Tamaris Healthcare (England) Limited

# Victoria Lodge Care Home

**Inspection report**

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Date of inspection visit: 11 and 12 February 2015
Date of publication: 14/05/2015

## 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

Victoria Lodge Care Home provides accommodation and nursing or personal care for up to 46 people. It is a purpose-built care home with two units. The ground floor unit provides care for younger adults who are physically disabled and the first floor provides care for frail older people, some of whom may be living with dementia. At the time of this visit the ground floor unit was full with 16 people and there were 21 people living on the first floor unit.

The last inspection of this home was carried out on 20 August 2013. The service met the regulations we inspected against at that time.

This inspection took place over two days. The first visit on 11 February 2015 was unannounced which meant the provider and staff did not know we were coming. Another visit was made on 12 February 2015.

The home did not have a registered manager at the time of this visit. The former registered manager had

# Summary of findings

voluntarily cancelled their registration in December 2014. A new manager had recently commenced working at the home and was going to apply to be registered as the 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.

During this inspection we found the provider had breached a regulation relating to the support and development of staff. This was because some staff had not received supervision or appraisals so they were not being offered support in their role. Also some staff had not been provided with training relevant to the needs of people who lived at the home. The provider had also breached a regulation relating to accuracy of care records. This was because some care records did not reflect the specific needs of people who used the service. You can see what action we told the provider to take at the back of the full version of the report.

People said they felt safe and comfortable at the home. Staff knew how to recognise and report any suspicions of abuse. Staff told us they were confident that any concerns would be listened to and investigated to make sure people were protected. Potential risks to people's safety were assessed and managed. People's medicines were managed in a safe way.

People told us there were enough staff to meet their care needs. Most people felt staff came quickly when they requested support, but a small number felt staff did not attend to them in a timely way. The manager was going to look into how staff were deployed. Staff were recruited in a safe way so that only suitable staff were employed.

Staff understood the Mental Capacity Act 2005 for people who lacked capacity to make a decision and deprivation of liberty safeguards to make sure they were not restricted unnecessarily. People's safety was protected without compromising their rights to lead an independent lifestyle. Staff told us people had choice and control over their own decisions and lifestyle.

The building was designed to meet the needs of the people who lived there. Many people on the ground floor were living with significant physical disabilities and the accommodation was equipped to support their needs. There were some decorative shortfalls to bathrooms on both units which were in need of refurbishment. The regional manager said the funds to address these items had already been requested from the provider.

The people we spoke with felt staff were competent in their roles and they supported them in the right way. People's comments included, "They know the job" and "they are very good". People were supported to eat and drink enough to meet their nutrition and hydration needs. The menus were repetitive, but people told us they could ask the cook for alternative meals if they did not fancy the two main dishes at each mealtime. Dietetic services told us the staff were good at managing the specialist tube-feeding methods of those people with significant physical disabilities. Any changes in people's health were referred to the relevant health care agencies.

People had positive comments about the "caring" staff. Many people described the care staff as "kind". When asked about the care they received people commented, "I am really happy with it" and "I like this place, they do their best for us". Relatives were also positive about the care people received. People and relatives felt the home was friendly and welcoming.

People and relatives told us there was a good range of activities at the home. Staff made sure people had the chance to go out shopping or to local places, including the church and pub. People had information about how to make a complaint or comment and these were acted upon. People and relatives said they could approach the new manager at any time and said she was approachable.

People and relatives felt the service was well run. One visitor commented, "The service is well managed for my [relative]." People felt they were asked for their views and opinions and there were regular residents' meetings.

Staff told us they felt the manager was approachable and open to their views. There were regular staff meetings for staff to be kept informed of the standards of care and expected practices. The provider had a quality assurance programme to check the quality of the service, but commissioners had identified several gaps in records,

# Summary of findings

training and support of staff. The new manager had begun to address these shortfalls but it was too early to check whether the planned improvements would be effective.

# 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?**

Good

The service was safe. People said they felt safe living at the home and comfortable with the staff who supported them. Staff knew how to recognise and respond to abuse in the right way.

There were sufficient staff to meet people's needs. The home only employed staff who had been vetted to make sure they were suitable to work with vulnerable people.

Staff managed people's medicines in a safe way.

**Is the service effective?**

Requires improvement

The service was not always effective. Staff had not had regular training, supervision or annual appraisals so had not been supported with their professional development.

People felt their needs were met and were positive about the support they received from staff. People were supported to eat and drink enough to maintain their nutritional health.

