Resthaven Nursing Home Limited

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Inspection report

Resthaven Home of Healing Limited
Pitchcombe
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Gloucestershire
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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 10 and 12 May 2016. Resthaven Nursing Home is located on the outskirts of Stroud with commanding views over the valley of Painswick. The home is registered to accommodate up to 42 people, who are predominantly older people. At the time of our inspection there were 34 people in residence. A recent extension to the premises had been completed providing additional en-suite bedrooms and communal facilities. The home is fully accessible to those people with mobility impairments.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Since the last inspection a new registered manager was appointed in October 2015. The previous manager had worked at the home for a 15 year period. The trustees engaged a consultant to review how the service was performing along with the new registered manager and a robust action plan had been put in place to address those areas where improvements were needed. Throughout the report we have identified those areas where the registered manager had already instigated changes and the plans for the immediate future.

Improvements were required 'as soon as possible' with care planning documentation and other care records related to how the staff monitored people's food and fluid intake and summaries of the full care plan. Completion of the charts was not being monitored by the qualified nurses at the end of their shifts and had not been picked up by the head of care nurse. Care planning documents did not provide a clear picture of people's needs and were not person centred. The service had already taken some steps to make improvements and planned to revert to a paper based care planning process. Despite this, people's care and support needs were being met.
All staff received safeguarding adults training as part of the mandatory training programme. They knew what to do if bad practice was witnessed, alleged or suspected and would take the appropriate actions. The registered manager was aware of the need to report events promptly to the local authority and CQC. There were safe recruitment procedures in place to ensure unsuitable staff were not employed. The appropriate steps were in place to protect people from being harmed.

Risk assessments were completed for each person as part of the care planning process and where risks were identified appropriate management plans were in place. The premises were well maintained and all maintenance checks were completed to ensure the home and equipment was safe.

The registered manager regularly checked that the staffing levels were reviewed and the care and support needs of each person could be met because there was sufficient staff. Staffing numbers had been increased following feedback from people and their families. People were not put at risk because staffing levels were not low.

New staff completed an induction training programme and there was a programme of mandatory refresher training for the rest of the staff team. The registered manager had implemented a programme of face to face training on a monthly basis. Care staff were generally only employed if they achieved a nationally recognised qualification in health and social care.

People were supported to make their own choices and decisions. Staff were aware of the need to ensure people consented to their care and support. The registered manager was aware when people lacked the capacity to make decisions, best interest decisions were made involving healthcare professionals. Staff were aware of the Deprivation of Liberty Safeguards and able to act accordingly when there was a need.

People were provided with sufficient food and drink. Their specific dietary requirements were catered for. A GP visited the service regularly on a planned basis and at other times whenever necessary. Arrangements were made for people to see other healthcare professionals as and when they needed to do so.

People were able to participate in a range of different activities and external entertainers visited the home. There were plans to increase the number of activity organisers and to involve the care staff in meeting people's social needs.

There was a staffing structure in place. Regular staff meetings were held in order to keep them up to date with any changes and developments in the service. There were also 'resident and relative' meetings and people were encouraged to express their views about things they wanted to happen. This feedback was listened to and acted upon.

There was a programme of audits and checks in place in order to ensure the quality and safety of the service was maintained. Some of the checks were completed on a daily basis, others on a weekly or monthly basis. The information collected from these audits was used to drive improvements. The trustees had an active role in monitoring the service, visited regularly and spoke to people and the staff team.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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 received care from staff who were trained in safeguarding and recognised abuse. Safe recruitment procedures were followed to ensure that unsuitable could not be employed.

Staffing levels were based on the collective needs of people in residence. There were enough staff to keep people safe.

People's medicines were being managed safely.

Is the service effective?

Good

The service was effective.

Staff received training and support in order to undertake their role effectively and meet people's needs. A more robust training programme had been implemented by the registered manager. Staff received regular supervision.

People's rights were protected because staff acted in accordance with the Mental Capacity Act 2005. The registered manager was aware when the appropriate applications would need to be made to the local authority to deprive a person of their liberty.

People were provided with sufficient food and drink. They were given choices about what they wanted to eat and drink.

People were supported to see their GP and other healthcare professionals when they needed to.

Is the service caring?

Good

The service was caring.

People were treated with respect and kindness and were at ease with the staff who were looking after them.

The care staff had good relationships with people and talked respectfully about the people they looked after.

