

Sunglade Care Limited

# Benedict House Nursing Home

## Inspection report

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Date of inspection visit: 3, 4 and 6 August 2015  
Date of publication: 11/09/2015

### Ratings

#### Overall rating for this service

Requires improvement



Is the service safe?

Good



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

Benedict House Nursing Home provides accommodation and nursing care for up to 41 older people. At the time of this inspection the home was providing care and support to 28 people.

The home did not have a registered manager in post. 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. A new home manager started work at the home on 14 July 2015.

At our last inspection 23 and 24 February and 6 March 2015 we found that systems for the management of medicines were not safe and did not protect people using

# Summary of findings

the service. Systems were not in place to protect people using the service and staff from the risks of infection. People's capacity to give consent had not been assessed in line with the Mental Capacity Act.

At this inspection we found that action had been taken by the provider to improve the way medicines were managed. Systems for the management of medicines were safe. The provider had taken action to make sure people using the service and staff were safe from the risks of infection. The home was very clean throughout. Twelve people's capacity to give consent about their care and treatment had been assessed in line with the Mental Capacity Act 2005. The manager was in the process of completing capacity assessments for all of the people using the service. However we found that staff were not receiving appropriate supervision in their role to make sure their competence was maintained and there was a lack of activities provided to people living at the home. You can see what action we have told the provider to take at the back of the full version of this report.

We found that there were appropriate safeguarding adults procedures in place and staff had a clear understanding of these procedures. Procedures were in place to support people where risks to their health and welfare had been identified. Recruitment checks took place before staff started work. The provider had yet to establish a full complement of qualified nursing staff to support people using the service with their health care needs. Recruitment for nursing staff was on-going.

People were provided with sufficient amounts of nutritious foods and drink to meet their needs. People had access to a GP and other health care professionals when they needed it. People's privacy was respected. Staff were knowledgeable about people's needs and how to meet these needs. People and their relatives, where appropriate, were consulted about and involved in developing their care plans. People were provided with information about the home and they were aware of the services and facilities available to them. People knew about the home's complaints procedure and were confident their complaints would be fully investigated and action taken if necessary.

Staff said they received good support from the manager. There was an out of hours on call system in operation that ensured that management support and advice was available to staff when they needed it. The provider carried out unannounced night time and weekend checks at the home to make sure people were receiving appropriate care and support. The provider had employed the services of a consultancy firm to help them make improvements to the quality of care they provided to people using the service. We have made a recommendation that the provider puts in place effective systems to monitor the quality and safety of the service that people receive.

# 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?

The service was safe. Medicines were managed safely and records showed that people were receiving their medicines as prescribed by health care professionals.

There were systems in place to prevent the spread of infections.

There were safeguarding adult's procedures in place and staff had a clear understanding of these procedures.

Appropriate procedures were in place to support people where risks to the health and welfare had been identified.

Appropriate recruitment checks took place before staff started work.

Good



### Is the service effective?

The service was not always effective. Staff were not receiving appropriate supervision in their role to make sure their competence was maintained.

The manager and staff understood the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

People were provided with sufficient amounts of nutritional foods and drink to meet their needs.

People had access to a GP and other health care professionals when they needed it.

Requires improvement



### Is the service caring?

The service was caring. Staff spoke to people in a respectful and dignified manner. People's privacy was respected.

People and their relatives, where appropriate, were consulted about and involved in developing their care plans.

People were provided with information about the home and they were aware of the services and facilities available to them.

There were arrangements in place to meet people's end of life care needs.

Good



### Is the service responsive?

The service was not always responsive. People were not receiving person centred care that reflected their needs or their personal preferences.

People's health care needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

Staff were knowledgeable about people's needs and how to meet these needs.

Requires improvement



# Summary of findings

People using the service and their relatives knew about the home's complaints procedure and said they were confident their complaints would be fully investigated and action taken if necessary.

## Is the service well-led?

The service was not always well-led. The home did not have a registered manager in post. Three managers had been appointed to run the home since January 2015. The current home manager started work at the home on 14 July 2015.