Staff understood how to apply Deprivation of Liberty Safeguards (DoLS), where applicable, to make sure people were not restricted unnecessarily, unless it was in their best interests.

**Is the service caring?**

Good

The service was caring. People and their relatives felt staff were caring and kind. They described the home as a very sociable place and said it had a good atmosphere.

People said they were able to make their own decisions and choices and to lead their own lifestyle.

People were supported with their personal appearance. Staff understood how to support people in a way that upheld their dignity and privacy.

**Is the service responsive?**

Requires improvement

The service was not always responsive. People's care records did not always include information or guidance for staff about their specific needs.

There were meaningful activities for people to participate in, either individually or in groups, to meet their social care needs. There were good opportunities for people to go out in the local community.

People knew how to make a complaint or raise a concern. They were confident these would be listened to.

# Summary of findings

**Is the service well-led?**

The service was not always well-led. People's safety was monitored and the provider checked the quality of the care at the home. However, we found some shortfalls had not been fully addressed yet by the provider.

People and relatives said the home was well managed. The home did not have a registered manager because they had left. People and staff said the new manager was approachable.

People and relatives said they were asked for their views and could make suggestions about the service.

**Requires improvement**

# Victoria Lodge Care Home

**Detailed findings**

## Background to this inspection

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

This inspection started on 11 February 2015 and was unannounced. The inspection team consisted of two adult social care inspectors, a specialist adviser 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. A second visit was carried out on 12 February 2015 by an adult social care inspector which was announced.

Before our inspection we reviewed the information we held about the service, including the notifications of incidents that the provider had sent us since the last inspection. We contacted the commissioners of the service, dietician services and the local Healthwatch group to obtain their views. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with 15 people living at the home and seven relatives and friends. We also spoke with the manager, a regional manager, three nurses, six care workers, an activity staff member and a member of catering staff. We observed care and support in the communal areas and looked around the premises. We viewed a range of records about people's care and how the home was managed. These included the care records of six people, the recruitment records of four staff members, training records and quality monitoring reports.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also joined people for a lunchtime meal in both units to help us understand how well people were cared for.

Good

# Is the service safe?

## Our findings

All the people we spoke with told us they felt safe at the home. When we asked them about this, their comments included, "It's lovely", "I am happy here" and "The staff are grand". One person said they felt safe with the staff but sometimes felt anxious when they were left alone on the toilet (which staff did to ensure their dignity). A relative told us their family member usually felt safe but became anxious at night because they did not always understand the accents of some night staff. We told the manager about these two comments so that she could look at how those people could be assisted in a way that reduced their anxieties at those times.

All the relatives and visitors we spoke with also felt people were safe at the home. For example, one visitor told us, "My [relative] is absolutely safe here. Nowhere is perfect but we are delighted with her care here."

All the staff we spoke with had a good understanding of safeguarding and how to report any concerns they had. Staff told us, and records confirmed, that they had completed training in safeguarding and whistleblowing. They were able to tell us about different types of abuse and were aware of potential warning signs. Staff said if they had any concerns they would report them immediately to the manager. For example, if they saw staff talking to somebody in an aggressive manner they would report it. One staff member told us they had reported concerns in the past and would be confident to do this again if necessary.

There was written information around the home for staff about the how to report any safeguarding concerns including the contact details of the local authority which takes the lead on any safeguarding matters. The provider had made three potential safeguarding referrals in the past year and had acted appropriately to address those matters. In this way the provider and staff at the home were aware of their responsibilities to safeguard the people who used this service.

Risks to people's safety and health were assessed and recorded in each person's care files. There were risk assessments about people's care needs, for example the potential for falls, pressure damage to their skin and using moving and assisting equipment. The risk assessments were reviewed each month. The provider also had a computer-based reporting system in place to analyse incident and accident reports in the home. This was to make sure any risks or trends, such as falls, were identified and managed.

Staff told us, and records confirmed that the home's maintenance member of staff carried out health and safety checks around the premises, including fire safety and hot water temperature checks. It was good practice that the home had a 'grab file' for any staff member to use in the event of an emergency in the home. The grab file included details of what to do and who to contact in the event of a flood, fire or staff absence. It also included the personal evacuation plans for each person who lived there.

