Care Quality Commission

Willover Property Limited

Stanley House

Inspection report

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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

Stanley House provides accommodation for people who require nursing and personal care. It is also registered to provide treatment for disease, disorder or injury and diagnostic and screening services.

This inspection took place on 1 and 2 April 2015. The first day was unannounced.

At our last inspection in March 2014 the service was meeting the regulations we inspected with regard to consent to treatment and record-keeping.

A registered manager was in place. 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 and associated Regulations about how the service is run.

Since our previous inspection in January 2014, we had received information from the local authority stating that a person living in the service did not have their dressings changed and that a staff member had abused another person.

The service was not following the guidance in people's risk assessments and people were at risk of unsafe care.

Summary of findings

This evidence constituted a breach of Regulation 12 (1) (2) (b) of the Health & Social Care Act 2008 Regulated Activities Regulations 2014. You can see what we have told the provider to do at the end of this report.

Staff had received training on how to protect people who used the service from abuse or harm. They demonstrated they were aware of their role and responsibilities in keeping people as safe as possible.

The safeguarding authority and the Commission had not been informed of situations of potential abuse to people which meant that monitoring action to prevent these situations had not been comprehensive.

Staffing levels needed to be reviewed to ensure people's needs were always met.

We found people largely received their prescribed medication in a safe way by staff trained in medication administration though medication had not been supplied as prescribed for one person.

Detailed risk assessments had not always been undertaken to inform staff of how to manage and minimise risks to people's health from happening.

Improvements in some aspects of caring for people with dementia were needed in terms of providing more stimulating activities and improving the environment.

The provider supported staff by an induction and some ongoing support, training and development. However, comprehensive training had not been provided to all staff.

The Mental Capacity Act (MCA) is legislation that protects people who may lack capacity to consent to their care and treatment. We found examples where the registered manager was following this legislation which informed us that people's capacity to consent to specific decisions had been assessed appropriately.

People who used the service had their dietary and nutritional needs assessed and planned for. People received a choice of what to eat and drink and staff supported them to maintain their health.

People who used the service and relatives told us they found staff to be caring, compassionate and respectful. Our observations largely found staff to be kind and attentive to people's individual needs though there were exceptions to this when staff had not communicated what care they were going to provide.

People who used the service were, as far as possible, able to participate in discussions and decisions about the care and treatment provided.

People who used the service and their relatives had been to share information that was important to them about how they wished to have their needs met.

The provider had internal quality and monitoring procedures in place. These needed to be strengthened to prove that necessary actions had been implemented.

The manager enabled staff to share their views about how the service was provided by way of staff meetings and supervision, although these opportunities had been infrequent.

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.

The safeguarding authority and the Commission had not been informed of situations of potential abuse to people which meant that monitoring action to prevent these situations had not been comprehensive.

Medication had not always been supplied as prescribed.

Staffing levels needed to be reviewed to ensure people's needs were always met.

Recruitment procedures designed to keep people safe were in place.

Staff were aware of how to report concerns to relevant agencies if the service had not acted properly to protect people.

Is the service effective?

Requires improvement

The service was not consistently effective.

Risk assessments were not fully in place to protect people health.

The provision of training to staff was not up to date to ensure all staff had the necessary skills and knowledge.

Staff were not aware of the process of assessing people's mental capacity to ensure people were always empowered to choose how they wanted to live their lives.

Staff received some supervision to support them to provide care to people, though this was not frequently provided.

People and their relatives reported that care was available when needed.

People reported the food was of good standard.

Is the service caring?

Requires improvement

The service was caring.

People and their relatives said staff were kind and caring, treated them with dignity and respected their choices.

Staff largely showed consideration for peoples' individual needs and provided care and support in a way that respected their individual wishes and preferences though this was missing on a small number of occasions.

People and their relatives reported they were involved in planning for their care needs.

Summary of findings

Is the service responsive?

Requires improvement 

The service was not consistently responsive.

Risk assessments of peoples' plans of care, needed to provide people with safe care, were not always in place for staff to follow.

Staff did not always have the most up-to-date information on people's needs as they had not read all of people's care plans.