Is the service responsive?

Requires Improvement

The service was partially responsive.

People received the care and support that met their needs. However care planning documentation was not accurate and did not provide a detailed account of what support was needed and what care had been provided.

People were able to participate in a range of social activities. People were listened to and staff supported them if they had any concerns or were unhappy.

Is the service well-led?

Good

The service was well led.

An experienced registered manager was in post and had implemented a programme of improvements. There was an active programme of improvements still to be achieved and this was regularly being monitored by the trustees (the registered care provider).

There was a programme of checks and audits in place and shortfalls were identified, actions were taken to make improvements. The prevalence of any falls, accidents, incidents and complaints were analysed to see if there were any lessons to be learnt.

Resthaven Nursing Home

Detailed findings

Background to this inspection

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

The inspection was unannounced and was undertaken by a single adult social care inspector. At the last inspection in July 2013 we found no breaches in regulations.

Prior to the inspection we looked at information about the service including notifications and any other information received by other agencies. Notifications are information about specific important events the service is legally required to report to us. We reviewed the Provider Information Record (PIR). The PIR was information given to us by the provider. This is a form that asks the provider to give some key information about the service, tells us what the service does well and the improvements they plan to make.

During our inspection we spoke with 13 people living in Resthaven Nursing Home and six relatives. We were able to speak with two healthcare professionals who were visiting the service the same time as us and have included their feedback in the body of the report. We spoke with the registered manager and 13 other members of staff. This included members of the care team, the compliance manager, the administrator, catering staff and the activity coordinator. Two of the trustees were available for the feedback session at the end of the inspection.

We looked at five people's care documentation and other records relating to their care. We looked at three staff files, training records, policies and procedures, audits, quality assurance reports and minutes of various meetings.

Good

Is the service safe?

Our findings

People told us, "I came here because I wanted to feel safe and that is exactly how I feel", "I always used to worry about getting my medicines mixed up. The nurses sort that now so I don't have to worry", "I am always spoken to nicely" and "There is staff around to help me". Relatives we spoke with said, "I have every confidence in the staff that they look after (named person) well", "I know that she is safe living here" and "Excellent, no concerns at all".

Staff received a range of training to ensure the service they provided was safe. This included safeguarding adults training, moving and handling, infection control and food hygiene.

Staff were aware of their responsibility to keep people safe and knew about the different types of abuse. They would report any concerns they had about the safety and welfare of people to the registered manager, senior managers or the nurse in charge. There was a safeguarding procedure in place for staff to follow. On the main noticeboard information was displayed about how to report concerns regarding any child's safety (children who were visitors to the service). It would be good practice to display information about safeguarding adults reporting procedures as well. A copy of these procedures were however kept in the room files located in each person's bedroom. The registered manager had already completed formal safeguarding training with Gloucestershire County Council and spoke about previous safeguarding investigations they had been involved in.

We looked at staff recruitment files. Appropriate checks were undertaken before new staff began their employment. These included two written references and evidence of the person's identity. Disclosure and Barring Service (DBS) checks were carried out before new staff commenced employment to ensure they were suitable to work with vulnerable people. A DBS check allows employers to check whether the applicant had any past convictions that may prevent them from working with vulnerable people.

A range of core risk assessments were undertaken to determine the level of risk to each person and then a management plan was devised to reduce or eliminate the risk of harm. Risk assessments had been completed in respect of the possibility of skin damage and pressure ulcers, the likelihood of falls, risks of malnutrition and dehydration, and moving and handling tasks. Where a person needed the care staff to support them with moving or transferring from one place to another, a moving and handling plan was written. A copy of these plans were kept in the room folders as well as the person's care file. These set out the equipment required and the number of staff to undertake any task. Other person specific risk assessments were completed where risks were identified, for example risk of choking or risks from behaviours.

The maintenance person had a programme of checks to complete on a daily, weekly and monthly basis in order to keep the premises safe. The records were well organised and all in order and showed checks had been completed. The registered manager monitored that these checks had been completed. The catering staff recorded fridge and freezer temperatures and hot food temperatures and the records seen evidenced this. There were measures in place to ensure all food was stored correctly and there were daily, weekly and

monthly kitchen cleaning schedules. A recent visit by an environmental health officer had resulted in the service being awarded the full five stars.