We looked at whether there were sufficient staff to care for people in a safe way. People who were able to express their views and their visitors told us they felt there were enough staff to support them. One person said, "The staff come in my room not long after I press the button." On the first floor most people we spoke with felt there were sufficient staff. Their comments included, "There are plenty and they come quickly" and "Yes I have never noticed a problem, they come willingly and quickly". However some people felt that staff did not attend quickly to requests for support. For example, one person commented, "They don't come quickly; I can wait a long time." A visiting relative also commented, "They come quickly to begin with, then go away and she has to wait a long time before they come back." We told the manager about these comments so she could look at the deployment and practices of staff to make sure they answered people's calls as a priority.

The nurses we spoke with also felt there were enough staff on duty to meet people's physical and social needs and they were supported to maintain their independence. They described the staffing levels as "in the middle" and "just about right". There were two nurses, two seniors and five care workers on duty during the days of this inspection. Night staffing levels were one nurse and four care workers. Staff rotas showed this was the typical staffing at this home (despite a recent reduction in occupancy). The provider had recently introduced a new staffing tool, called CHESS, to determine the staffing levels. The new tool used the dependency levels of each person (for example, if they had mobility needs or were cared for in bed) to calculate the number of care and nursing staffing hours required throughout the day and night. The new staffing tool indicated that the staffing levels provided were sufficient.

Good

# Is the service safe?

We looked at the recruitment records of four staff members. We found that recruitment practices were thorough and included applications, interviews and references from previous employers. The provider also checked with the disclosure and barring service (DBS) whether applicants had a criminal record or were barred from working with vulnerable people. This meant people were protected because the home had checks in place to make sure that staff were suitable to work with vulnerable people.

The provider carried out monthly checks to make sure that nursing staff were registered with the Nursing and Midwifery Council (NMC). This helped to make sure people received care and treatment from nursing staff who were required to meet national standards and abide by the professional code of conduct.

There were vacant posts for registered nurses (of 60 hours a week). These hours were being covered by the existing nurses (including the manager), and by 'bank' nursing staff. The manager said staffing levels were safe, and that 30 nursing hours would be covered by a new deputy manager when one was appointed. There were contingency arrangements for staff absences although the manager tried not to use agency staff unless it was critically essential as they would not be familiar with people's needs.

People were supported with their medicines in a safe way. All the people we spoke with said staff made sure they took their medicines in the right way at the right times. One person commented, "They watch me take them." We saw staff gave appropriate support and time to people when offering them their medicines. We saw one person being offered one of their medicines before lunchtime, as was required in the person's care plan.

We looked at medication administration records (MARs) for six people. We saw the person's name was clearly written, as well as any known allergies. Medicine due times were clearly identifiable as was the prescribed dosage. We found no gaps in the MAR charts we checked.

The nurse on duty described the ordering, receipt and disposal of medication procedures. When new people moved to Victoria Lodge care home, the nurses contacted their GP to confirm the person's medicines. People's care records showed their medicines were reviewed by their GPs at intervals.

Requires improvement

# Is the service effective?

## Our findings

Staff completed computer-based training in mandatory areas of health and safety and care, such as fire safety, moving and assisting, infection control and food hygiene. However, some nurses had no recorded training in some specific areas of nursing care that affected people using the ground floor unit. For example, support with percutaneous endoscopic gastrostomy (PEG) which is a way of feeding through a tube directly into the stomach; multiple sclerosis; dysphagia or swallowing problems; and end of life care. Two nurses did not have recorded training in catheterisation. There was no record in the home of any training in these nursing care tasks for one nurse who carried out night duties.

We looked at how the provider supported the development of staff through supervisions. Supervisions are regular meetings between a staff member and their supervisor, to discuss how their work is progressing and where both parties can raise any issues to do with their role or about the people they provide care for. Nurses told us they felt they received support and supervision regularly. However we found that care staff did not have regular supervision which was contrary to the provider's own supervision policy. Many staff had not had an annual appraisal since 2013. This meant the provider had not made sure that the professional development of staff was supported or assessed. The regional manager confirmed that there had been gaps in the supervisory and appraisals of some staff. The new manager had designed a planner to ensure that supervisions for all staff were scheduled in for the remainder of the year.

These matters were in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with felt staff were competent in their roles. One person commented, "Yes, they know the job." Another person told us, "They are all good and are well trained." The new manager had begun to identify training needs and gaps in training records for staff. She had started to develop an annual training plan for group training through a local training agency for care providers (called Tyne and Wear Care Alliance).

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests'. The manager was aware of an important supreme court decision about DoLS to make sure people were not restricted unnecessarily, unless it was in their best interests. The staff had made three applications to the local authority in respect of people who needed supervision and support at all times. This meant staff were working collaboratively with the local authority to ensure people's best interests were protected without compromising their rights.