People and their relatives told us that they had received care that met their needs.

Formal complaints had been investigated and a detailed response sent by management to these issues. Informal complaints had not been recorded and followed up in the same way so it could not be proved that action had been taken to resolve the issue.

Is the service well-led?

Requires improvement 

The service was not consistently well led.

Incidents involving people had been reported to us so that we could consider whether we needed to inspect the service to ensure it was meeting its legal obligations to keep people safe.

Staff told us the registered manager provided good support to them and had a clear vision of how quality care was to be provided to people.

People told us that management listened and acted on their comments and concerns.

We found out systems had been audited to try to ensure the provision of a quality service, though issues identified had not all been followed up.

Stanley House

Detailed findings

Background to this inspection

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

The inspection took place on 1 and 2 April 2015 and was unannounced. The inspection team consisted of two inspectors.

We also reviewed information we received since the last inspection including information we received from the safeguarding team from the local authority.

During our inspection we spoke with the registered manager, a visiting GP, a visiting podiatrist, the deputy manager, eight people that lived in the service, four relatives, one qualified nurse, four care staff and one domestic worker.

We observed how staff spoke with and supported people living at the service and we reviewed four people's care records. We reviewed other records relating to the care people received. This included the provider's audits on the quality and safety of people's care, staff training and recruitment records and medicine administration records.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires improvement

Is the service safe?

Our findings

People told us they had received their medication when they were supposed to get it. We observed staff supplying medication to people. This was carried out with a drink supplied to make the medication easier for people to take.

We checked medication systems and found them to be secure but not always well managed. For example, we found that a person had not been supplied with one medicine on one day because it had ran out. The manager said this would be followed up with staff and they would review the systems to ensure medication was to be ordered on time.

We also found that this anti-sickness medication had been supplied to the person four times a day, when the prescription stated it should have been supplied three times a day. The deputy manager stated this had been a mistake and she would follow this up with staff. This meant the person's health needs had not been met in a safe way.

We found that a number of people using the service were experiencing sore groins. We also found that a person had not had their cream applied as it was prescribed . This meant there was a risk that creams had not been administered as prescribed and that people could develop pressure sores as a result.

We saw that a person had been assessed as having a very high risk of developing a pressure sore. However, there was no specific risk assessment in place to prevent this from happening. The manager said this would be followed up to ensure their care was delivered in a safe way.

We saw another record where a person had been assessed as having challenging behaviour and had a risk assessment in place for anxiety. The risk assessment stated staff should liaise with the person's GP if she had regular episodes of this behaviour. However, there was no recording in place to indicate this referral to the GP had happened. This meant there was a risk to the person's safety and other people's safety as a result of the risk assessment not being followed.

This evidence constituted a breach of Regulation 12 (1) (2) (b) of the Health & Social Care Act 2008 Regulated Activities Regulations 2014.

People and relatives we spoke with told us they felt safe with staff that provided care. One person said: "I feel very safe here. Staff are very friendly and caring.'' A relative told us, "Yes, I feel that [my relative] is safe here. We know staff well and totally trust them, we have been visiting twice weekly for 3 years. We have recommended the home to other people."

We saw risk assessments in place in people's records of care we looked at. For example, there was a risk assessment relating to nutrition, falls, pressure sores, bedrails, continence needs and a behavioural risk assessment that included risks to the person and other people. A risk assessment that assessed how to support a person to move identified that a hoist was to be used together with specific slide? sheets and it also detailed the number of staff required to assist. This ensured the persons safety. Risk assessments had been reviewed monthly to ensure that they continued to meet people's needs.

Staff told us, and we observed that people in the main lounge area were always supervised. Some people in their bedrooms where able to use the nurse call system. People we spoke with told us that at busy times there could be delays of five to ten minutes, but staff always responded. We activated the nurse call in a bedroom we were visiting and staff arrived in two minutes. People in their bedrooms had hourly checks by staff who signed a record when they attended[CJ6] which helped ensure people's safety.

We saw the home was clean and tidy. A domestic staff told us there were three domestic staff working during the week and two at weekends. A domestic worker told us, "This allows us to deep clean all areas including toilets to ensure they are totally clean."

