Danaz Healthcare Limited

Pax Hill Nursing Home

Inspection report

Pax Hill
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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

The inspection took place on 24 February 2015 and was unannounced. Pax Hill Nursing Home is a 98 bed nursing home registered to provide care for older people and younger adults. The service is registered to provide care for people who experience physical health or mental health conditions including dementia. Care is provided on three separate floors. Balmoral unit provides residential care; Montgomery unit provides nursing care for people experiencing dementia or mental illness and Windsor unit provides nursing care. At the time of the inspection there were 84 people using the service.

The service has a registered manager. 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.

Staff had not followed the provider's post-falls protocol for monitoring and observing people following a fall. People's falls care plans were not always updated by staff

Summary of findings

when they fell. People were not consistently safe following falls as staff had not implemented the guidance provided. Following the inspection the registered manager took action to ensure staff followed guidance.

People who experienced dementia did not receive consistent effective care. At lunchtime processes to order and serve meals did not take into account the specific needs of people who experienced dementia. Staff focused on the task of serving meals rather than interacting with people. Staff training on dementia awareness was insufficient to enable them to effectively support people who experienced dementia to have an enjoyable lunch time service that met their needs effectively.

Records did not accurately demonstrate what care people received at night. This placed people at risk of receiving unsafe or inappropriate care.

Staffing levels were sufficient to meet the needs of the number of people accommodated. On occasions staff worked excessive hours to cover staff sickness. We have made a recommendation in relation to legislative requirements for staff rest periods.

People's needs were met by staff who had undergone comprehensive pre-employment checks to ensure their suitability for their role.

People had assessments in place in relation to various risks. Where risks to people had been identified plans were in place to reduce the risk of their occurrence. People told us they felt safe. Staff understood what might constitute a safeguarding risk to people and how to report incidents. People were safe from the risk of abuse. People received their medicines safely from staff who had received relevant training and whose competency had been assessed.

Staff received an induction to their role and training. Staff were supported through supervisions and an annual appraisal of their work. People received their care from staff who received appropriate support to carry out their role.

Where people lacked the mental capacity to make specific decisions staff were guided by the principles of the Mental Capacity Act 2005. This ensured any decisions made were in the person's best interests. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLs applications had been submitted for people where required. People's liberty was only restricted where this was legally authorised.

People were happy with the meals they received. People's nutritional intake was monitored and the cook was informed of any relevant dietary information. People's nutritional needs were met.

Where staff identified the need for people to see the speech and language therapist, dietician or mental health nurses, they identified this need with the GP. The GP determined if people required referral. People were supported by staff to see healthcare professionals.

People had caring relationships with staff. People were treated with respect and dignity. People had been consulted about their care and preferences about how it was provided.

People had care plans in place that addressed their individual needs. When people's care needs changed the service recognised this and made changes to their care.

There were systems in place to monitor the quality of the service people received. When issues were identified by the registered manager and provider actions were taken to drive improvements.

People's complaints were responded to appropriately by the provider.

People told us the service was well led by the registered manager. The registered manager was supportive to staff and accessible to people. Even though there was a whistleblowing policy in place not all staff felt the provider had created a culture of openness within which they felt able to freely express their views to them.

We found a number breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were not safe following a fall. Staff had not followed the post falls guidance. The registered manager took immediate action to ensure staff followed the guidance to reduce the risks to people.

Sufficient staff were allocated to provide people's care to meet their needs safely. On occasions staff worked excessive hours to provide cover at short notice for staff absences. Staff had undergone comprehensive pre-employment checks to ensure they were suitable to work with people.

People were safe from the risk of abuse. Staff had received training and understood their roles and responsibilities.

People received their medicines safely from staff who were trained.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported to receive enough to eat and drink and their weight was monitored. However, staff training was not effective in ensuring the needs of people who experienced dementia were met during lunch times.

Staff received an induction into their role, ongoing training, supervisions and an appraisal. People received their care from staff who were supported in their role.

Where people lacked the mental capacity to make specific decisions staff were guided by the principles of the Mental Capacity Act 2005. This ensured any decisions were made in the person's best interests.

Staff supported people to access health care services.

Is the service caring?

Good

The service was caring.

People said staff treated them kindness and compassion. People were cared for by staff who took action if they were uncomfortable.

People had been consulted about the provision of their care and preferences. People were supported by staff to express their views.

People told us staff treated them with dignity and respect. Staff were observed to speak to people respectfully and to preserve their dignity.