The service had a business continuity plan in place. This covered the procedures to be followed in the event of any emergency, for example fire, flood, utility failures and extreme weather. Because of the isolated position of the service they had an emergency electricity generator on site. The fire risk assessment had last been reviewed in June 2015. A monthly health and safety inspection was completed to ensure the premises and equipment remained safe, well maintained and comfortable.

Staffing numbers were based upon the level of needs of people in residence. A dependency tool was used to calculate how many staff were needed for each shift to ensure that each person's care and support needs could be met. At the time of our inspection during the day time there were two qualified nurses plus eight care staff in the mornings and two nurses and four care staff on a late shift. Overnight there was one nurse and four care staff. In addition there were catering, housekeeping and maintenance staff on duty to meet people's support needs. The dependency scores for each person were reviewed on a monthly basis and staffing was adjusted as necessary.

Feedback we received from all but one member of staff was that the staffing numbers were sufficient. Because of concerns the registered manager had already identified regarding management of the staff duty rota, this task was now purely managed by him. Comments were also made about how some nurses managed their shift, that some nurses did not work with the care staff and provide hands-on care and that the head of care had limited involvement in people's day to day care. The registered manager had begun to address these issues with the staff team.

All but one person was supported with their medicines. For the others their medicines were administered by the nursing staff. It was unclear from looking at the care planning documentation whether people were offered the choice (where appropriate) to remain responsible for their own medicines. The registered manager told us this was being addressed as the nurses and care staff were being guided to adopt a person centred approach to people's needs. For the one person who administered their own medicines, a risk assessment had been completed, a locked drawer was provided in their bedroom and agreement had been sought from the person's GP.

The service had policies and procedures in place for the safe handling of medicines. Protocols were in place for those medicine prescribed on an 'as required or PRN' basis. A weekly audit of medicines including controlled medicines was completed by the compliance manager. There had been no errors involving medicines in the last 12 months. As part of the registered providers and registered managers planned improvements for the service, senior care staff will be administering medicines following safe administration of medicines training and regular competency checks.

There were safe systems in place for the ordering, receipt, storage and disposal of all medicines. There were suitable arrangements in place for storing those medicines that need additional security. Records showed that stocks of these medicines were checked regularly and could all be accounted for.

Good

Is the service effective?

Our findings

People told us about the care and support they received. They said, "I am well looked after and don't want for anything", "The staff help me get up in the morning, all my food is delivered to me, and they help me to the toilet when I need to. Everything is done for me" and "They help me have a bath using a brilliant gadget (a hoist) that lifts me up and lowers me in to the water". Relatives said "I was so glad mum was able to come here for her final days", "Dad is being so well looked after and is so much happier than where he used to live" and "I visit almost every day and I am very pleased with how (named person) is looked after".

The registered manager stated it was policy that new care staff would only be recruited if they had already achieved a level two qualification in health and social care. Any new starters would have an induction check list and a number of training tasks to complete. This included fire awareness, a practical moving and handling session and food hygiene. The registered manager was aware of the Care Certificate and had contacts with a local college to meet this requirement. The Care Certificate was introduced in April 2015 as the new minimum standard for induction for those commencing a career as an adult social care worker. The Care Certificate comprises of 15 Standards aimed at ensuring new workers were suitably trained and assessed to deliver safe, effective, responsive care.

All staff had a programme of refresher mandatory training to complete. Staff confirmed their training was up to date. This programme included fire safety, moving and handling, safeguarding and first aid. The registered manager had identified that online computer training was not fully effective and had therefore arranged face to face training sessions for the staff team. Arrangements were already in place to deliver further Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), end of life and person centred care planning training for the staff team. Training sessions were being arranged on a monthly basis.

We checked whether the service was working within the principles of the MCA. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in the person's best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The registered manager was in the middle of completing level three advanced MCA and DoLS training with Gloucestershire Council.

People were encouraged to make their own decisions about their day to day life and we heard people being offered choices throughout the day. Staff understood they should enable people to make choices and decisions, but were less clear about the MCA and DoLS. The registered manager had already identified this as a training need and was arranging face to face training sessions and will issue written guidance on mental capacity facts.

There was a programme of regular supervision. Staff supervisions were all carried out by the head of care on

a two monthly basis. The registered manager supervised the senior members of the team. Staff we spoke with confirmed they had received a recent supervision. The registered manager planned to introduce yearly appraisals and use these as a means of improving work performance and compliance with the planned changes being instigated. We discussed the fact that the head of care and some of the nurses did not work alongside the care staff.