We saw statements written by staff in a person's care plan describing an incident in 2014 where a person may have been abused. Another person may have been neglected. We asked the manager why a safeguarding referral had not been made. She said this had been assessed and investigated and it did not need to be referred. She acknowledged that, as there was a possibility of abuse, this needed to be reported to the safeguarding authority and to us. The manager said she would follow this procedure in the future.

A staff member told us that until recently some staff had moved people by underarm lifting rather than using a hoist. This technique is an illegal manoeuvre and could injure people by not ensuring their safety. The manager

Is the service safe?

stated she had not observed this herself or had been informed of it. She said she would investigate this allegation and inform us as to the outcome of the investigation.

The provider had safeguarding policies and procedures in place. These were designed to protect people from harm. Staff we spoke with had a good understanding of their responsibilities and told us they would immediately raise any concerns with their line management. They told us that they were confident that the management team would then take action to report the concerns raised. If not, staff knew of relevant agencies to report their concerns to, although not all staff knew all of the relevant agencies. The manager stated all staff would be appraised of this information.

People and relatives we talked with said they felt there were normally enough staff on duty to care for them. However, they said their call bells were not always answered quickly. During our inspection we tested a call bell in a lounge and staff responded quickly to it.

Staff members told us that there generally enough staff on duty to meet people's needs and staffing had improved recently. One staff member told us she did not think there were enough staff on at night. This was because she came in and sometimes found people had possibly been left without assistance for some time. Also, there were a number of people with dementia that walked around the home at night and needed supervision. With only two care staff on duty at night attending to people's care needs this meant that if someone needed to staff there was only the nurse in charge able to attend the remaining 29 people accommodated. The manager said she would review staffing levels and send this information to us to see whether people's needs had been met.

Staff reported there was a ratio of staff to the numbers of people accommodated in the home. The manager said this was not correct as staffing levels depended on people's dependencies. A staff member told us that agency staff were not used to fill in staff shortages if staff rang in sick on the day of their duty. The manager said this was not the case and agency staff were used when necessary.

Staff told us they had followed various recruitment procedures such as completion of an application form, interview, and proper criminal checks had been taken up. We looked at four staff files and found recruitment processes, designed to keep people safe, had been followed.

Requires improvement

Is the service effective?

Our findings

We spoke with a member of staff who told us they had worked for 5 years as carer at the home. They told us, "I have completed all the other training with regular updates including safeguarding." Other staff thought training was sufficient to equip them with the skills they needed to deliver effective care.

We saw that a system was in place to provide staff with training. We looked at the training matrix, which showed the training that staff had undertaken. We saw that staff had not always been provided with training in line with the provider's training programme. For example, a large percentage of staff had not had training in areas such as first aid, health and safety, the Mental Capacity Act and prevention of pressure sores. Some staff had not had training on dementia and safeguarding people. The manager stated that recently staff had been directed to take part in training. We saw a letter to staff stating they had to attend training or they could be subject to disciplinary proceedings. This showed us that the manager was in the process of ensuring all staff had received relevant training.

We saw evidence that training courses had been arranged in 2015 for staff to receive this training, though it did not identify if all staff would receive this training. This meant some staff may not have the latest knowledge and skills in key topics needed to deliver effective care. The manager later sent us information about relevant training that staff would be directed to attend.

We saw evidence of staff supervision. This meant staff had an opportunity to discuss their roles and their training needs. However, we saw that some staff had not received supervision for up a year. The manager stated she recognised this and would be ensuring staff would receive regular supervision in the future.

The provider was ensuring that the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were being followed. The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves. The DoLS are a law that requires assessment and authorisation if a person lacks mental capacity and needs to have their freedom restricted to keep them safe.

Records we looked at showed people's capacity to make decisions was assessed and there was information in relation to specific decisions, such as receiving personal care and nutrition.

Staff we spoke with understood the basic principles of the MCA. They gave examples of how they offered choices to people and ensured their consent before providing support. Training records we saw confirmed staff had undertaken training in the MCA and DoLS as part of a safeguarding course.