Is the service responsive?

Good

The service was responsive.

Summary of findings

People's care needs had been assessed prior to them being accommodated by the service. People had care plans in place to address their needs.

People were able to participate in a range of activities across the week tailored to their needs.

The service had a complaints policy which people used to make any formal complaints. People's complaints were actioned and responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led

People's records did not accurately show what care they had received from staff at night. It was not possible to ascertain at what time people were checked and by whom.

The provider had not ensured there was an open and transparent culture at all levels of the service to support staff to report any issues.

People were cared for by staff who practised the values of the service.

The service was well led by the registered manager. People's care was provided by staff who were supported in their role by the registered manager.

There were processes and systems in place to enable the registered manager to monitor the quality of the service people received. Action was taken to drive improvements in response to people's feedback and the results of audits.

Pax Hill 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

This inspection took place on 24 February 2015 and was unannounced.

The inspection team comprised of two inspectors, a specialist advisor who is someone who has clinical experience and an expert by experience. The specialist advisor had clinical nursing experience and knowledge of working with people who experience dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of this type of service.

Before the inspection the provider completed a Provider Information Return (PIR). 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 the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events which the provider is required to tell us about by law. Prior to the inspection we spoke with a GP, two social workers and a mental health nurse about the service provided.

During the inspection we spoke with eight people and two people's relatives. People who lived on Montgomery unit experienced dementia and could not all speak with us. We used the Short Observational Framework for Inspection (SOFI) on this unit. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. During the course of the inspection we spent time observing staff interactions with people on all three floors. We observed a staff handover when new staff joined the shift on Balmoral unit. We also spoke with the registered manager, the provider and seven staff.

We reviewed 11 people's care records, three staff recruitment records, three staff induction and recruitment records and other records relating to the management of the service.

We previously inspected the service on 18 December 2013 where no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

People were not safe following a fall as the provider's system to keep people safe did not protect them from potential post-fall complications. One person had been found bleeding from their head following a fall. A record had been made of the accident and it was recorded 'Kept under observation' as the action taken by staff. There was no record to demonstrate these observations had been completed. There was no evidence the person's falls care plan had been updated either following this fall or a subsequent fall. Records showed a second person had fallen twice. Although accident forms had been completed, their falls care plan had not been reviewed following the fall. People were at risk as action had not been taken by staff to monitor them for injuries or adjust their care to prevent further falls.

The registered manager had recently introduced a post falls protocol which records confirmed. The protocol provided staff with guidance in relation to the actions they should take if a person fell and the observations on people's health which should be completed and recorded. Four people's care plans demonstrated staff had not followed the post falls protocol. The registered manager said they were not due to audit the new falls protocol until March 2015 so they had not identified staff were not using it. They told us the use of the post falls protocol would be addressed with nursing and senior care staff at a meeting on 25 February 2015. Following the inspection they provided evidence of the discussion of this protocol. People were unsafe after a fall as staff had not followed guidance. The registered manager took action to ensure staff learning took place in relation to post falls management and to reduce the risks to people after a fall.

The failure to ensure people's welfare and safety was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities).

People had risk assessments in place to reduce risks to them from being moved, pressure sores, and risks associated with conditions such as diabetes. Where risks had been identified there were plans in place to reduce these risks. Pressure relieving equipment was provided if people were at risk from the development of pressure sores and people were moved safely by the correct number of staff.

Three people said they thought that there were not enough staff at times. The registered manager told us they did not use a staffing tool to assess how many staff they required. Instead they used a monthly dependency tool to assess people's staffing requirements. In addition they told us they monitored people's needs and amended staffing as required. Records showed the three units were adequately staffed to meet the needs of the number of people accommodated. People did not feel staffing levels impacted upon the quality of their care, staffing levels were sufficient.

Two people told us sometimes staff worked double shifts over a 24 hour period. The registered manager and records confirmed this had happened once on the night of 25 December 2014 due to staff sickness. They confirmed there had been three occasions when staff had worked between a 13 hour and 16 hour shift to cover for staff who had become sick. There was no evidence that this had posed a risk to people however it contravened legislation on staff working hours. The registered manager told us this only happened in exceptional circumstances. People were cared for by sufficient staff but on occasions staff had worked excessive hours.

Staff had undergone comprehensive recruitment checks as part of their application and these were documented. These included the provision of suitable references, proof of identity and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff had completed and signed an application form providing details of their employment history. Staff had been required to complete a health declaration form to demonstrate their fitness to work. People were protected as the provider operated comprehensive recruitment processes.

