Care Quality Commission

# Havering Care Homes Ltd

# Upminster Nursing Home

## Inspection report

Clay Tye Road
Upminster, RM14 3PL
Tel: 01708 220201
Website: www.haveringcare.co.uk

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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? | Requires improvement |
| Is the service well-led? | Requires improvement |

## Overall summary

This unannounced inspection took place on 23 February 2015. Upminster Nursing Home provides accommodation and nursing care for up to 35 older people, some of whom may have dementia. There were 25 people living at the home when we visited. The home was based in a large purpose built building and the bedrooms were on four floors. The communal rooms were on the lower ground and ground floor.

The last inspection was on 1 November 2013, when we judged that the service was meeting the regulations we looked at.

The home had a registered manager at the time of the inspection. 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.

People told us they felt safe in the home. The provider took appropriate steps to protect people from abuse, neglect or harm. Training records showed staff had received recent training in safeguarding adults at risk.

Care plans showed staff assessed the risks to people's health, safety and welfare. However where risks were

# Summary of findings

identified, the actions to minimise these were made as general statements and not as measurable actions. People were not protected as well as they could be because actions had not been taken to minimise falls.

We observed that the provider did have a system to assess and monitor staffing levels in relation to people's needs but we saw appropriate staffing levels were not provided at all times to meet the needs of people who used the service.

People were supported by staff to take their medicines when they needed them. They were protected against errors in medicine administration by the steps the provider had taken.

We saw the home was generally clean and free of malodours. We did see some chairs had torn material and bed rail protectors were ripped; these may be difficult to keep clean because of the damage seen.

People were cared for by staff who received appropriate training and support. Records showed there was an annual training programme in place, and most staff were up to date with their training programme. Information showed supervision should take place quarterly, although not all the staff we spoke with were aware of this. The recruitment processes were appropriate, in that staff were appointed following an application form, interview, criminal record checks and suitable references.

The service had not taken appropriate action to ensure the requirements were followed for the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). These safeguards ensure that a service only deprives someone of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them.

People were supported to eat and drink sufficient amounts to meet their needs.

People were supported to maintain good health by having access to healthcare professionals.

Overall, we saw people being treated kindly by staff. People were happy with the care they received, but we also heard from other family members and a visitor who were not so happy with the care given by staff. It was evident from our observations the staff knew the people they were caring for and their preferences.

But at times, staff did not explain what they were doing and did not engage in a meaningful way with the person. We heard staff speaking loudly and in harsh tones on several occasions.

Staff carried out half hourly checks on people who were staying in their rooms, as well as comfort rounds each hour. Almost all people had a call bell close by when they were in their bedrooms, although we saw five people who were in bed did not have a call bell within reach. We did hear several people continually calling for a nurse for help and although staff did attend to them we observed at times there could be a delay for up to 15 minutes.

A pre assessment visit was carried out before a person came to live at Upminster Nursing Home. This was followed with a longer and more detailed assessment when the person moved in. As far as possible where a person had capacity and family that could help, they were encouraged to be part of the assessment and care planning process.

We observed people's dignity was maintained when staff were caring for peoples personal needs. We heard people spoken to in a kind manner as the staff assisted them and being treated with respect most of the time, but we also observed a person being ignored when they tried to engage with staff. People were not always given the opportunity to develop positive relationships with staff and other people at the home.

The service employed an activities coordinator. The coordinator was not on duty on the day of our visit and the manager told us staff had been organising activities while the coordinator was absent and at weekends but we did not see any evidence of this. People were involved in the development of the new dementia friendly garden but told us access to the garden was restricted and they could only go out when a member of staff escorted them. The manager said they would review this arrangement.

The provider had arrangements in place to respond appropriately to people's concerns and complaints. People we spoke with were confident to raise any concerns with either the nurse in charge or the manager.

Complaints were dealt with in a timely manner.

The provider did not have effective systems in place to assess and monitor the quality of the service. The provider commissioned an external organisation to carry

# Summary of findings

out unannounced quality assurance visits on a quarterly basis. However, there was a lack of evidence to demonstrate the service had responded to their recommendations.