Staff said they received good support from the manager. There was an out of hours on call system in operation that ensured that management support and advice was available to staff when they needed it.

The provider carried unannounced night time and weekend checks at the home to make sure people were receiving appropriate care and support.

The provider had employed the services of a consultancy firm to help them make improvements to the quality of care they provided to people using the service.

**Requires improvement**



# Benedict House Nursing Home

## Detailed findings

### Background to this inspection

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

The unannounced inspection was carried out over three days 3, 4 and 6 August 2015. The inspection team consisted of four inspectors, one of whom was a pharmacy inspector, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this

type of care service. Before the inspection we looked at the information we held about the service including notifications they had sent us. We spent time observing the care and support being delivered. We spoke with nine people using the service, the relatives and friends of five people, eight members of staff, the manager and the provider. We looked at records, including the care records of seven people using the service, seven staff members' recruitment and training records and records relating to the management of the service.

Not everyone at the service was able to communicate their views to us so we also 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.

# Is the service safe?

## Our findings

At our inspection on 23, 24 February and 6 March 2015, we found that people were not always protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage people's medicines. We asked the provider to make improvements on how medicines were managed.

At this inspection we found there were systems in place to ensure that people consistently received their medicines safely, and as prescribed by health care professionals. We found that appropriate arrangements were in place for obtaining medicines. We looked at the medicine administration records (MAR) for sixteen people using the service. We saw appropriate arrangements were in place for recording the administration of medicines. The records showed people were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving people their medicines were recorded.

We saw staff completed pain assessments to check if people needed to take painkillers which were prescribed as required. When medicines were administered covertly to people we saw there were signed agreements in place, which included the signature of the person's doctor and family member. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature. Records showed that controlled drugs were managed appropriately. We saw the last medicines audit had taken place the week prior to the inspection visit. Records showed any concerns were highlighted and action taken. We saw there were also daily checks to confirm the MAR charts had been fully completed.

At our last inspection we found that effective systems were not in place to reduce the risk and spread of infection. We asked the provider to make improvements on their systems for preventing the spread of infection.

At this inspection we found that the home was clean throughout and there were effective systems in place to reduce the risk and spread of infection. The provider had appointed a housekeeper whose role included monitoring infection control procedures within the home. We saw completed daily and weekly cleaning schedules which included deep cleaning people's bedrooms, sluice rooms,

toilets, bathrooms and clinical areas. We found that sluice rooms were clean and tidy. Monthly infection control audits were being carried out. A relative told us, "This place is always clean. There is never any bad smells here." Another relative said, "I've noticed a big difference lately, the home is always really clean."

At the time of this inspection the provider had yet to establish a full compliment of qualified nursing staff to support people using the service with their health care needs. Since our last inspection the deputy manager and previous manager, both Registered General Nurse's (RGN), had left employment at the home. The home had relied on two full time RGN's and agency nurses to cover shifts. A new manager who was an RGN, and another RGN had started working in the home from the 14th July 2015. Three RGN's had recently been recruited at the time of this inspection, the provider was awaiting references and criminal record checks before allowing them to start working at the home. The provider acknowledged there had been a high turnover of nursing staff in the last twelve months. The home is registered to provide nursing care for up to 41 people however the provider told us they had limited the numbers of people they would support at the home to 30. They said they would not accept any people with complex needs until the home had established a fully functional nursing team that would meet peoples health care needs.

People using the service and their relatives told us there were usually enough staff around to meet people's needs. One person said, "There are enough people to look after me and I need looking after because I'm old." A relative said, "I visit every day and there seems to be plenty of staff around." Another relative said, "Sometimes they do seem a bit short of staff. But it's a big house and staff might be doing things with other people. If I or my mum needs anything there will always be someone around to help."