All of the people we spoke with about whether they felt safe in the service confirmed they did. One social worker said they had no safeguarding concerns and another said the service had responded appropriately to a safeguarding concern. The registered manager told us staff received annual safeguarding training and had access to the provider's safeguarding policy and the multi-agency policy, which was confirmed by a staff member. The registered manager told us they learned from safeguarding incidents and told us of the actions they were taking as a result of a

Requires Improvement

Is the service safe?

safeguarding incident. Records showed 100% of nurses and 91% of care staff had completed training in safeguarding vulnerable adults. Staff demonstrated their understanding of what might constitute abuse and what incidents they should refer to the safeguarding team. Staff we spoke with understood the equality and diversity policy and there was no evidence people were discriminated against on the basis of their age, gender, ethnicity or disability. People were protected from the risks of abuse.

Two social workers and a GP told us there were no issues regarding medicines management at the service. A mental health nurse said the service used 'As required' medicines for people appropriately. These are medicines which people should be offered when they exhibit symptoms. They told us the service ensured people only received anti-psychotic medicines for as long as they needed them in accordance with guidance. Records showed one person's ability to self-medicate had been assessed. They had been involved in this process. People only received medicines they needed and where appropriate they were supported to take medicines themselves.

The registered manager told us nurses and all senior care staff updated their medicines training annually with the pharmacist. Senior care staff only administered medicines to people on Balmoral the residential unit. People's medicines on the two nursing units were administered by nurses. Staff records showed the competency of staff to administer medicines had been assessed. Staff were observed to administer people's medicines safely. Staff told us people's medicine administration records were checked to ensure staff had signed them and an external audit was completed by the pharmacy. People's medicines were managed and administered safely.

We recommend the service accesses information in relation to legislative requirements with regards to staff minimum daily rest periods in every 24 hours.

Requires Improvement

Is the service effective?

Our findings

Lunchtime practices were not effective in meeting the needs of people who experienced dementia. People were not provided with the lunch menu in a pictorial format, to enable them to understand the choices available. People had to make their choice of meals the day before and may have forgotten what they had chosen. A staff member confirmed people did forget. People were not shown the meals available when they were served to visually remind them of what the meal was and whether they liked it. Meals arrived in the dining room ready plated so people could not see the choice of vegetables available and choose what they wanted. People could not make a spontaneous decision about their portion size. Staff focused on the task of serving meals rather than interaction with people. Most staff were seen to put people's meals in front of them without explaining what the meal was. Staff asked people if they wanted apple crumble without either showing it to them or the alternative to enable them to make a choice. People's lunchtime experience was the same on all units. The service had not taken into account that the needs of people who experience dementia were different when planning how to deliver care to people at lunchtime. They required a more flexible approach to the lunch service. People who experienced dementia did not experience effective care at lunchtime to meet their needs.

The registered manager told us staff received two hours dementia awareness training. Records showed this had been completed by most staff. The training staff received had not been effective in providing staff with sufficient knowledge and skills to support people, who experienced dementia, with their lunch.

The failure to deliver care in a way that met people's individual needs was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities).

The registered manager told us new staff received a three day induction with senior care staff; this was confirmed by a member of staff. Staff completed the Skills for Care Common Induction Standards (CIS) over 12 weeks. CIS are the standards people working in adult social care need to meet before they can safely work unsupervised. Staff training records showed nursing staff completed additional training. This included managing behaviours that might challenge others, nutrition, pressure sore prevention, wound dressing, care planning, Parkinson's, end of life care, oral care, diabetes care and clinical checks. Staff received an annual appraisal and supervisions. People were supported by staff who had received an induction to their role, on-going training and supervision.

A mental health nurse said the provider had involved them in assessing people's mental capacity. Records showed 84% of nursing staff and 78% of care staff had completed training on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLs). A staff member confirmed they had completed this training and demonstrated their knowledge. The MCA provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. People were cared for by staff who had received training and understood their role in relation to MCA 2005 and DoLs.

The registered manager told us DoLs applications had been authorised for six people and a further 23 had been submitted. We reviewed two people's records who were subject to DoLs and found the provider was complying with the conditions applied to the authorisation. Two people had safety stair gates fitted to their bedroom doors; these restrict people's movement and can be a form of restraint. There was evidence either the person or their representatives had requested their use. Where people had restrictions upon their movements in place these were legally authorised.