The provider conducted half yearly surveys with people and relatives and a telephone monitoring survey, where relatives and friends of a person were contacted for feedback on the care provided. Overall the feedback from all the surveys seen was positive. Action plans had been developed to address any issues mentioned but there was no evidence that the action plans were met, how they were shared with people and staff or whether the impact of any changes had improved services for people.

The manager also undertook unannounced night visits, to ensure the quality of service was maintained at night and to have the opportunity to speak to night staff, who may not be available during the day for a meeting.

The registered manager had regular meetings between the home's owners; these meetings ensured the manager was up to date on any issues or changes that may affect the running of the home.

We observed staff were supportive of each other and the atmosphere in the home was friendly. However we did not see any evidence that staff were empowered to contribute to the running of the service, through team meetings, information sharing or the development of the service provided.

# 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. The provider did not ensure that there was enough staff at all times to care for and support people and to meet their needs.

People were kept safe from injury and harm by regular assessments of risks in relation to their care; however the actions staff needed to take to minimise these risks were not always clear.

The provider checked the environment and equipment regularly to ensure these were safe and did not pose a risk to people. But there was a lack of actions and details in the risk management plans as to how any findings would be addressed.

People were supported to take their medicines safely and were protected against errors in medicines administration by the steps the provider had taken.

**Is the service effective?**

**Requires improvement**

The service was not always effective. Staff received regular training and had the knowledge and skills to support people who used the service, but we did not always see this put into practice.

People were supported by staff to eat well and to stay healthy. Healthcare professionals were available when needed to support people stay healthy and well.

We found the location was not meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

**Is the service caring?**

**Requires improvement**

The service was not always caring.

Staff did not always ensure people's dignity was respected. At times, the care people received tended to be task led rather than according to their needs. We heard staff speaking loudly and in harsh tone on several occasions.

Call bells were not always within reach of people so they could summon help when they needed this and these were not always answered within a reasonable time.

**Is the service responsive?**

**Requires improvement**

The service was not always responsive. Care plans were developed after people's needs were assessed and were generally comprehensive and tailored to a person's individual needs.

# Summary of findings

The service employed an activity coordinator and the manager told us staff organised activities when the coordinator was off and at weekends but we did not see any evidence of this on the day of our visit.

We saw and people told us that most of their concerns and complaints had been dealt with appropriately.

**Is the service well-led?**

**Requires improvement** 

The service was not always well led.

The provider commissioned an external organisation to carry out unannounced quality assurance visits. However, there was a lack of evidence to demonstrate the provider had responded to the recommendations reported.

Overall the feedback from all the surveys seen was positive.

We observed staff were supportive of each other, the atmosphere was friendly, with staff communicating openly with each other and with management.

The home had a registered manager in post who was clear about their role and responsibilities.

# Upminster 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 23 February 2015 and was unannounced. It was carried out by an inspector and a specialist advisor who was a qualified nurse and a lead person in safeguarding adults at risk. Before the inspection, we reviewed information we had about the service such as notifications the service was required to send to the Care Quality Commission (CQC).

During our visit we spoke with 11 people living at the home, three relatives, one nurse, four care staff, and three ancillary staff. We spoke with the manager and a director of the provider company. We also spoke with four visiting healthcare professionals including a GP, two physiotherapists and a tissue viability nurse (TVN). We observed care and support in communal areas. To do this 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 looked at the care records for 11 people. We also looked at other records related to how the home was managed including the quality assurance audits the manager and provider completed. We also reviewed six staff employment files and the training records for all staff employed at the home. We reviewed medicines records for all the people living at the home.