When we arrived at the home on the first day of this inspection we found there were five health care assistants and one registered general nurse (RGN) on duty. An agency nurse had not turned up for their shift. The home manager, a RGN, supported the nurse and people using the service throughout the day. On the second and third days of the inspection there were two RGN's on duty and five health care assistants. The manager said staffing levels were arranged according to the dependency needs of people using the service. They said if people's needs changed then additional staff cover was arranged.

## Is the service safe?

People told us they felt safe and that staff treated them well. One person said, "I feel safe living here, there's nothing to be afraid of." A relative said, "My mum is very safe here. There's no problem. The staff are good with the residents."

The manager told us they were the safeguarding lead at the home. The home had a policy for safeguarding adults from abuse and a copy of the "London Multi Agencies Procedures on Safeguarding Adults from Abuse". The manager said the home's policy was used alongside the London Multi Agencies procedure. Staff training records confirmed that all staff had received training on safeguarding adults from abuse. Four staff we spoke with told us they had received safeguarding adults training. All were able to describe the action they would take to protect people and to report allegations of abuse, including the process for whistle-blowing if necessary.

The provider had reported safeguarding concerns to the Care Quality Commission and the local authorities as required. Since our last inspection the local authority had completed seven safeguarding investigations relating to the quality of care received by people using the service. Five of the investigations had been concluded. Some of the concerns investigated related to the management of wound care and falls. We saw evidence that the provider had taken disciplinary action against staff where required to keep people safe.

The provider told us they had learned lessons from the safeguarding investigations and had put measures in place to prevent those types of concerns occurring again. We looked in seven people's care files and saw care plans relating to the management of wound care and falls. Peoples care plans for wound care were up to date. We saw diagrams and photographs and appropriate wound care treatment plans. People that were on bed rest had dynamic air mattresses in place and the mattresses were

functioning correctly. Two staff told us they had received training in ensuring that people's mattresses were at the right pressure to keep people safe from skin care problems. This greatly reduced the risk of pressure injury. Where a concern was identified relating to one person's skin integrity we saw a referral had been made to a tissue viability nurse. We saw falls risk assessments and care plans and moving and handling plans were in place in all of the files we looked at.

Thorough recruitment checks were carried out before staff started working at the home. We looked at the personnel files of seven staff that worked at the home. We saw completed application forms that included references to their previous health and social care experience, their qualifications and their full employment history. Each file included two employment references, health declarations and proof of identification. The manager showed us evidence that criminal record checks had been obtained for all of the staff that worked at the home.

There were arrangements in place to deal with foreseeable emergencies. People had individual emergency evacuation plans which highlighted the level of support they would need to evacuate the building safely. Staff said they knew what to do in the event of a fire and told us that regular fire drills were carried out. Staff training records confirmed that all staff had completed training on fire safety. We saw that people had call bells available to them in their rooms and that these were located within reach. This enabled them to call for help in emergencies or when they needed support. We tested three call bells, one on each floor of the home and saw on each occasion staff responded quickly. We saw that the provider and manager were attentive to this and enquired what the issues were and what the staff had done to support each individual.



# Is the service effective?

## Our findings

At our inspection on 23, 24 February and 6 March 2015, we found the provider did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. People's capacity to give consent had not been assessed in line with Mental Capacity Act (MCA) (2005). We asked the provider to make improvements for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.

At this inspection we found that there were no assessments of people's capacity to give consent or make decisions about the care and treatment provided for them in any of the seven care files we looked. The provider told us the previous manager had completed capacity assessments for people where required. However the provider could not locate these documents. The current manager acted promptly and had completed capacity assessments for twelve people during the course of our inspection. They completed the assessments starting with people with dementia or communication difficulties. These assessments had been completed for specific decisions and had been retained in people's care files. The assessments recorded if a less restrictive option had been considered and the person's ability to understand, retain, weigh or communicate information in relation to the decision being made. The manager told us they were in the process of arranging "best interests" meetings and would submitting DoLS applications to the local authority where appropriate. They said they would also notify the CQC when any DoLS applications had been authorised.