People's records showed if decisions in relation to their care had been made with their consent or in their best interests. An assessment tool was used to record decisions about whether people lacked the capacity to make specific decisions. Where people lacked the mental capacity to make decisions the service was guided by the principles of the MCA 2005 to ensure decisions were made in the person's best interests. People's records demonstrated if they had a lasting power of attorney, advance decision, involvement of the Court of Protection or Independent Mental Capacity Advocacy (IMCA). The service followed legal requirements in relation to consent.

Requires Improvement

Is the service effective?

All people we spoke with said they received enough to eat and drink and most said they thought the food was good. There was one hot meal for lunch and one hot meal for supper. This gave people a choice of the time they wanted a hot meal. Neither of the hot meals was vegetarian therefore the vegetarian choice on the day of the inspection would have been a jacket potato or salad.

People had been weighed regularly and their Malnutrition Universal Screening Tool (MUST) score calculated. MUST is a screening tool to identify adults, who are at risk from either malnourishment or being overweight. If it was recorded when people had lost weight. Their nutrition care plan provided staff with guidance about the need to give fortified foods and fluids. These are foods which have additional calories added. People had food and fluid charts when required and a staff member confirmed people's intake was monitored. There was an advice sheet for the cook which provided them with key information about any allergies or needs people had in relation to their diet. People's nutritional needs had been met.

Two people told us they regularly saw the GP and the chiropodist who both visited the home. A social worker said referrals were made as required by staff at the service to other professionals. One person's records showed they had seen the physiotherapist. People also saw the dentist and optician as required and were supported to attend hospital appointments. Staff identified when people became unwell or showed signs of experiencing dementia or further deterioration. The current health referral system did not support staff to engage appropriate health professionals at the earliest opportunity so that people could be supported to maintain their physical and mental health for as long as possible. People's access to specialist healthcare services was via a GP referral. The only professional staff could refer to directly was the tissue viability nurse. Some people had been identified by the provider as needing the input of a speech and language therapist, dietician or mental health practitioner. Their records showed that although the provider had referred them to the GP the GP had not always agreed further referral was needed. People might not receive the benefits of early treatment or intervention. The registered manager told us they planned to discuss access to other health professionals with the community matron and the GP.

Good

Is the service caring?

Our findings

People told us care staff were caring, polite and considerate. A person told us "The staff are very good, every one of them here care, it's a very good place." A person said they had a good relationship with one of the nurses and talked to her every day. Two people told us staff knew them well and what they wanted. Two social workers and a GP confirmed staff were caring in their interactions with people.

Records showed the provider used a form 'This is me' to gather information about people's background and inform staff. People's families had also been asked to provide background information about people's personal history, interests and preferences. Staff had information about peoples' needs, wants and wishes, this ensured people's preferences were understood by staff.

People's records provided staff with guidance about how to communicate with them in a caring manner. One person's care plan said they could refuse personal care and staff should manage this by explaining to them and encouraging them. Staff were observed to use touch to physically guide a person. Staff spoke with a person as they supported them to move. They told them what they were doing and gave them instructions about what they needed to do. Staff were caring when communicating with people.

A staff member told us what caused a person agitation and how they alleviated this person's distress by providing them with clear information in advance of appointments where possible.

Staff were seen making a person comfortable. They fetched pillows to ensure the person was sat comfortably in their chair. Records showed staff ensured people's calls bells were within reach for them to summon assistance and bells were seen to be within people' s reach. Staff took action to ensure people were comfortable.

People were given control over their daily routine. One person we spoke with told us their preferences were respected by staff in relation to what time they wanted to get up in the morning or go to bed in the evening. A social worker said they observed a nurse discuss the person's care plan with them. Another social worker said they had heard staff ask the person their views and the person's preferences had been recorded.

People told us staff sought their views about their care. A person's record showed their care plan was discussed with them, including their wishes and preferences in relation to their care. It also demonstrated their relative had been consulted. People's records reflected how they wanted their care to be provided. One person's hygiene care plan said "Enjoys a shower or body wash each day as she prefers." Two people's records documented people's preference for a female care staff to provide their personal care. One person's care plan noted they preferred to spend their time in their room. We saw this person spent their time in their room according to their plan. People's views were sought and their wishes respected.