Requires improvement

# Is the service safe?

## Our findings

People told us they felt safe in the home. One person told us, “The staff are kind.” A visitor said, “It’s a nice atmosphere here.” One visiting professional said they had never seen anything to cause them concern at the home, but if they did they would report it at once to the manager or to the local authority. The provider took appropriate steps to protect people from abuse and there were policies and procedures available to staff which set out how they should do this. Training records showed staff had received recent training in safeguarding adults at risk. Staff knew and explained what safeguarding meant and could give examples of what would constitute abuse. For example, a staff member said "if I saw a person being treated rough, I would report it to the nurse in charge". Another staff member said she had recently completed her safeguarding and Mental Capacity Act training. Where there had been safeguarding concerns about a person, the provider had worked with the safeguarding team from the local authority to deal with these appropriately.

Care plans showed staff assessed the risks to people's health, safety and welfare. Records showed these assessments included details of a person’s mobility, dexterity, continence and nutrition and skin viability. A mental capacity assessment and a bed rail assessment were also included. However where risks were identified, the actions to minimise these were made as general statements and not as measurable actions, so staff were not clear of what they needed to do to keep people safe. For example where a person had been identified as being at risk of falls, the action in the risk management plan was to monitor the person but there was no mention of how often or what preventative measures should be put in place.

We reviewed the accident and incident folder and found forms were completed as required. Where a person had several forms completed, staff completed a risk assessment which reflected the person’s on-going risk. However the risk assessments were not clear what action staff needed to take to minimise subsequent accidents such as falls.

The lack of actions and details in the risk management plans was also noted from a recent quality assurance visit by the provider in December 2014 where no action had been taken to address the findings. Records also showed one person liked to have a bath but had only received bed baths because the hoist needed to assist the person would not go under the bath. We checked the bath hoist and found it was faulty and reported this to the manager and director who were unaware of this fault. This lack of attention to risks meant that people were not protected as well as they could be and actions had not been taken to address issue of risk that had arisen. This was a breach of Regulation 9 and 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the provider did always ensure that they took appropriate action to reduce the risks of the spread of infection. We also saw a few chairs had torn material and bed rail protectors that were ripped. These may be difficult to keep clean because of the damage to them, where dirt could accumulate. We also observed four members of staff wearing jewellery on their fingers and or wrists which could pose a risk in relation to the spread of infection. We saw infection prevention and control was part of the mandatory training, which staff had attended. Audits of infection control were also undertaken by an external organisation as part of the provider’s quality assurance measures. However, our findings showed that these measures were not that effective in identifying the issues we found during the inspection so appropriate action could be taken to address these. We spoke to the manager about the wearing of jewellery in work and they said this would be addressed with staff and stopped. Torn or damaged material on items would also be replaced.

We observed that the provider did have a system to assess and monitor staffing levels in relation to people’s needs but we saw appropriate staffing levels were not provided at all times to meet the needs of people who used the service. We received comments from people that would suggest there were not always enough staff to meet their needs. One person said, "The staff are alright, but there isn’t enough of them." Two people said they had to wait a “long time” to be cared for at night. We checked the rota and saw three staff (one registered nurse and two care staff) were on the rota for the past seven nights, which the manager confirmed. These three staff worked across the four floors.

There was usually one registered nurse (RN) and six care staff on day duty. On the day of our visit the service was one care worker short, as they were off sick. The home did not

Requires improvement

# Is the service safe?

use agency staff and were reliant on their own staff to cover shifts, including emergency cover. Whilst this helped to ensure a consistency of staff, this also meant that on the day of our visit the service operated with less staff than the set staffing levels. There was no evidence that the provider had assessed the staffing requirements for the service, whether at night or during the day, and kept the staffing levels under review in line with the needs of people who used the service. We spoke to the manager about the staffing levels and the changing needs of the people, they said that staffing levels would be reviewed and changes made.

We looked at six staff files and saw appropriate recruitment processes and checks, including references and criminal record checks had been carried out. There was also evidence of staff disciplinary procedures, where actions were taken by management to ensure staff had additional training and support to help them with their role and to ensure people's safety.

People were supported by staff to take their medicines when they needed them. The service used an electronically linked medicines administration system, which allowed external monitoring of the process and helped to act as a failsafe against errors, as it triggered an alert if a medicine dose was missed.