We saw that staff understood the importance of obtaining people's consent to their care. For instance, asking people for their agreement before supporting them with their mobility, using equipment or at mealtimes. Staff working on the ground floor described people as "living their own lives" and having "choice and control" over their own decisions and lifestyle. All staff had completed e-learning in MCA. People's care records identified where they could make decisions, or where they need support from other people, including advocates, for more complex decisions. This meant the provider was following the requirements of MCA.

The building was designed to meet the needs of the people who lived there. Many people on the ground floor were living with significant physical disabilities and the accommodation was equipped to support their needs. For example, level access into and around the home, wide corridors to allow two wheelchairs to pass with sufficient space, overhead tracking where needed for hoists and laminate flooring for easier manoeuvrability of wheelchairs. People on the first floor were older people, some with mobility needs. There was a lift to service the first floor, wide corridors assisted bathing and plenty of sitting spaces for people to choose from.

There were some decorative shortfalls to bathrooms on both units which were in need of refurbishment. Although these did not present a health and safety risk to people or staff, they did not promote the dignity of the people who used the service. For example, a ground floor shower room had no blinds or curtains, and the walls and flooring were scuffed. On the first floor the plastic wall covering to

# Is the service effective?

bathrooms were dented or torn and the flooring was heavily marked. The regional manager stated that a budgetary request had been forwarded to the provider for bathrooms to be redecorated.

People who were able to express a view told us their nutritional needs were met. Some people told us they could ask the cook for alternative meals if they did not fancy the two main dishes at each mealtime. For example, one person commented, "We get a choice for meals, but we can ask for other things if we want and the cook always tries to accommodate us." Another person told us, "It is a decent meal. They come with the menu in the morning, if I don't like it I ask for something else." Other people commented, "I fancied egg and beans and they did it for me" and "I like scampi and they do it for me".

People on both floors were offered the same menu, even though people on the ground floor were a younger generation. The menus were rather traditional and lacked variety. For example, desserts mainly consisted of rice pudding, tapioca, semolina or sponge. This menu might not reflect the age and preferences of the younger people on the ground floor, and might account for the number of individual alternative requests received by the cooks. We told the manager about this so she could make sure people's preferences were included in the menu selections. Menus were also very repetitive. For example, in one week the alternative choice at main meals was either sandwiches, toasties, buns, BLT or cheese on toast.

We joined people for a lunchtime meal in two of the dining rooms. The food was of good quality. There were pureed foods for people who needed their meals prepared in this way. The cook and staff were familiar with people's special dietary needs, for example if they required a 'soft' diet or were diabetic. People who needed physical assistance to eat their meal were assisted with this and staff were, in most cases, engaged with the person they were supporting. People's weight was monitored and recorded by care staff. The cook described how care staff would let them know if someone was losing weight so they could use fortified foods to help to build them up.

People had access to drinks throughout the day. We saw staff used a prescribed powder for people who needed their drinks to be thickened. But staff used the same person's powder for two different people. We told the manager about this who agreed to re-instruct staff about the making sure they only used people's individually prescribed thickening powders.

Community dietetic services felt the home staff were good at managing people's nutritional needs. A dietitian told us, "[Staff] have been trained on Malnutrition Universal Screening Tool and engaged with the process. Victoria Lodge engages with training when patients have feeding tubes in situ and are the first choice preference for when patients are discharged from hospital to a care home with a nasogastric tube in situ. Victoria Lodge also have several patients with a PEG (gastrostomy) tube. The home refers into our service appropriately."

On the day of this visit there was some misconception amongst staff that people could no longer order takeaway meals due to a change in the provider's policy about potential allergens. This compromised people's choice to purchase their own meals outside the home. However, the regional manager confirmed this could easily be resolved by asking the takeaway outlets to provide information on the ingredients of their dishes so that people could continue to order takeaways.

People felt the home staff supported them to access other health care agencies when needed. For example, one person told us, "They would get a doctor quickly if it was necessary." People's care records showed when other health professionals visited people, such as their GP, dentist, optician, podiatrist and dietitian. This meant that people received treatment when they needed it and were supported to maintain their health.

One relative of a person who was unable to communicate told us, "Staff are very familiar with what my [family member] needs. They always involve me in decisions about [their] care. They helped to get the GP to agree to an end care plan that means [the person] won't have to go to hospital and a palliative nurse would visit instead."