There were capacity assessments in the records we saw. There was also a 'DoLS Checklist' to determine potential deprivations of liberty. Where people had capacity[CJ3] to understand they signed care plans, where they did not have then their relatives signed their care plans. This effectively gave consent to care and treatment in people's best interests. We saw that a person assessed as having capacity to consent to their care had not signed consents in their care plan and it had been done by relative instead. .The manager said she would follow this up and accepted that it if the person did have capacity to consent they should have been asked whether they consented to relevant issues. In relation to this person the record stated the family had Power of Attorney but there was no copy of this on the person's record. The manager told us they were waiting for this and it was being checked with all people and relatives.

We saw a best interests meeting had been held to make a decision for covert medication following refusal of medicines by a person. The consultant, the person's son and home staff made the decision to covertly administer medication if it was necessary. This showed that care was supplied effectively to the person.

We asked two visitors if they had given consent on behalf of their relative to ensure their care was given effectively. One visitor said: "My [relative] does not have capacity. I remember I was asked to sign a care plan when [my relative] was admitted, we went through her needs etc. I have since signed decisions about providing cot-sides (bed guards) after discussions." This was clearly a decision in the person's best interests to ensure they were support effectively.

When supplying care, we found staff asked people whether it was acceptable to them to help them. Capacity assessments were in place. With the one exception above,

Is the service effective?

where people did not have capacity to consent to their care, relatives signed care plans and were involved in best interests decisions. The provider had followed the principles of the MCA.

Each person had a nutritional assessment. We saw that people had been referred to dietician where there were concerns about eating. We saw that people's weight was monitored on a monthly basis and saw that one person had gained weight of 15kg in one month. This weight gain did not seem feasible, as was a weight gain of nearly 5kg for another person recorded in a month. These weights were questionable. The manager agreed they must have been incorrect and she would follow up to ensure staff took action when weights had markedly changed. This showed us that people were not always receiving effective support for their nutritional needs.

Three people we spoke with told us they liked the food and were happy with the choice, quantity and presentation of the food. We saw the mid-day meals were served in the dining room/lounge area. There was a choice of main dishes and desserts. People chose and enjoyed their meal in a calm relaxed atmosphere. We saw that several people who needed staff support to eat were supported sensitively and appropriately by staff. There was a positive dining experience for people. We also saw two people having lunch in their bedrooms. They praised the choice and quality of the food.

We saw drinks were available and given to people throughout the day. People in their bedrooms had drinks to hand. They both told us that drinks were within reach during the night.

A visitor told us, "My (relative) has liquidised meals and she is given them with support from staff. There is a food and fluid record in her room that I look at regularly. She has good care and good food and drink."

The cook showed us information displayed in the kitchen which indicated people's preferences and how food should be prepared to protect people's health, such as the texture of food needed. She said there was one person accommodated at the moment from a minority community but they had not requested food from their cultural background. We looked at this person's care plan. The care plan had contained information about religion but no information as to the person's food preferences. The manager said this would be followed up.

We saw that the menu included a choice of meals. People also confirmed that if they did not like the food offered the cook would prepare something else for them.

Staff told us that daily handovers took place so that staff could update the next staff on shift about people's needs and if any changes in their care had been identified. Staff we spoke with told us the handover was a good source of information and helped them to meet people's needs.

The manager stated that she was in the process of making facilities more stimulating for people with dementia. The refurbishment of the corridors would mean corridors would have themes displayed such as seaside scenes, local history, and shops from the past so that people could identify with them. Bathroom doors had been painted a different colour to identify them more easily to people. A number of bedroom doors had photographs of the person earlier in their life to help them identify where their bedroom was. This will mean people would live in an environment which is designed to provide effective care.

We spoke with a visiting GP who said that she thought good care was being provided to people living in the home. Staff always listened and acted on her advice and treatment. She found that the atmosphere in the home was relaxed and friendly and staff were positive in their dealings with people.