We arrived at 9am and found the 8am medicines round had been completed. The nurse said "We aim to give medicines promptly as it can affect people if there is a delay." We inspected the medicines trolley and found it to be neat and tidy and the medicines tray for each person was appropriately sectioned by the time of day medicines were due (morning, afternoon, evening and night). We reviewed the medicine administration record (MAR) charts for all 25 people. The charts were up to date and medicines were signed for correctly. Controlled drugs were safely stored. These were checked weekly and there was documented evidence to support the weekly checks. The above shows that people were protected against the risks associated with medicines administration by the steps the provider had taken.

One person told us "They clean my room every day and wash my clothes. It's very clean here." The home had two domestic staff on duty each day as well as a housekeeper. Bedrooms, bathrooms and communal areas were cleaned each day and checked by the housekeeper. We observed the carpet in a bedroom being cleaned and the person who was in bed being reassured by staff about the noise of the machinery. The laundry room was well organised with clear procedures for dirty and clean laundry. Staff understood the temperatures required for washing bedding to help prevent the spread of infections.

We saw the home was clean and free of malodours; except for one bathroom that was out of use. The manager told us they had a flooding problem with the shower and this was being investigated. They said the fault would be corrected as soon as possible.

Requires improvement

# Is the service effective?

## Our findings

The service had not taken appropriate action to ensure the requirements were followed for the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). These safeguards ensure that a service only deprives someone of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. The care plans we reviewed all contained a record of a mental capacity assessment in relation to people making decisions about their care. These were completed appropriately, dated and signed. However they had not been updated to take into account people's changing capacity to make a decision at a specific point in time. We discussed this with the nurse on duty and asked if the service had considered applying for a deprivation of liberty safeguard (DoLS). Staff did not fully understand how or when to apply for a DoLS assessment. The manager said they would take further advice from the local authority to ensure a person's liberty was not restricted and the correct procedures were followed. This lack of arrangements to ensure DoLS requirements were being met meant that people were not protected from the risk of being deprived of their liberty inappropriately. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were cared for by staff who received appropriate training and support. Records showed there was an annual training programme in place. The training records we looked at showed most staff were up to date with their training programme. We were told by the manager there was a training programme considered mandatory by the provider, every year for staff which lasted for two days and was designed so staff had the skills to meet the needs of people who used the service. Two care staff were scheduled to attend a training day in the week we visited, but were unable to tell us what topics were being covered. On asking the manager we found the topic was entitled "innovation". We saw the mandatory training dates were booked for the year ahead, but staff we spoke with were not always aware of these dates.

We spoke with two care staff that started working at the home recently. Both said they had received an induction pack with lots of information, but they were not clear about the sign off process and when they were expected to complete their induction by. The manager said the induction should be completed within a month of starting, although this could vary depending on the individual.

We asked how staff competency was assessed and a care staff member told us they received monthly supervision from a registered nurse and were observed undertaking duties to ensure they were competent. Information we saw showed supervision should take place monthly with the manager supervising the nurses, and the nurses supervising the care staff, although not all the staff we spoke with were aware of this. Of the six staff files we looked three had evidence of supervision taking place. We have since been informed that supervision takes place quarterly, however when we spoke with the manager about staff being unaware of training and supervision dates, they said they would ensure that staff knew these dates in advance so they could prepare for the training and supervision. Staff said knowing these dates in advance could help them prepare for and benefit more from the training and supervision, which they said would have a positive effect on their care delivery.

People were supported to eat and drink sufficient amounts to meet their needs. One person said "The grub is ok, the food is good here." Other people told us they could choose their meals and one said their wishes were respected in relation to their meal choices. People told us what they had eaten for breakfast and said they were happy with the portion sizes. Although another person complained that the tea cups were too small and only half full. They understood it was for safety so that people did not scold themselves. In response to the complaint, staff had started to offer two cups of tea, which the person was satisfied with.