People told us care staff were caring, polite and considerate and their privacy and dignity were maintained. One person said their dignity was preserved when care staff carried out personal care. Another said "The staff are polite and treat me with respect." People said visitors could come and go whenever they wanted. A person said they had access to a telephone in their room so they could contact their relatives whenever they wished. One person told us they enjoyed visits from their children, grandchildren and great grandchildren. Staff were observed at all times to speak to people politely and respectfully. Staff were friendly to people when they spoke with them. Personal care was provided to people in private. People were treated with dignity and respect.

Care plans provided staff with guidance about how to promote peoples' independence. One person's care plan said 'Offer as many choices as possible, e.g. what clothes she likes to wear.' Staff were seen to offer choice, supportive prompts and gentle reminders to people who were confused or wandering. There was signage on Montgomery unit showing the direction of the lounge and dining room. The activities schedule was provided in a pictorial form to help people understand it. People had memory boxes which contained items that meant a lot to them positioned outside their bedrooms. This provided people with a visual prompt as to which was their bedroom. People's independence was promoted and support provided when this was required.

Good

Is the service responsive?

Our findings

People told us that staff responded to their needs. One person said staff met their needs. They told us there were plenty of activities. Another commented "This is an excellent home with lovely staff I've just got back from activities, an exercise class." One person told us their GP had said that the swelling and movement in their ankles had definitely improved since they had been attending the physical movement activity sessions. Another person commented "They are very helpful; they will make every effort to get what I want."

People's care needs had been assessed prior to them being offered a service. People had care plans for their hygiene, nutrition, communication, moving and handling and mental health needs. The provider assured themselves they could meet people's needs before they were offered a service.

People's changing needs were noted and responded to by staff. A staff member told us information about people was shared during the daily shift staff handovers. Units had a communications book, within which staff recorded key information about changes to people. We observed staff received an update on each person during a staff handover. Following this handover staff signed the communications book to evidence they had read the updated information about each person's needs. A member of staff was able to tell us about a person's individual care needs. Information about changes to people's needs was communicated between staff

Two people whose care records we reviewed were diabetic. They had a care plan in place showing what care they required to manage their condition and informing staff of the need to report all changes to the GP. Their care plans informed staff to be aware of the potential signs of hypoglycaemia. This is when a person with diabetes experiences low blood sugar levels. Records showed where people experienced visual impairment staff were given guidance about how best to support the person. One person's mobility was variable and there were different instructions for staff to follow depending on the person's level of mobility. If the person's mobility was good the care plan stated "Encourage him to walk." People had care plans that reflected their individual needs and provided staff with guidance about how to meet them.

It had been documented who people wanted involved in reviews of their care and how often they wanted reviews involving their relatives to take place. A social worker told us they and the person's family had been involved in a review of their plan of care. People's care plans had been reviewed monthly by staff.

The three activities co-ordinators organised a variety of different activities to meet the different needs of people on each unit. Activities included music, craft, games, exercises, bingo, films, quizzes, newspapers and one-to-one sessions with people. In addition the hairdresser visited weekly, the Pets as Therapy (PAT) dog visited monthly and there was Holy Communion. Staff were seen on Balmoral unit running an exercise class. People were engaged with the activity and enjoyed it. On Montgomery unit people were seen participating in activities across the day. Staff told us they arranged various activities for different people depending on their stage of dementia. A person in the earlier stages was being supported to complete a puzzle whilst a person at a more advanced stage had been given a tactile object to explore. The activities co-ordinator had ensured they arranged activities in response to individual's needs.

One relative we spoke with told us they would go to the manager if they had a problem. The registered manager told us every person or their representative was issued with the complaints procedure. The registered manager said in 2014 the service received four complaints and in 2015 two complaints had been received to date. Records demonstrated people's complaints had been investigated and responded to. The registered manager gave an example of a change to practice that had taken place as a result of a complaint received. They told us they had reviewed the way information was documented in people's records to ensure it was clear who the person wanted contacted first in the event of an emergency. The outcome and learning from complaints were discussed at staff meetings. People's complaints were documented and investigated to enable the provider to identify learning points from people's experience of the care provided.

Requires Improvement

Is the service well-led?

Our findings

There had been an incident where a person experienced an injury at night. However, it was not possible to ascertain at what times they had actually been checked by staff in order to identify at what time the incident may have occurred and if the person required medical attention. In two people's care records it was noted they had been checked upon by staff at a two hourly interval the night before. However, these records did not demonstrate at what time they had been checked upon or by whom. Therefore if an incident occurred during the night it would not be possible to ascertain at what times the checks took place or which staff had been responsible for checking the person. We spoke with the registered manager about this and they took immediate action. Following the inspection they provided evidence they had introduced a new night check form for staff to complete. People had been checked upon during the night; however records did not adequately demonstrate which staff had checked upon them and at what time. People were not protected against the risks of unsafe or inappropriate care as their night care records did not contain appropriate information.