The manager demonstrated a good understanding of the MCA and the Deprivation of Liberty Safeguards (DoLS). They said that most people using the service had capacity to make some decisions about their care and treatment. Where they had concerns regarding a person's ability to make specific decisions they said they would work with them, their relatives, if appropriate, and the relevant health and social care professionals in making decisions for them in their 'best interests' in line with the MCA. Training records showed 10 members of staff had received training on the MCA and DoLS since our last inspection. The MCA and the DoLS sets out what must be done to ensure the human rights of people who lack capacity to make decisions are

protected. Four staff we spoke with demonstrated a basic understanding of the MCA and DoLS. One member of staff said, "People need to be able to make important decisions about their care for themselves, they may need support with this. This might involve support from their family and social services."

We saw applications had been made to the local authority for DoLS authorisations for people where required. The manager showed us three DoLS applications had been authorised to deprive people of their liberty for their protection. The authorisation paperwork was in place and kept under review and the conditions of the authorisations were being followed.

We spoke with four members of staff about training and supervision. They all told us they had completed an induction when they started work and they were up to date with the provider's mandatory training. Training records confirmed health care assistants had received mandatory training in: safeguarding adults, infection control, health and safety, moving and handling and fire safety. Most staff had received training on dementia awareness. The training record for nursing staff included the training completed by four RGN's. One RGN had completed the provider's mandatory training as well as training on venepuncture, catheterisation and medicines in care homes. Another RGN, that started working at the home on 14 July 2015, had completed training on wound care and venepuncture. The manager showed us that further training had been arranged for health care assistants and RGN's in 2015. Training for health care assistants included first aid and wound care in August and infection control in September 2015. Training planned for RGN's included wound care in August, venepuncture in September and catheterisation in October 2015.

Staff were not receiving appropriate supervision in their role to make sure their competence was maintained. One member of staff said they had not formal supervision in five months. They felt this was due to the absence of a registered manager in recent months. Another member of staff said they had not received any supervision since they started working at the home in June 2015. They said this was important because their training needs had not been fully discussed. We saw a staff supervision and appraisal matrix which recorded that 10 of the home's 17 health care



## Is the service effective?

assistants had received supervision with the previous manager between March and June 2015. Seven health care assistants had not received any supervision and no staff working at the home had received an appraisal.

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

The manager told us they planned to carry out group supervisions for staff and they were in the process of arranging one to one supervisions for all staff working at the home. They said where staff had worked at the home for over one year they would have an annual appraisal.

People were provided with sufficient amounts of nutritional foods and drink to meet their needs. People's care plans included assessments of their dietary needs and preferences. These assessments indicated their dietary requirements, food likes and dislikes, food allergies and their care and support needs. Care plans included information relating to people's dietary needs for staff to refer to. For example, we saw risk assessments had been completed for malnutrition and there was guidance for staff to follow for supporting people who had difficulty swallowing.

All of the staff we spoke with were able to tell us about the dietary needs of people using the service including the names of people on special or pureed diets. They also knew the names of the people who had chosen to take meals in their bedrooms and the social implications of this. The chef and two staff we spoke with described how people were given a choice of meals. They explained there was always a choice of two main meals each day, but that individual choices were also catered for at any time. The chef was present to serve hot food and to ensure people on special diets were served appropriate meals. We saw that five people who required pureed diets were served their correct meals promptly.

People were provided with adequate support at mealtimes. We observed how people were being supported and cared for at lunchtime. Some people required support with eating and some ate independently. Some people ate their meals in the dining room and some ate in the lounge. We were told that others had eaten in their rooms as was their choice, or had eaten before we started our observation of mealtimes. The atmosphere was relaxed and not rushed and there was plenty of staff to assist people when

required. There were two options on a menu for people to choose from at lunch time. We saw that the staff interacted regularly with people they were supporting verbally and using eye contact and facial expressions to communicate. This was important for some people who did not easily communicate verbally. We saw staff were available to support people on a one to one basis when they required support to eat their meal and that the staff explained what food was to be served to them, and gave them sufficient time to eat their meal calmly.