The majority of people in their bedrooms had drinks within reach but we did see that three people on the lower ground floor did not. Staff explained these people would not be able to access a drink independently and would be assisted with this. Staff when asked did not say how often they would offer fluid to a person unable to help themselves. We spoke to the manager about this and they said this would be rectified so that people would be offered a drink each time staff popped in to see them.

We looked at the menus, which varied for each week in the month. We observed staff sitting with people to help them choose their meals. The menu was colour coded to help

Requires improvement

# Is the service effective?

identify those requiring a special diet, such as vegetarian, pureed, soft or a diabetic diet. We reviewed the menu feedback survey and responses varied. Some people felt the portion sizes were too small, while others thought they were too large. Changes had been made to the menu based on people feedback, for example, trifle was removed and then reinstated based on the feedback received from people. People received a choice of food and the provider responded to peoples comments about the food.

People were supported to maintain good health by having access to healthcare professionals. We spoke with a visiting GP, who visits the home at least once a week; they said they had been treating people at the home for over 10 years. They felt staff were knowledgeable of people's needs and were able to carry out their role effectively. We spoke with the tissue viability nurse (TVN), who was treating a person at the home. The TVN was positive about the service and the staff. The TVN said if she was worried she would speak to the manager or senior nurse. Another visiting professional said, "Staff don't have enough time to deal with some people who have behaviours that challenge." They also told us they were unable to have access to the care plans of the person they were visiting or to write in them but had to write separately on paper that was then inserted into the care plan. Each person's file has a section for multidisciplinary team (MDT) visits and reviews. By healthcare professionals not having access to a person's care plan may mean that information relevant to the person is not shared with other professionals. The manager when asked was not aware of this practice and said in future healthcare professionals would have access to the care plans of the people they were visiting.

Requires improvement

# Is the service caring?

## Our findings

Overall, we saw people being treated kindly by staff. People told us “Staff are not too bad” and “You can communicate with staff, they are very polite,” and “Staff are kind.” One family member said, “I can’t sing their [staff] praises high enough, you get some good banter here.” A visiting friend said, “Staff are caring and they are careful with people.” But we also heard from other family members and a visitor who were not so happy with the care given by staff. We observed the care given tended to be task led. Staff did not explain what they were doing and did not engage in a meaningful way with the person. The staff spoke to each other when dealing with people and not always to the person they were assisting. We heard staff speaking loudly and in harsh tones on several occasions, for example, a staff member calling out “I’ll do [X],” and “Just do [X] at the table” when talking about helping a person to eat and talking to other people and not the person they were helping. We saw another staff member sitting with a person and helping them with their lunch, but then the staff member got up and walked away and then came back again without telling the person what they were doing. They did not ask the person if they had had enough to eat but took the plate away without asking or saying what they were doing.

Staff carried out half hourly checks on people who were staying in their rooms, as well as comfort rounds each hour. We asked if the regular checks made a difference to people and the staff said it was important they checked people were comfortable. Some people we asked were unable to comment about the regular checks, but others said, “Staff are in and out all day and they are easy to talk to.” Almost all people had a call bell close by when they were in their bedrooms. We saw five people on the lower ground floor who were in bed did not have a call bell within reach. One person told us their call bell keeps falling out (of the wall), and no one had come to fix it yet. They felt worried when this happened, as it meant they could not use the call bell and were left waiting for the next comfort round before someone came to them.

We heard several people continually calling for a nurse for help and although staff did attend to them we observed at times there could be a delay of up to 15 minutes. On one occasion when no staff were on the same floor as a person who was calling out for assistance and they were unable to press their call bell, we pressed it for them and staff attended. When we asked a staff member why the person kept calling out they replied "[X] is always like that" and indicated the person had dementia. We asked staff how they managed consent for people with dementia, one staff member said they explained to the person what they intended to do before carrying it out. Training records showed staff had received dementia awareness training.

