiving the care they need.

From our discussions with staff we were told increasingly care and support was being provided for people with dementia or at the end of their life. A nurse we spoke with said they had not received relevant training in end of life care and recognised this would help to ensure practice was safe and promote people's dignity at this time. From our observations during the lunchtime period, we saw some staff were not able to effectively communicate with people with dementia needs. One staff member said dementia training had been offered however was not fully completed as the external training provider did not complete the full course programme. Specific areas of training and development should be provided to guide staff in the safe and effective delivery of people's care and support.

Staff spoken with also told us they had not received formal supervision for some time. Clinical supervision of nursing staff also needed updating. Supervision sessions are used amongst other methods to check staff progress and provide guidance, as well as ensuing staff have the knowledge and skills needed to carry out their role effectively. We discussed this with the manager and area manager. It was acknowledged that changes in the staff teams had impacted on the support provided. Staff said support systems needed improving. One staff member said, "We need more support, think this would boost morale."

This meant there was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw policies and procedures had been developed by the provider to guide staff on how to safeguard the care and welfare of the people using the service. This included guidance on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). These procedures help ensure that people's rights are protected in a way that does not wrongly restrict their freedom.

The manager told us there was no-one currently living at the home that was subject to a DoLS. We were told, where necessary, a DoLS application would be completed where a person, following assessment, was deemed to lack capacity to make decisions for themselves. Applications would be submitted to the funding authority responsible for authorising and reviewing any DoLS imposed.

Staff were provided with a programme of training in MCA and DoLS. Whilst some care staff spoken with were aware of the MCA and DoLS procedures, two new care staff were not able to demonstrate their understanding. Training information provided showed that this was planned as part of the induction and training programme for all staff. This training should help staff understand that assessments should be undertaken, where necessary, to determine if people have capacity to make informed decisions about their care, support and treatment. It should also help staff understand that if a person is deprived of their liberty, they will need special protection to make sure that they are looked after properly and are kept safe.

Prior to this inspection we had been informed by the provider of their intention to close the nursing dementia unit (Pilsworth). So that suitable alternative placements

Is the service effective?

could be found for people, the provider had liaised with the local authority. Mental capacity assessments had been completed and best interests meetings had been held with people's advocates, where necessary, so that relevant decisions could be made. During the inspection we found the unit had closed.

Information in the care records showed staff at the home involved, where necessary, other healthcare professionals in the care and support of people who used the service. We saw evidence of visiting opticians and chiropodists and records of hospital visits. A review of one person's care led to them being referred to a nurse who specialised in the care of wounds to help ensure the most appropriate care and treatment was provided. We were also told that an Outreach Consultant regularly visited the home. Arrangements were made for those people with changing needs to be seen so that their health care needs were addressed.

During our inspection we were made aware that a nurse from the local hospice palliative care team had visited the unit to check on a person who was very ill. This meant this person was being monitored and cared for in a way which met their individual needs.

We were told formal meetings were held as well as handovers at each shift change. This helped to ensure staff were kept informed of events within the home. Daily meetings were also held with the home manager, clinical service manager and heads of departments. Any issues within the service were discussed and monitored. We saw records of such meetings.

We saw that people were given enough food and drink to keep them healthy. One person who used the service told us, "Nothing wrong with the food, it's good." Another person told us, "I enjoy the food, I get plenty to eat."

We spent time in the dining room shared by Hopwood and Summit units observing the lunch time period. We were told meals would usually be served by a hostess; however staff identified for the post had yet to start. Care staff were seen serving and helping people with their meal. The lunchtime period was not well organised. Whilst people were brought to the dining at the same time, some people had to wait a long time before being offered their meal. One visitor said, "Usually it's chaotic." We saw those people who needed help with their meal were appropriately supported by staff. Two visitors we spoke with told us they visited at lunchtime so they could help their relative with their meal. The relatives of one person told us they were not always sure their relative was given their meals. They spoke of one incident when a meal was missed. We discussed the concern with a staff member who told us that, to reassure the family and ensure meals were not missed, they would arrange for a fluid and food chart to be put in place.

We spoke with two care staff and asked them what they thought about the food provided for the people who used the service. Staff told us they felt the meals were good and there was plenty of choice. We were told that one person had bought their own fish and the chef was cooking it for them for their lunch that day.