People using the service said that the food was very good and that it was always served hot and usually on time. One person said, "The staff are very attentive and helpful at mealtimes, and I have always seen them help people quickly when they need it." Another said, "I couldn't ask for better food, nobody here goes wanting for anything when it comes to decent meals." A third person told us, "The staff are always very helpful and respectful and we always get the food we asked for." We saw that people were also provided with drinks throughout the day and these were available in the lounge. A kitchen assistant confirmed that people could have a snack or drink at any time they requested it and that the kitchen staff were always available at weekends to ensure people's needs were met.

People using the service and their relatives said they were able to see health care professionals when they needed to. GP and healthcare professional's visits were recorded in all of the care files we looked at. Where there were concerns people were referred to appropriate health professionals. People also had access to a range of visiting health care professionals such as dentists, physiotherapists, dietitians, speech and language therapists, opticians and podiatrists. One person using the service said, "I get regular visits from the dentist, optician and podiatrist. I can see my GP when I need to." A relative said, "They have all they want here, if they need to see the doctor the manager calls them in."

The provider told us they had met with a GP practice in March 2015 in order to improve communications between the home and the practice. A GP from that practice told us that communication with the home had significantly improved since that meeting. There were fewer inappropriate calls for home visits, and up to date clinical records were available when GP's from the practice

## Is the service effective?

attended the home. A visiting healthcare professional told us they had visited to the home for the first time. They said the nurse in charge was very professional and the staff they met were very friendly.

# Is the service caring?

## Our findings

People and their relatives told us staff were kind and caring. One person told us, “The staff are very friendly. I am confined to my bed but they come to see me and always have time for a chat.” A relative said, “My mum is very happy here. The staff are pleasant, they make my mum comfortable. I think they are caring.” Another relative said, “My mum has just moved in and everyone wants to help. The handyman put up some pictures for her. All the staff are kind.” A third relative told us, “My mum is always clean, well presented and well looked after. The standard of care here is very good.”

A hairdresser told us they had been visiting people at the home once a week for the last eight years. They said, “Things have got better over the last three months. It’s more organised. The home is cleaner. I don’t have to go looking for residents to do their hair. Staff seem happier and are more helpful. I always see them care for people in a compassionate and professional way. Everything seems to flow better now.”

Throughout the course of our inspection we observed staff treating people in a respectful and dignified manner. The atmosphere in the home was calm and friendly. Staff took their time and gave people encouragement whilst supporting them. People’s privacy and dignity was maintained. We saw that people’s care records were stored in a locked room when not in use. Staff were aware of the need for confidentiality and we saw them speak quietly with people about the support they needed. When people received personal care we saw that staff ensured their privacy by drawing curtains and shutting doors.

People were provided with information about the home in the form of a service user guide. This was produced in larger print following a comment made by a person using the service recorded in our last inspection report. We saw

copies of the service user guide in people’s bedrooms. The guide ensured people were aware of the homes philosophy of care, fire evacuation, meal times and medical services which could be arranged.

People using the service and their relatives told us they had been consulted about their care and support needs. One person said, “The staff talk to me all the time about what I need. I think they all know what I need by now.” A relative told us, “I told them what my mother wanted when she came here. They put it all in place.” Another relative said, “My mum’s needs were assessed before she came here. We met with the manager and told them about mum and made some suggestions on how she liked to be cared for. They always keep us updated about mum.” A third relative said, “My mum moved here about two weeks ago. I was able to meet with the manager and tell them what my mum liked and didn’t like. The staff are pleasant and so far it’s all going very well.”

People received appropriate end of life care and support. A local hospice end of life care team had been supporting one person using the service with pain management. This person told us, “A nurse from the hospice comes to see me every week. They are really helpful, the nurses and the other staff here are helpful too. I think people care for me and look out for me.” We saw a “Thinking ahead” document in their care file which recorded their wishes regarding their end of life care and support needs. This document had been completed by them and the nurse from the hospice. We saw a Do Not Attempt Cardio-pulmonary Resuscitation (DNAR) form in their care file. The DNAR is a legal order which tells a medical team not to perform Cardio-pulmonary Resuscitation on a patient. However this does not affect other medical treatments. We also saw Do Not Attempt Cardio-pulmonary Resuscitation (DNAR) forms in three other the care files we looked at. These had been fully completed, involving people using the service, and their relatives, where appropriate, and signed by their GP.