A person had diabetes that was diet controlled. An appropriate diet was defined and known to staff. An entry in the care records stated: '13/03/14 Liase with GP to monitor blood sugar levels'. Nothing in subsequent records confirmed this liason with the GP. The manager told us a referral had been made and a form completed by the GP. However, there was no record or copy of this. The manager said the form was retained at the surgery. There was no written proof this had happened and nothing in the care records to suggest who and how often the Blood Sugar levels should be checked. The manager said this would be followed up.This would then prove that effective care had been supplied to the person.

We saw in a person's care records that a relative had expressed concern about their mother's condition in March 2015 and wanted her to see a GP. The records indicated that this information had been put in the GP folder for four days later. The service has an arrangement whereby the GP will visit twice a week. However, the person was not seen during the first visit, and had to wait a further three days to

Requires improvement

Is the service effective?

see a GP. In effect, if someone wishes to see GP, unless it is an emergency situation, they would need to wait for the routine GP visit to the service. This could mean preventable deterioration of health could take place and people's wishes to see a GP quickly may not be followed. The manager said she would review this procedure.

Care records had information outlining peoples' diagnosed conditions and the actions needed to ensure their health needs were met. We saw that referrals had been made to the GP, community psychiatric nurse,[CJ10] tissue viability specialist, epilepsy nurse specialist and diabetic nurse specialist. Records demonstrated how people's day-to-day health needs were met.

A relative told us, "The GP has visited [my relative] recently. In fact the GP visits quite regularly. If [my relative] has any health concerns they are seen by the GP. We are always involved and consulted."

We spoke with a NHS podiatrist visiting the home. She had arranged to see two people whose conditions meant they were at health risk. The home had been notified. She told us she saw people in their bedrooms to ensure privacy and dignity. The podiatrist said, "Staff are very helpful and knowledgeable about people's needs and are able to offer information about the people to I see."

Requires improvement

Is the service caring?

Our findings

Six people we talked with said all the staff were caring and friendly. A visiting relative told us, "[My relative] has been here four years and is perfectly happy and very well looked after. I check the records in their bedroom regularly. Yesterday I checked and found that hourly checks to their bedroom had been made. There are always drinks and food available to [my relative]. The place is clean and the bed etc checked regularly. We are always kept informed of any changes or concerns. When entering the room staff identify themselves they knock and say "Hello [person's name] it is [give their name].They provide excellent care. We have no complaints."

Another visitor said, "Last week [my relative] was taken from the relative quietness of their bedroom to the lounge where there were activities, including dancing and singing. It was too much for [my relative] and they reacted loudly. We expressed concern to staff about the dramatic change of environment and the staff member said we'll move [my relative] straight away to the small lounge. They did this and they were calm for half an hour before returning to bed.'' This was an example of people being listened to and appropriate action being taken.

A visitor said their relative had behavioural problems recently and said, "I witnessed this on one occasion. Staff came and responded quickly and calmly and dealt with the situation extremely well. We are very happy with the care here."

A person we saw in their bedroom told us the staff would do anything for you, you only have to ask. "It was cold last night. I used the call system. Staff came immediately and provided an extra blanket within 2 minutes. That is an example of how they respond."

During our inspection we observed generally positive relationships between people using the service and staff. People were treated with respect and approached in a kind and caring way. Staff were able to give us examples of how they protected people's privacy and dignity when supporting them with personal care. We also saw a staff member react to the request of the person who wanted her handbag. The staff member immediately went to get her handbag and gave it to the person.

We saw examples where people were supported to express their views and be actively involved in making decisions about their care.

We found staff were calm and patient and mostly explained things well, except for some situations where staff had not explained what care they were going to be providing or their attitude had not been friendly. For example, a staff member took an apron off of a person without informing them. Another staff member told a person to lift their foot up when they were in a wheelchair without saying please. Another staff member said to a person: "Want to go to the toilet?'' in a gruff and unsmiling way. On another occasion a person was calling out for help. A staff member was nearby but did not speak with or acknowledge the person. The manager said staff would be spoken with about how they should positively interact with people at all times.

People told us that staff offered them choices. For example, there were choices of food, of clothes and when they wanted to get up and go to bed. We also saw that people had a choice as to whether they wanted to participate in activities.