We saw jugs of fluids were provided in people's room, particularly for those people who stayed in their rooms for most of the day. Staff showed us the daily food and fluid charts that were used to document people's food and fluid intake. This helped to ensure people received adequate hydration throughout the day.

We looked at the kitchen, food stocks and spoke with the chef. We saw that sufficient dried, fresh and frozen food supplies were available. We saw information about people specific dietary needs was shared with catering staff including written guidance where people had been assessed by the dietician or speech and language therapist. This helped to promote people's nutritional needs.

We saw that staff monitored people's weight regularly and that people were assessed in relation to the risk of inadequate nutrition or hydration. In one care record we saw that a referral had been made to a dietician because the person had lost an unacceptable amount of weight in a short period of time.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us they were happy with the care they received and said they were looked after well. One person told us, "If you need to be in a care home this is the place to be. The staff are smashing." Another person told us, "I am very, very, happy here." We were also told, "I am well looked after and I more or less do what I please. I went out shopping with my daughter yesterday and bought a new coat and some lovely ankle boots." Other comments from people included; "I love it here" and "The carers are lovely."

During our inspection we spoke with relatives and friends who were visiting people who lived in the home. Comments they made to us included; "I can't fault it. It is absolutely brilliant; such a good home to live in", "Generally it's very good; I've not had any concerns" and "The staff are brilliant. As soon as I saw this home I knew it was the right one."

Prior to our inspection concerns had been raised with us about night staffing arrangements. Therefore we arrived early so we could speak with night staff and look at the support people received. Staff on the nursing unit told us they were expected to get a number of people up early, so they were washed and dressed prior to day staff arriving. We saw an entry in the staff diary stating which people staff were expected to get up. We were told the people concerned were generally those not able to speak for themselves. This did not demonstrate that some people were care for in a dignified manner. We shared our findings with the home manager and area manager. We were told this would be addressed immediately. Following our inspection the manager informed us they had spoken with staff, their discussions confirmed our findings. A staff meeting was to take place advising staff poor practice would be taken seriously and night spot checks were to be undertaken to monitor the situation.

For those people not able to tell us about their experiences, we spent some time observing how they were spoken to and supported by care staff. Staff were seen to be respectful and kind towards people. Staff were seen to provide encouragement and reassurance when assisting people with the use of hoisting equipment.

We sat with a small group of people and staff on the Wham bar unit, who were having breakfast together. We were told this encouraged social interaction and provided a more relaxed atmosphere on the unit. One person we spoke with said they enjoyed this and liked spending time with staff.

We saw staff respected people's privacy and dignity. Personal care and support was carried out in private and staff were seen to knock on people's door before entering. From our discussions and observations of staff we found they had a good understanding of people's individual needs. From our observations people looked clean and well cared for and those people being nursed in bed looked comfortable.

We were able to see some bedrooms during our inspection. Rooms seen were homely, personalised and comfortable. One person told us, "They keep my room very clean."

Good

Is the service responsive?

Our findings

The seven care records we looked at showed that people were assessed by a senior member of staff from the home before they were admitted. This was to help ensure their individual needs could be met. As part of the assessment process staff at the home asked the person's family, social worker or other professionals, who may be involved, to contribute to the assessment if it was necessary at the time.

Care records we looked at contained enough information to show how people were to be supported and cared for. Records were kept under review so that information reflected the current and changing needs of people. The care records for one person we looked at documented that the person had a pressure ulcer that required a wound dressing. The care record however had not been updated for over five weeks and there was no information about the condition of the pressure ulcer. This was despite the unit having information from the NICE (National Institute for Health and Care Excellence) guidelines in relation to the pressure ulcer management pathway. This meant good practice guidance had not been implemented or followed so that people received safe and effective care.

The care files we looked at contained relevant information about people's background history including, where possible, people's preference, wishes, likes and dislikes. For example, food preferences, routines and people who mattered to them. This helped to guide staff in the care and support people wished to receive.

Suitable aids and adaptations were in place to promote people's independence and movement around the home. These included suitable walking aids, such as walking sticks and frames. Other items to promote people's well-being were provided depending on the individual needs of people. One person we spoke with said they were provided with a special type of bed that helped staff position then more easily and therefore aid comfort. This person told us they had been made very comfortable. We saw other people used specialised wheelchairs which met their physical needs. People told us that staff members responded to call bells, which meant people needing assistance received this as promptly as possible. One person said, "I ring my bell if I need anything and they come."