# Is the service responsive?

## Our findings

People using the service were not receiving person centred care that reflected their needs or their personal preferences. We spoke with three people using the service about activities. They told us that sometimes there were activities they enjoyed. For example there was a coffee morning on Wednesdays and visitors from local churches attended the home on Sundays to engage in prayer meetings and to sing hymns. One person said, "There is not that much going on, there's a coffee morning and some staff play games with us occasionally. But that's about it." Another person said, "I sometimes want to go to the shops for myself but I get told I can't go out because there's no one to go with me." Another said they liked to watch TV programmes such as Coronation Street but they weren't sure when it was on and often missed it. A relative told us, "There could be a bit more for people to do. There is no activity coordinator at the moment." Another relative, whose mother stayed in her room, said, "My mum doesn't receive enough visits from staff. They need to do more."

There was no evidence of any specialised activities or resources in use to help staff meaningfully engage with people living with dementia in order to promote their individual wellbeing. At our last inspection we recorded that the home had appointed an activities coordinator. The provider and staff told us that the activities coordinator had had a positive effect on people using the service. However the activities coordinator had left that post in May 2015.

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

The provider told us they had recruited a new full time activities coordinator and were awaiting references and criminal record checks before allowing them to start working at the home.

People's health care needs were assessed and care and treatment was planned and delivered in line with their individual care plan. The care files we looked at were well organised, easy to read and accessible to staff. We saw that people's health care and support needs were assessed before they moved into the home. The provider told us that people's care plans were developed using the assessment information. Care plans included detailed information and guidance to staff about how people's needs should be met. Care plans covered areas such as, for example, medicines,

pain management, safety, communication, dependency, falls, manual handling and skin integrity. We saw daily notes that recorded the care and support delivered to people. Most of the care plans we looked at had been reviewed by the previous manager in May and June 2015, some were reviewed in July and August.

We saw evidence on the first day of this inspection that the current manager and the nurse (RGN) on duty had been auditing the care files of all of the people using the service. They both told us about the introduction of a 'resident of the day' scheme. They said the residents of the day care plans would be reviewed to make sure all the information about their needs was up to date. The manager told us that mental capacity assessments would also be completed for each person using the service as part of the scheme. They said two people's care plans would be reviewed each day and one person's care plans would be each night by the RGN's on duty. Twelve people's care files had been recently been reviewed and updated.

Staff were knowledgeable about people's needs and how to meet these needs. For example we observed one person using the service was upset and anxious. A member of staff sat with them holding their hand and talking with them which had a calming effect. On another occasion we saw one person shouting at a member of staff during their meal. This member of staff remained calm and spoke with them respectfully until they had finished their meal. A member of staff told us they were working with one person to try to motivate them to take their meals in the dining room, and we saw they were sensitive to the person making their own choice about this. All of the staff we spoke with said they had the opportunity to attend daily handover meetings where people using the services individual care needs were discussed; this kept them informed about people's current needs.

The home had a complaints procedure in place. One person using the service told us, "If I need to complain, I know what to do. But I haven't needed to." A relative said, "I see the provider here every time I come. If I had a concern I would just mention it to him. I had a concern before and he sorted it out no problem." We saw a complaints file. This included a copy of the complaints procedure and forms for recording and responding to complaints. Records showed

## Is the service responsive?

that when issues had been raised these were investigated and feedback given to the complainant. The provider told us that any complaints received at the home were reviewed and used to ensure similar complaints did not occur.