Good

# Is the service caring?

## Our findings

People had positive comments about the "caring" staff. Many people described the care staff as "kind". When asked about the care they received people commented, "I am really happy with it" and "I like this place, they do their best for us". Relatives were also positive about the care people received. One relative told us, "The family come every day. We are delighted with [their] care."

People and relatives felt the home was friendly and welcoming. One person commented, "The atmosphere is of a good, happy place." A visitor told us, "It's very pleasant. There is a good social atmosphere." There was a convivial, sociable atmosphere in the home. People and staff chatted and joked together. People were visibly relaxed and comfortable with care staff. One person described how she was teaching some younger staff members how to knit.

People said staff members tried to spend some time with them. One lady said, "They sit on my bed or chair and talk to me." A relative told us, "Staff do talk to [my family member] especially the activities lady." Two of the 15 people we spoke with felt staff did not have enough time to talk to them.

People felt they were treated with respect and dignity by staff. A relative also commented, "I have never heard anyone here treated otherwise." Another relative commented, "They treat her as family and have the patience of a saint, they are wonderful."

All the people we spoke with said that staff asked them for their permissions before helping them with anything. People said they were able to make their own decisions and choices and to lead their own lifestyle. One person said, "I do what I want when I want. I'm in control of my day. I can go out by myself to local shops or the pub or just watch TV in my room – it depends what I choose."

People were supported with their personal appearance. One relative told us, "The staff always make sure my [family member] is clean and comfortable." Staff were able to describe how they made sure people's privacy and dignity was respected when they were being supported. For example, making sure bathroom doors were closed when in use and knocking and awaiting permission before going into people's bedrooms.

People received gender-appropriate support with their personal care whenever this was practicable. For example, two men preferred the support of male staff with toileting, so when male care staff were on duty they were requested to support those people.

Relatives said they were consulted over care reviews and kept informed about care plans where this was appropriate. There was regular telephone contact between the home and relatives in the event of any changed conditions. Family members told us they were made welcome to call at the home at any time.

We saw that staff had good, warm relationships with people and they went about their work showing care and concern for people. For instance, we saw care workers took time to reassure people when they assisted in a hoist from their wheelchair to an armchair. The staff we spoke with were knowledgeable and respectful of people's individual needs, abilities and preferred daily lifestyles. One relative said, "They treat them as people, as human beings."

Requires improvement

# Is the service responsive?

## Our findings

We looked at the care records of eight people to see if these set out their individual needs and how they required assistance in a personalised way. The care plans did not always fully reflect the specific needs and support that people required, which meant that people's needs may be missed or overlooked. For example, the admission notes for one person stated they suffered from epilepsy. However there was no care plan for the person in relation to epilepsy and no record of their last seizure. There was no guidance for staff about what triggers to look out for or about the actions they should take in the event of a seizure. For another person their nutritional care plan did not include the fact the person had diabetes. The medicines care plan of another person did not mention their medicine for Parkinson's disease, which has to be given in a time-specific way. For some people there were no social care plans about their preferred activities and lifestyle.

There was not enough detail in the care records we saw to make sure that people received personalised care that was tailored to their specific needs. The lack of guidance about how staff should support people could lead to inconsistent practice. Daily notes were brief and information was about the basic care delivered. There were few records about interactions with each person, their well-being, mood or presentation. Some records were also difficult to decipher and had abbreviations, crossings out and correction fluid. This meant that it was not always possible to be clear if a person was appropriately cared for and supported because care records were not always accurate and complete. This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt the service met their individual needs. One person told us, "The nurses are on top of everything." A relative commented, "The nurses really know my [family members] needs very well and they can detect even the slightest changes in her." Another relative told us, "The staff are very familiar with what my [family member] needs. They always let me know if anything has changed and contact me if she's not well."

The staff we spoke with were able to describe each person's needs well. When asked how they obtained a history of each person the nurse on duty told us, "We talk to people about their life story and we involve their families." When asked how they supported people's independence a staff member told us, "We give people the chance to do things. For examples we give people time to wash their face independently, to make their own cup of coffee and wash dishes if they want to."

All the people we spoke to had positive views about the activities provided in the home. The home employed an activities co-ordinator who arranged a range of in-house activities in consultation with the people who lived there. For example one person told us, "I do knitting, baking and pamper sessions. We go out in the minibus, we went to the Glass Centre." People described frequent shopping trips to a large supermarket next door. A relative told us, "They have chit-chat mornings, and then staff take them across to the pub for lunch most Fridays. They go shopping and a group went on holiday to Haggeston Castle."