The home employed an activities co-ordinator. Their job was to help plan and organise social and other events for people, either on an individual basis or in groups. We looked at how people spent their time and spoke with people about the activities offered within the home. We saw information displayed on some of the units advising people about the activities available that week. These included crafts, coffee morning, films, bingo and music. Occasional outings were planned as well as fundraising events. People were also offered the opportunity to go out to the local town centre shopping should they wish.

One person we spoke with said they had previously been out shopping. They also visited a local animal farm with a small group of people who used the service and staff. They said this was something they liked to do, adding, "I really enjoy going there; it's really nice." Other people we spoke with said they preferred the privacy of their own room, relaxing watching television, reading or doing puzzles. We later saw a small group of people playing ball games in one of the lounges. Those people less able to take part in group activities were offered one to one time with staff, however we were told this had been more difficult due to changes in staff. We discussed this with the home manager and area manager, who told us the appointment of new staff, should help to provide more flexibility in the support offered to people.

We saw the provider had a system for the reporting and responding to people's complaints or concerns. Information was made available for people advising how they could raise any issues or concerns. We saw information to show any issues raised had been explored and a response sent to the complainant in relation to their findings. We discussed current issues with the home manager and area manager. We were told that arrangements had been made, where necessary, to meet and speak with people about their concerns. Records were maintained of issues brought to their attention and action taken. One relative told us the new manager had introduced herself to them and they had been able to discuss some concerns about their relative's care. They said, "I've every confidence in the new manager; she seemed nice and was very approachable."

Requires Improvement

Is the service well-led?

Our findings

The registered manager had been off sick and subsequently resigned at the beginning of October 2014. Interim management arrangements were put in place until a new appointment could be made. During our inspection we met with the newly appointed manager. The manager told us they intended to apply to be registered manager. It is a condition of registration that the provider must ensure that a manager with the necessary skills and experience is employed by the home and is registered with the CQC.

The manager was supported in her role by a regional manager, clinical services manager (CSM) and department managers. Staff spoken with during our inspection were aware of their responsibilities, however they felt recent changes in management had been unsettling. Some of the staff and visitors spoken with were happy with the appointment of the new manager. One staff member said, “Some staff are doing what they want because there’s no clear leadership.” They added, “The new manager seems nice, I hope she can sort things out.” One person living at the home and their relative told us the manager had been to introduce herself. They described this as ‘nice’ as they had been previously unaware who was managing the home

We looked at how the provider monitored and reviewed the quality of the service provided for people. The CSM told us that both she and the home manager were responsible for completing audits across all areas of the service including medication, care planning, care needs, infection control, laundry and housekeeping and health and safety. We were told, when necessary, the service also had the support of BUPA's quality monitoring team should specific areas of the service require improvement.

Arrangements were in place to seek feedback from people living at the home and staff. We saw information to show the last residents meeting and staff meeting on Pilsworth unit had taken place in July 2014. Feedback surveys were also distributed however no recent comments had been received. The CSM told us they did a ‘weekly walk around’. This was recorded and provided an overview of the needs of people living at the home. A morning meeting was also held between all department heads to discuss and issues or events which needed to be addressed that day. The CSM completed additional monitoring was completed of any hospital admissions, complaints and concerns, pressure care and weights.

Further audits were the responsibility of the home manager. These explored other areas including staff recruitment and training and development. Whilst action plans had been drawn up where areas of improvement had been identified, shortfalls found during the inspection had not been found. The CSM acknowledged that a high number of audits were to be completed and caused a lot of duplication. The area manager said the auditing system was currently under review and a more robust system was to be put in place.

We found that information about the home was provided in the entrance hall and that this included the latest Care Quality Commission inspection report together with a service user guide. This provided information about what people should expect should they choose to live at the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **The provider should ensure the safe management and administration of medicines so that people's health, safety and welfare is protected.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The provider should ensure that sufficient numbers are available to meet the individual assessed needs of people so that their health, safety and welfare are maintained.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The Provider must ensure staff receive appropriate training, professional development and support to carry out their role safely and effectively so that people are kept safe.**