# Is the service well-led?

## Our findings

The home did not have a registered manager in post. The previous registered manager left employment in December 2014. Since then three managers had been appointed to run the home. One manager left in January 2015 after a short time working at the home. Another manager, appointed in March, left their post in June 2015. The current home manager was appointed on 14 July 2015. The provider said the current manager would apply to the CQC to become the registered manager for the home once they had passed their probationary period.

The provider told us they had employed the services of a consultancy firm to make improvements to the quality of care they provided to people using the service. They said the consultancy firm also provided advice on managerial matters and were an additional level of support during the time of change at the home. An associate from the consultancy firm was present on the third day of our inspection. We saw the associate discussing audits with the administrator and advising the provider on how improvements could be made at the home.

The provider showed us an “uplift plan” for the home. They told us this plan was put in place to allow the home time to stabilize and address issues identified by themselves and the consultancy firm. The plan referred to the provider’s restriction on admissions to the home. Any admissions to the home would be assessed, monitored, reviewed by the consultancy firm. The plan also outlined the timescales and safety measures required to re-open beds at the home.

We saw records from recent care file, wound care, staff file, medicines, health and safety and infection control audits. We also saw records of regular call bell, bed rail, and pressure mattress and hoist checks. We saw reports from night time and weekend unannounced spot checks. The provider said they carried these out to make sure people were receiving good quality care at all times. Records of accidents and incidents were also kept with monthly audits taking place to look for any recurring themes or preventable causes. However we noted that the care file audits had not identified that assessments of people’s capacity to give consent about their care and treatment not had been retained in their care files.

The provider showed us a new electronic clinical governance system. This had been introduced to the home

in July 2015. This monitored areas such as, for example, incidents and accidents, complaints, safeguarding, care file audits, maintenance, infection control and staff training, supervision and appraisal. The provider told us the new system would enable managers to find and fix issues quickly and prevent them from happening again. We were not able to assess the impact of the clinical governance system on people's care at the time of inspection as it had only just been introduced to the home.

The provider said the consultancy firm had carried out an audit and identified areas where the home needed to make improvements. The provider told us they had put new systems in place to improve communication and monitor quality within the home. For example “flash meetings” took place at 2pm each day. These were attended by the manager, nursing staff, health care assistants, the maintenance man, the chef and the administration team. The focus of these meetings was to communicate the needs of people using the service for example, individual health issues of people such as pressure sores or weight loss. Information from these meetings was passed to staff. The manager also carried out a “walk around” the home each day and observed, for example, if the home was clean and odour free and if staff were carrying out their duties as required. Any concerns identified during the walk around were discussed at flash meetings. New staff handover forms had also been introduced. These were completed for each person using the service at daily handover meetings and recorded any health care support needs. For example, one handover form recorded that a person was visited by a GP; the GP’s advice was recorded. Another person had been anxious and staff were required to make an appointment for the person to see the GP.

Staff said management support and advice was always available when they needed it. There was an out of hours on call system in operation. They said that the manager and provider were very approachable and listened to any ideas they had for making improvements. For example one member of staff said they had spoken with the manager about how to motivate a person using the service to get out of bed for mealtimes and this was listened to and acted on. Two members of staff said that people’s individual health and wellbeing, and any concerns about their safety such as from falls or bedsores were discussed daily. This ensured staff were aware of any action required to keep people safe.

## Is the service well-led?

We listened in on a flash meeting and found this to be the case. Other staff we spoke with confirmed daily handover meetings took place so they were kept up to date with any changes to people's care and welfare.

We saw that relatives meetings took place on a three monthly basis. The minutes from the last meeting in May 2015 indicated the meeting was well attended by the

relatives of people using the service. The provider and the manager were also present. Issues discussed at the meeting included, management changes, staff recruitment, the CQC report, care planning and making complaints. We noted the minutes from the last meeting were placed on the notice board at the entrance for visitors to read.



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

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Some staff were not receiving appropriate supervision in their role to make sure competence was maintained.

Regulation 18 (2) (a).

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

People using the service were not receiving person centred care that reflected their needs or their personal preferences.

Regulation 9 (1) (c).