People were provided with sufficient food and drink. The registered manager had reintroduced the provision of home cooked meals. This change had been met with approval by the kitchen staff and the people living in the service. There was a four week seasonal menu plan but this was amended to celebrate various events throughout the year. People were provided with a choice of two meal options at the midday meal plus alternatives if requested. The kitchen staff were aware of people's likes, dislikes and preferences and were informed if a person had lost weight so they could provide fortified foods and drinks. They catered for people's specific dietary needs as required, for example pureed meals, soft meals and diabetic diets.

The registered manager had plans in place to improve the dining experience for people. A practice had developed in the service where people were served their meals in their bedrooms. The registered manager wanted people to be offered their meals in the dining room, for the tables to be laid up 'hotel style' and meal times to provide a social function during the day. People we spoke with after the lunch time meal said, "We get lovely cakes with our afternoon tea", "The meals we are served are much nicer now", "I get enough to eat and drink, sometimes too much" and "The food choice is very limited and I have never been asked what I would like to eat". We spoke to the registered manager about the last comment. We were assured that this person who had specific food preferences was asked what they wanted to eat and despite encouragement frequently chose the same meal.

People were registered with a local GP. If they had previously lived in the same area and their GP agreed to visit the service when necessary, they retained their family doctor. If not, they were registered with the local Painswick surgery. The GP visited on a fortnightly basis and saw those people whose healthcare needs needed reviewing. The GP would also fully review two or three people each visit, including the medicines they received. The GP would also be asked to visit any person who was unwell as needed.

Good

Is the service caring?

Our findings

We asked people about the staff who looked after them and in general we received positive comments. These included, "I am settling in and quite happy here thank you", "Everyone is kind but I have my favourites", "There is one member of staff who I do not like and they are forbidden to come in to my room" (we checked this with the registered manager and this was that person's choice) and "I don't think I could be better looked after". Relatives said, "I don't need to visit every day now because I know my dad is well cared for and the staff are fond of him", "(named member of staff) has a very good relationship with my husband and cheers him up" and "The staff are very kind and he is getting better". Two healthcare professionals told us that people were very well looked after and the staff "genuinely cared". One of them commented that the staff looked after people who were at the end of their life with "compassion and sensitivity".

We were shown the compliments folder and these are an example of feedback the service had received about the service received: "She was delighted with the care she received following her move to Resthaven", "Thank you for the kindness and sympathy you showed me and my family" and "My dad was very fortunate to spend his last years at Resthaven".

During the inspection we noted care staff having positive interactions with people. People were smartly dressed and looked well cared for. One person said that when the care staff helped them have a bath, they always ensured the bathroom door was closed and they were treated respectfully. Several people had had their hair washed and set on day two of the inspection. One lady said, "I like my hair to look nice" and another said "In general we heard people being addressed by their first names". The name people preferred to be called by was recorded in their care plans.

There was some evidence in people's care plans to show they had been consulted on how they wanted to be looked after. For example one person had stated their preference to be looked after by female care staff only and another said "I like to keep my facial hair well groomed". The plans also contained information about the person's life story, activities they liked to do, people who were important to them and significant life events.

On each of the bedroom doors the name of the person's room was displayed along with a framed picture of a flower. Staff were expected to knock on bedroom doors before entering and we saw this in practice. Where the person was asleep or unable to answer, they paused for a few moments before entering. People's bedroom doors and the doors into bathrooms and toilets were closed when people were receiving care.

The service aimed to continue looking after people when they had reached the end of their life and also admitted people who were receiving palliative care and at the end of their life. Nursing staff were trained to administer end of life medicines. The service would work with the person's GP, district nursing services and palliative care services in order to provide the care and support the person needed.

Requires Improvement

Is the service responsive?

Our findings

People told us they were supported with their care and support needs. They said, "I get all the help I need", "My keyworker checks with me regularly that everything is going OK", "They help me wash and dress" and "I wish we were offered more cups of tea and I didn't have to ask for one. They do bring me a cup of tea when I ask but I sometimes feel as if I am a bother". This comment was discussed with the registered manager. Relatives we spoke with were very satisfied with the way their family member was looked after". Comments included, "My husband gets all the help he needs" and "We count ourselves as very lucky that mum was able to come and stay here. We know it is only going to be for a short time but we have been told this is the best nursing home around here".