The layout of the main lounge, with chairs around the edge of the room in a semi-circle did not encourage small group or one to one conversation. There was a television in the room which was on the whole time during our visit. One person said “I prefer to stay in my room, they [other people] just stare at the TV, and no one really talks to each other." We also observed a person being ignored when they tried to engage the staff in a game the staff member had initiated. The above shows that people were not always treated in a caring way and were not always given the opportunity to develop positive relationships with staff and other people at the home. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite our observations above we observed people’s dignity being maintained when staff were caring for their personal needs. We heard many people spoken to in a kind manner as the staff assisted them and staff treating people with respect at those times. We also saw staff knew the people they were caring for and what their preferences were. For example, when helping a person with dementia to make a menu choice, the staff member knew the person’s preferences and helped them choose that preference; this was also documented on the summary plan about the person.

One person told us they like to choose what they wear each day and how they spent their day and staff helped them to do so. Another person said their television had a remote control and they could choose what they wanted to watch. People were involved in the development of the new dementia friendly garden. They were asked what having a garden meant to them and which flowers they liked. Their discussions were recorded and made into a DVD for them and their relatives to keep. The garden was created based on people’s preferences. For example a dementia specialist horticulturalist had planted thorn free roses, which helped to minimise the risk of thorn injury.

Requires improvement

# Is the service responsive?

## Our findings

A pre assessment visit was carried out by the manager or senior staff before a person came to live at Upminster Nursing Home. This was followed up with a longer and more detailed assessment when the person moved in. We saw that on the whole care plans were comprehensive and had considered who the person was, their background, life style, knowledge and wishes of how they would like to be cared for. This information was used to build a care plan that was tailored to a person's individual needs. As far as possible where a person had capacity and family that could help, they were encouraged to be part of the assessment and care planning.

The service employed an activity coordinator Monday - Friday 11 - 4pm. The activities coordinator maintained their own records for each person; these showed the visits they had made to people and what activity was offered, according to the persons preferences. For example, the coordinator sat with one person in their room to select their favourite television programmes for the day from the TV times. Another record showed the coordinator had worked with a group of people making items for Valentine's Day. The manager told us staff organised activities when the coordinator was off and at weekends but we did not see any evidence of this. We were also told outside entertainment came to the home but people were only able to tell us about the church services which were held each month.

People told us "I like to listen to the radio, but the television is always on" and "There is no entertainment here" and "I would like to go out but there is no-one to take me." Another person told us about the bingo games they played and the knitting they did. We saw some people had a daily paper or a crossword puzzle book. There was a bookcase with books in the lounge but these were inaccessible as the spare wheelchairs and walking frames were stored in front of them. This meant some people did not have as much choice in the activities they would like to engage with. We spoke with the manager about the lack of activities on the day of our visit, about the books being inaccessible and the television being on all the time. They said that staff were very busy that day as they were one staff member short and there were several visits from healthcare professionals that needed their attention. They did say they would ensure the books were made available to people and consideration would be given to people who wanted to listen to the radio or music.

People told us access to the new dementia friendly garden was restricted and they could only go out when a member of staff escorted them. People said their relative or visitors were not allowed to assist them into the garden. Once a person was outside staff would leave them alone to enjoy the garden. One person said they would like to visit the garden, but the service did not have a wheelchair suitable for them, as they were unable to sit upright.

We saw that the garden had only recently been developed and individual risk assessments had not been put in place to assess whether a person either alone or with family could access the garden without staff. We asked the manager about this and they said that ensuring a person was safe from falls was their main priority but they would risk assess people and ensure any additional safety precaution were put in place to allow people to use the garden when they wanted to. We also spoke to the manager about the lack of a suitable wheelchair for one person and they said this was an on-going issue that they were trying to resolve.

The provider had arrangements in place to respond appropriately to people's concerns and complaints. People we spoke with were confident to raise any concerns with either the nurse in charge or the manager. They said the manager had an open door policy and would address any concerns immediately, once they were bought to their attention. One person told us about a recent complaint they had made to the senior nurse and they were happy with the way the complaint was addressed and they felt they had been listened to. The manager told us they give feedback to staff following a complaint if appropriate. From the records we saw the provider had received a number of complaints in the past year. The manager responded to complaints within the timescales as stated in the complaints procedure, except where there were mitigating reasons such as when complaints were also part of safeguarding referrals.