The failure to ensure people's safety through the maintenance of an accurate record was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities).

One person and a relative said they thought the home was well managed. Another person said the staff were supportive of each other and worked as a team. A mental health nurse said the registered manager was supportive and the GP felt the service was well run. We found the service to be well led at the registered manager level.

A member of staff we spoke with about leadership told us the service was well led and they were happy working at the service. There was a whistleblowing policy which stated staff were encouraged to report matters of serious concern involving any staff at all levels freely to the provider. However this was not what we found when we reviewed recent letters of resignation from two staff. These letters showed not all staff felt the provider had developed and promoted an open and transparent culture to ensure staff felt fully supported and able to report any issues. These staff had only felt able to express their views at their point of resignation. There was no evidence to demonstrate the content of these letters had been acted upon by the provider, to effect change in the culture of the service in response to the staff feedback received. There was no evidence to demonstrate people's care had been impacted upon by the issues raised by these staff.

The registered manager informed us staff learnt about the values of the service during their induction and these were covered again as part of the appraisal process. The provider had a mission statement. Staff were observed to uphold the providers values as they provided people's care.

The registered manager told us they visited each floor daily and spoke with people. They said each floor had a qualified nurse as a unit manager. They told us to support them in their role as registered manager an additional nurse had been recruited to commence work as their deputy from March 2015. The deputy was to work as part of the nursing team on the units whilst undertaking the deputy role. This would enable the deputy to observe staff practice. On the two nursing floors both unit managers received additional hours to ensure they had time to complete their duties in relation to the management of the unit and ensuring people's care plans were up to date. There was a leadership structure in place to oversee people's care on each floor and the registered manager was visible and accessible to people.

The registered manager told us they kept themselves up to date in relation to regulatory requirements and clinical practice. They attended a range of external forums to enable them to form links with outside organisations and to keep up to date with best practice. Unit managers were being supported in their development by the registered manager. The delivery of people's care was well-led by the registered manager.

The quality of the service people received was monitored through surveys, meetings and audits. A quality assurance survey had been circulated to people in July 2014. The results overall showed people were happy with the quality of the service received. Where issues were identified actions had been completed to address them. Following the survey a menu survey had been completed in response to the feedback in order to gain people's views on the catering. A new hairdresser had been appointed. As a result of feedback received. A memorandum had been circulated to staff about speaking English whilst working on the Windsor unit. Resident meetings were held on Windsor and Balmoral units to give people the opportunity to express their views. On Windsor unit it had been discussed with

Requires Improvement

Is the service well-led?

people how often they wanted staff to check upon them at night and if they wanted the frequency varied from the existing two hourly routine. They were also asked how often they wanted residents meetings to take place. There was a comments box in reception for people or their relatives to make comments. People's feedback on the service was sought and actions taken in response to their feedback.

The registered manager completed a range of audits of the quality of the service across the year. An internal medicines audit had been completed on 22 December 2014. There was one action point for the registered manager to address with the GP which they informed us they had completed. A care plan audit was completed on 2 December 2014 this noted all people should have evidence in their records of their consent being sought or best interests decisions made where they lacked the capacity to consent. People's records contained evidence that this had been done. A fire audit had been completed on 5 September 2014 and an accident audit on 14 January 2015. The registered manager reviewed people's accident forms and noted where falls took place and their cause. The last fall's audit stated fall risk assessments were to be used and we saw these were on people's files. Other areas of the service that had been audited included complaints, safeguarding, activities, garden, health and safety, catering, admissions, discharges and infection control. A range of aspects of the service were reviewed to identify if the service could be improved. Where areas had been identified actions had been taken to improve the service people received.

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	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The provider had not taken proper steps to ensure people were protected against the risks of receiving care that was inappropriate or unsafe. They had not planned and delivered care in a way as to meet people's individual needs or ensure people's welfare and safety. Regulation 9 (1) (b) (i) (ii) of the Health and Social Care Act 2008 (Regulated Activities).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The provider had not ensured people were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them arising from the maintenance of an accurate record in respect of each person which includes appropriate information and documents in relation to their care and treatment. Regulation 20(1) (a) of the Health and Social Care Act 2008 (Regulated Activities).