Pre-admission assessments were carried out by the head of care nurse, prior to people being offered a bed at Resthaven. If the head nurse was not available, other senior staff would undertake these assessments. This ensured the service would be able to meet the person's individual needs and any specific equipment (hoists or specialist beds) was available. Where people were part funded by the local authority or the clinical commissioning group (health funding) information was gathered as to the person's needs. These documents identified the type of care the person needed and the level of any risks. The assessment covered all aspects of the person's daily life and the information was used to write the person's care plan.

All care plans were written by the head nurse based upon the information gathered during the assessment process and from any health and social care professionals. Care plans covered the person's personal care needs, mobility, nutrition, continence, wound care and where appropriate, end of life care needs. The plans were signed by the person where this was appropriate, stating they were in agreement to what was written.

The care plans were not easy to read. The service used an electronic care planning system and some information was pre-loaded into the plans. For example each person's nutrition plan stated they needed to drink two litres of fluid per day to remain well hydrated. Staff explained the plan was then personalised to reflect a realistic fluid intake, however they were all 'personalised' with the same instructions. Each person had a wound care plan irrespective of whether they had a wound or not. Where there was no wound, the plan detailed the measures to be taken to prevent damage to the person's skin integrity. The registered manager advised us there had been agreement amongst the trustee's to stop using the electronic care system and return to a paper copy care planning system. The registered manager will be auditing the implementation of this to ensure the plans were written with people's involvement and were person-centred, based upon their specific needs.

In addition to the care plans room files for each person had been introduced by the registered manager. These room files contained food and fluid charts, bowel charts, topical medicine charts with body maps identifying where creams or ointments were to be applied and a summary of the care plan. The level of detail in these summaries was sparse, for example "wears dentures". There were no details about what support the person needed from the care staff.

The food and fluid charts we saw did not provide a meaningful account of how much people had eaten and

drunk in a 24 hour period. The quantity of food eaten was recorded as full, ¾, ½, ¼ or only a spoon full but there was no record of the meal served or its' size. There was either no recording or very poor recording of fluid intake in the evenings and overnight. It was evident the nurse in charge of the shift was not checking the charts at the end of the shift so that they could identify if someone was at risk of malnutrition or dehydration. There were no signatures to show they had checked the charts.

This was a breach of regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulation 2014.

Care plans were reviewed on at least a monthly basis and a programme of formal and full six monthly reviews had been introduced. People were now being encouraged to have a say about their care and support and to speak up if they were unhappy about anything or wanted things done differently. Relatives or friends were being invited to participate in this process. One relative who was at the service during the inspection for one of these reviews said, "I am very impressed with this new arrangement. Communication is so much better now with the staff".

A handover report was given to staff coming on shift. This ensured that important information was shared between the staff and any changes to people's care needs were passed on to the next shift.

There was a programme of activities for people to participate in. The programme of activities was displayed on the wall by the main entrance. Alongside were photographs of previous social events and activities. People had recently received a visit from newly born lambs. In May the following activities were arranged: a memory walk in Stratford Park, music singing and dance, a church service and visits by the hairdresser. The activity organiser also spent time with individual people and did person centred activities. Examples of this would be reading to a person in a foreign language, finding a poem that was important to a person and sourcing Gilbert & Sullivan dvd's. The activity organiser said, "I like to find out what people want to do". All events were evaluated to check how beneficial they were for people. The registered manager was planning to recruit an additional activity worker and planned to involve the care staff and nurses in meeting people's social care needs.

The activity organiser had arranged a number of events in the local community. People had attended an art group in the village hall. Others had been along to a Christmas Tree festival, a pantomime in Stroud and a flower festival in Painswick. Local people had visited the home and given talks and there had been visits by a teddy bear maker and restorer and a ukulele player.

A 'Resident and Relative meeting' was held in December 2015 and will then be arranged on a six monthly basis. The meeting notes showed that the new registered manager had introduced themselves and talked about the plans for the home. It was evident that feedback provided by people and their families was listened to - staffing numbers were increased, a daily walk-around by the senior team was implemented and weekly monitoring of the call bell system was commenced.

We asked people and relatives we met, if they would feel comfortable raising any concerns or complaints they had. They said, "Yes, I would. And I know I would be listened to", "I am perfectly happy here and have no complaints but I would say if I did" and "I have had grumbles in the past but they were dealt with and you can't ask for more than that".