People and their relatives said they were involved in making decisions about their care. They told us they were aware of their plans of care and had input into their reviews.

People told us staff protected privacy when supporting with personal care. For example, they checked with them about their wishes and preferences and knocked on their bedroom doors before entering.

People told us their friends and relatives could visit them at any time and staff always welcomed visitors.

Requires improvement

Is the service responsive?

Our findings

We saw care records of a person with a pressure sore. A dressing had been applied to the wound. There was no further recording to indicate when or if the dressing had been changed or any progress. On the same day a second wound had been identified and recorded but there was no subsequent information about treatment. The nurse said the dressing had probably been changed and monitored but there was no record.

We also saw in the same person's record a further entry that month that a sore had healed. However, was no record of this wound, and the nurse was not aware of this, so we could not see if the person had received responsive care.

We saw that this person had an assessed high risk of developing pressure sores. The risk assessment stated a 'pressure cushion should always be in place'. We saw the person sitting in the lounge for several hours and moving between seats but they had no pressure relieving cushion in place. This meant the person had not received responsive treatment to meet their identified needs.

We found that wound care in the home was poor. Recording, monitoring and treatment was inadequate. This did not meet professional standards. Preventive measures identified following a waterlow assessment and a risk assessment had not been followed to ensure the support given was responsive to people's needs.

This evidence constituted a breach of Regulation 12 (1) (2) (b) of the Health & Social Care Act 2008 Regulated Activities Regulations 2014.

The home provides two beds for people with palliative care needs. This is an Enhanced Team Project sponsored/ supported by the Health Authority. [CJ5] The places provide carer relief or care for people with end of life conditions. The home works closely with the McMillan nurses at the Royal Derby Hospital. The service includes symptom control and anticipatory medicines are made available in advance. One person was using this service at the time of our inspection. The manager told us that the previous day a syringe-driver had been put into place. Part of the end of life plan includes relatives' wishes about being contacted at various time of the day or night in the event of any deterioration.

The home were providing care for a couple. Each had their own bedroom (next to each other). They had breakfast together in a bedroom. Both went to the dining room for lunch. Both people were happy with the care they received. They used the call system when needing help, saying responses were swift and good. They had no complaints about the care they received at Stanley House as they were responsive to their needs.

Referrals are made to external health professionals where specific needs are identified. For instance we saw that two people had been identified as having 'challenging behaviour'. They had been referred to a CPN and had charts for recording behaviours and behaviour management plans outlining actions to be taken to divert and manage their behaviours. Staff were aware of these plans. We saw two examples during our inspection where staff successfully used diversionary methods to de-escalate situations and avoid potential harm to people. The home seemed to manage these situations well.

People's records provided evidence that their needs were assessed prior to admission to the home. Each care record contained a summary page giving very brief information about the person's support needs, past medical history, communication issues and details of key contacts.

Care plans contained some information about people's preferences for daily living and their past history. The manager said the activities organisers were currently obtaining this information from people and their relatives so it would be more detailed in the future to enable staff to understand people's individual needs.

We saw that a person from a minority community did not have their likes and dislikes recorded so that staff could be aware and ensures that care always followed their preferences. The person's religion was recorded that was no evidence that staff had tried to involve representatives from this person's church. The manager said she would ensure action was taken to follow up any information about people's preferences so that proper individual care could be supplied.

We saw an instance where staff had provided a cushion to support a person's back when sitting in a chair. However, there was also an instance where staff had not supplied a pressure cushion to a person with an assessed need of protecting them from developing a pressure sore. The manager said this would be followed up with staff.

Requires improvement

Is the service responsive?

People we talked with said there were activities for them to participate in which they enjoyed, and we observed some people being involved in Easter festivity activities. However, in the main lounge, the TV was on loudly with no one watching it. The manager told us she would follow this up.

People told us that singing was popular and we saw this was offered as an activity in the activities programme, but there was no evidence that staff had tried to initiate singing as a regular activity in the lounges when there was no other relevant stimulation available to people. The manager said this would be followed up.