People told us the activities co-ordinator was "excellent" and "very good" at arranging events, but also at making sure people's individual interests were supported. For example, one person told us that they could no longer read so the activity co-ordinator read stories to them. The relative of someone who had significant physical and communication needs told us, "They try to involve my [family member] in everything, even though she can't take part in activities. They even arranged for her to go on holiday to Keilder last year."

People were given information in a welcome pack when they moved to the home. This included details of how to make a complaint. The complaints procedure was also displayed on the wall in the home's reception area. In this way, people and visitors had information about how to raise any complaints.

People said they would feel comfortable about making comments or complaints. People said they could discuss any issues with care staff but would make a complaint to the manager if necessary, and were confident she would act upon any concerns. One visitor told us, "She's a new manager but I would feel confident about approaching her about any issues." Another person told us, "I would be very comfortable about approaching the manager if I was not happy about something."

The provider kept a record of any complaints which included the details of any investigation and outcome. There had been six complaints received in the past year

Requires improvement

# Is the service responsive?

which related to a range of issues, such as nail care, maintenance of a wheelchair, attitude of a staff member and the return of clothes from the laundry. The records showed these complaints had all been investigated and appropriate action taken where necessary. The manager told us that any future complaints were going to be recorded on the provider's 'datix' system (a computer-based management reporting tool) so that the provider could analyse complaints for any trends and make sure that outcomes or actions were completed.

Requires improvement

# Is the service well-led?

## Our findings

There was not a registered manager in place at the time of this inspection. The former registered manager had voluntarily deregistered in December 2014. A new manager had recently commenced working at the home and was to apply for registration in due course.

The people and relatives we spoke with felt the service was well run. One visitor commented, "The service is well managed for my [relative]. The staff have been here a long time, they know their duties and are conscientious." People felt the service was improving, for example a relative said, "I was not impressed at first but it is better now."

People felt they were asked for their views and opinions. People told us there were regular residents' meetings. One person told us, "There are about five or six people go. I like the activities lady who takes it. They ask for our opinions and try their best." Relative also commented on their opportunities to contribute their comments and suggestions about the running of the service. A relative said, "We go to the monthly meetings, and the family come too. We asked about taking them on holiday and they took them."

Staff told us they felt the manager was approachable and open to their views. For example, one senior staff member told us, "I can speak to the manager. I feel listened to." Staff told us they felt supported by the manager. For example a nurse told us, "When the manager has time she is on the floor, asking if everything is alright." Another staff member commented, "The manager is very nice. She works the floor with us and I know I can knock on her door."

Staff meetings were used to support staff with expected standards. We saw minutes of the most recent staff meeting that had been held in January 2015 (and December 2014 for members of night staff). Staff said they were able to contribute ideas and suggestions for improvements within the home at staff meetings.

We saw that nurses had designated roles to champion and lead on the standards in specific areas of care, such as infection control and end of life care. However, the nurses we spoke with were not aware of their allotted lead roles so the potentially positive impact of these roles was lost. However the new manager was planning to re-establish these designated roles within the home.

The provider had a quality assurance programme which included monthly visits by the regional manager to check the quality of the service. We saw detailed reports of these visits and action plans and timescales for any areas for improvements. We saw the regional manager checked that any actions had been completed at the next visit.

The provider had systems in place to analyse incident and accident reports so it could make sure any risks or trends were identified and managed. There were also regular in-house audits, for example of health and safety and the medicines system. We noted that the last two dining experience audits (in June 2014 and February 2015) had identified a couple of areas for improvement, that is the menus should be on display and the cook should be present to ask people their views. However no actions had been set and the same issues were repeated at the next audit. This meant the quality assurance process had identified improvements but had not led to corrective practice. The regional manager agreed to look into this.

The home had been the subject of audits by health and social care commissioners. A joint monitoring visit by the Clinical Commissioning Group (CCG) and the local authority on 28 January 2015 scored the home 44% for the health commissioning standards. The main areas for improvements related to incomplete or out of date care records, poor dining experience and gaps in training and supervision of staff. The provider had started to carry out work to address these shortfalls, but it was too early to assess their effectiveness.

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>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>People were not protected from the risks of unsafe or inappropriate care and treatment because care records were not always accurate and complete. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>People were cared for by staff who did not receive sufficient training, supervision and appraisal to support them to deliver care and treatment to an appropriate standard. |