Good

Is the service well-led?

Our findings

People told us, "Everything seems to happen on time", "All the staff are so busy. Some are more efficient than others but on the whole everything is OK" and "No complaints from me, my meals arrive at the right time and I am left alone to 'daydream' when I want to be on my own". One relative told us, "We had heard this was a very well run home so we wanted (named person) to come and live here".

Staff we spoke with were generally on-board with all the changes and improvements being implemented by the registered manager. One staff member said, "The changes are good for the residents". Another staff member felt there was too much paperwork to do and most of it was unnecessary but this was not an opinion shared by the rest of the care team. We asked several of the staff team if they would recommend Resthaven as a home for a family member and they said they would.

Since the last inspection there have been several changes to the management structure. The previous registered manager who had worked at the service for 15 years had left and an experienced manager was appointed and is now registered with the CQC. The registered manager was supported by a newly appointed quality compliance manager and the head of care nurse. The post of senior care assistant had been introduced and there were plans to up-skill these members of staff to take on lead roles in delegated areas. Each day there was two qualified nurses on duty and a team of care staff. There were also housekeeping, catering, maintenance and administrative staff employed.

The registered manager had plans to enable the nurses to provide more hands-on care with the care staff and to monitor their work performance and to take lead role in for example infection control and medicines. The role of the head of care was also to be reviewed to provide more hands-on care and oversee the work of the nurses. The management team have identified an issue that some of the nurses did not manage their shifts well and or monitor the work of the care staff.

Following the departure of the previous manager, the trustees had commissioned a consultant to review the service. As a result of this review 24 recommendations were made of improvements. This formed the basis of the homes improvement action plan and progress in meeting the recommendations was monitored regularly.

The registered manager had monthly board meetings with the trustees. Additional meetings were arranged as and when needed. The trustee meeting that was held on day two of the inspection had been arranged to discuss the electronic care planning system and a decision was reached to revert to a paper based process. Trustee's visited the service on a two/three monthly basis, they spoke with people and staff on duty, checked the premises, discussed any events that had happened in the home (accident, incidents, safeguarding and complaints) and checked progress with the improvement plan.

The registered manager was aware when notifications of events had to be submitted to CQC. A notification is information about important events that have happened in the home and which the service is required by law to tell us about.

A programme of 'manager' walk-a-rounds had been introduced by the registered manager. These were to be undertaken by the head of care, the quality compliance manager and the registered manager (three times a day) to assess the environment, the cleanliness, the completion of room file charts and staff interactions with people. We recommend that improvements be made with the checking of the room charts because this shortfall had not been picked up. Another change that had been implemented was the presence of management staff at the weekends. One relative told us, "The fact that we can now see a manager at the weekend is brilliant. The last manager we had to make an appointment to see. This new manager is available and more visible".

There was a programme of audits in place to check on the quality and safety of the service and information gathered in these processes was then used to drive improvements. The programme of audits included care plan reviews, medicines, health and safety and reviews of any events. Any falls, accidents and incidents, or any complaints received were logged. The registered manager had introduced reflective meetings to analyse these events in order to identify any changes they could make to prevent or reduce a reoccurrence. In addition the care homes support team from Gloucestershire NHS and the local pharmacist had completed medicines audits and the outcomes of these had been included in the homes improvement plan.

The provider had a complaints policy in place. This stated any verbal or written complaint would be acknowledged with 48 hours and fully investigated and responded to within 28 days, in writing. A copy of the complaints procedure was displayed in the main entrance and included in the home's brochure. The registered manager explained there had been no recorded complaints since 2011 however had received a letter that morning that would be handled according to the complaints procedure. CQC have not received any complaints about this service however had been contacted by the service in connection with the issues regarding this new complaint.

Regular staff meetings were held to keep them up to date with changes and developments. A 'stand up' meeting was held at 10am every weekday morning and attended by the heads of department. The purpose of these meetings were to update everyone on activities, events, tasks and audits to be completed. A meeting had been held with the kitchen staff in April 2016 to discuss the planned refurbishment of the kitchen. Care staff meetings had been held in November 2015 and February 2016 – the notes of the meeting evidenced that staff had contributed to those meetings. Qualified nurse meeting notes documented that the introduction of the room files was discussed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons must ensure that accurate, complete and contemporaneous records are kept in respect of each person, including a record of the care and treatment provided. Regulation 17) (2) (c).