Requires improvement

# Is the service well-led?

## Our findings

The provider did not have effective systems in place to assess and monitor the quality of the service. The provider commissioned an external organisation to carry out unannounced quality assurance visits on a quarterly basis. Their feedback included a report of their findings and recommendations. However, there was a lack of evidence to demonstrate the service had responded to the recommendations. Although we were told by the manager the recommendations were always acted on immediately. For example, the last monitoring visit occurred in December 2014. Five recommendations were made: risk assessments required strengthening with actions to be taken, care plans needed to be more consistent, risk assessments and audits needed to be undertaken, with evidence of them to be retained, pedal bins to be purchased for all bedrooms and bathrooms and conservatory to have heating.

We did not see an action plan for how these recommendations would be implemented. However from our observations it was evident pedal bins had been purchased for all bedrooms and bathrooms and the conservatory was now heated. We could not evidence that action had been taken against the other recommendations. This meant that the quality assurance systems were not robust enough to provide audit trails to show that actions had been taken to improve the service where areas for improvement were identified

The provider conducted half yearly surveys with people and relatives. Analyses of the people and relatives surveys were not available at the time of the visit and were emailed to us after the inspection. The surveys covered January to December 2014, a total of 12 people had returned the questionnaires and the majority of replies to the questions were either very satisfied or satisfied.

The provider also conducted a telephone monitoring survey, where relatives and friends of a person were contacted for feedback on the care provided. We saw the results of these calls, although the forms were not dated, so it was unclear when the surveys were conducted. Overall the feedback from all the surveys seen was positive. Action plans had been developed to address any issues mentioned, such as replacing carpets in the communal area; ensuring families were involved in the care planning process and considering new name badges. But there was no evidence that the action plans were met within the identified timescales, how it was shared with people and staff or whether the impact of any changes had improved the services for people. This may mean that people and families were not always aware of improvements or changes that had occurred as an outcome of their comments.

The manager also undertook unannounced night visits, to ensure the quality of service was maintained at night and to have the opportunity to speak to night staff, who may not be available during the day for a meeting. However although the date of the visits was documented, the findings and any actions arising from the visits was not. We spoke with the manager about this and they said in future they would document their findings on night visits.

The home had a registered manager in post and one of the senior nurses acted as the deputy manager. There were regular meetings between the home's owners and the registered manager and we saw the minutes of these. These meetings ensured the manager was up to date on any issues or changes that may have occurred that could affect the running of the home.

We observed staff were supportive of each other, the atmosphere was friendly, with staff communicating openly with each other in a non-threatening way. Staff said they were a 'good team' and they 'worked well together'. Staff said the manager had an open door policy and she was easy to talk to if they had concerns. Similarly, the care staff also found the nurse in charge to be supportive. During our visit one of the directors of the company was on site, we observed staff knew who they were and were happy to speak with them.

We saw the minutes of the last team meeting held in October 2012. Two staff told us staff meetings were not being held. We did not see that the views of staff were gathered to help in developing the service, although some staff spoke about a staff survey, they could not remember when it was nor had they seen the results of it. The lack of team meetings, information sharing and involvement of staff in the development of the care provided may mean staff were not empowered to contribute to the running of the service and did not have a forum where they could share their views about the service.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>People who use services were not protected against the risks of inappropriate care and treatment by means of the planning and delivery of care to meet the service users' individual needs and to ensure the welfare of the service user and ensuring the premises were safe to use for their intended purpose.<br>Regulation 12(1)(2)(a)(b)(e) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br>The provider did not have suitable arrangements in place for obtaining and acting in accordance with the consent of people who use services in relation to the care and treatment provided for them.<br>Regulation 11(1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect<br>People who use services were not treated with respect and dignity at all times while they are receiving care and treatment.<br>Regulation 10(1)(2)(b) |