We looked at the activities programme. These showed activities were provided on three days a week. There had been no trips out since summer 2014. The manager said she would be looking at organising trips out.

We looked at individual records of people being involved in activities. This showed up to five days between activities. The manager told us additional activity staff had been recruited to provide activities seven days a week, and having further provision for people with dementia such as tactile equipment and memory boxes.

Five visitors and one person using the service told us that they were aware of the complaints procedure. they said they would make a complaint to a member of staff. One person, happy with their relative's care told us, "I would be quite happy confronting staff if I saw something I didn't like and I would feel comfortable making a formal complaint."

We looked at details of complaints. We found evidence that concerns had been recorded and followed up. We saw the person had complained about the time it took for a call bell to be answered when they needed help. The response from management was that it may take longer for their call bell to be answered due to staffing on particular shifts. This did not fully answer the persons concerns. The manager acknowledged this and said this would be followed up.

Also, the complaint found in the Carers Communication Book with regard to a person not receiving proper skin care, had not been recorded in the complaints book so did not have a proper follow-up to investigate the issue. The manager recognised this and said any future concerns would be recorded as a complaint and then followed up.

There was no complaints book for staff to record any concerns they received about the service in. The manager agreed this was needed and staff would be asked to record any such concerns.

The complaints procedure showed that people could complain to management and included information about how to raise concerns with the ombudsman if necessary. However, it did not give details of the lead authority for investigating complaints. The manager said the procedure would be amended to include this and take out the reference to the Care Quality Commission investigating complaints, which is not a legal duty of the Commission.

Requires improvement

Is the service well-led?

Our findings

We saw evidence of an incident where people living in the home had been subject to alleged abuse. There was no evidence that these incidents had been reported to the local safeguarding authority, or to CQC. The provider has a legal duty to report such incidents to both CQC and the local authority. There had been no evidence of what action had been taken in relation to the staff member subject to one of the allegations. The manager stated that all such incidents would be reported properly in future. Since the inspection she sent us information as to what action was taken in relation to the staff member.

Relatives told us that management were very approachable when they had raised any issues, they had been quickly responded to.

All the staff we spoke with said that the management were always available to speak with about any issues they had and they always provided positive support. One member of staff told us, “The manager and deputy manager are there if we need them. We will always get a proper response from them.” Staff also told us that the manager had emphasised that people's rights should be protected and promoted. We saw a poster displayed in the home which included details of how to preserve people's dignity. This gave a strong message to staff as to the importance of preserving and enhancing peoples’ dignity.

We saw evidence that people and their relatives had been provided with a satisfaction questionnaire to give their views of the service. This had been analysed with actions in place to meet the issues raised.

We saw evidence of other audits. These included reviews of hygiene and infection control, health and safety, accidents and management audits of care plans, safeguarding, staffing, training, a provider review, social activities and medication. Some audits did not appear to be in depth. For example the falls audit noted a person had 14 accidents between July and December 2014. In the section entitled ’actions/trend analysis’ there was no information as to whether any lessons could be learnt to prevent such falls in the future. This meant factors that caused incidents may have still been in place and there was a risk they would be repeated, harming peoples' health.

There were other quality assurance and audit processes in place, such as medication, premises and plans of care audits. These helped management identify any problem. There were action plans in place to show that effective action had been taken to ensure a quality service was provided.

However, audits had not always been detailed. For example, the tissue viability audit held in March 2014 did not include whether people had received all preventive treatment. For example, whether creams had been applied and whether pressure mattresses were at the correct pressure. The manager said audits would be reviewed and made more meaningful in the future.

There was evidence that resident meetings had been held. However, these were infrequent, every six months. Meetings provide an opportunity for people and their relatives to feedback comments or concerns to the management team. We saw the meeting minutes of October 2014. They stated that people had enjoyed the reminiscence group and proposed that they should be more groups during the week. They also suggested day trips to the garden centre, art gallery, museum, bus trip and the pub. However, there was no evidence that these issues had been actioned. The manager recognised this and said they would be held more frequently in the future and that there would be evidence of consideration to people suggestions.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe care because risk assessments and care plans were not being followed.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.