

Four Seasons Health Care (England) Limited Manor Park Care Home

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?

Good



Is the service responsive?

Good



Is the service well-led?

Requires improvement



Overall summary

This inspection took place on 11 June 2015 and was unannounced. This meant the provider did not know we would be visiting. A second day of the inspection took place on 16 June 2015 and was announced. We last inspected the service in April 2014 and found the provider was meeting all legal requirements we inspected against.

Manor Park Care Home is registered to provide accommodation and personal care for up to 49 people, including some people who were living with dementia. At the time of our inspections there were 46 people using the service.

No registered manager was in place at the time of our inspection. Due to the lack of registered manager the provider had ensured a peripatetic manager had been in post since April 2015. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Summary of findings

Staff we spoke to told us they were confident in safeguarding. We noted all staff members had received training in safeguarding vulnerable adults, of which the training included identifying different types of abuse.

The risk assessments viewed during our visit were thorough and contained information required for people to know the exact process to follow to minimise the risk. For example we noted one person had a moving and handling risk assessment.

During our visit we noticed call bells were answered in a timely manner and we noted no times whereby people were waiting for support or not receiving the care that was required.

We saw that as part of the recruitment process all staff had completed a Disclosure and Barring Service (DBS) check. We also saw the provider carried out reference checking in line with their recruitment policy.

The manager advised they were in the process of refurbishing areas of the home. We noted two rooms had already been refurbished. The manager advised that people were included in decisions in relation to the refurbishment, such as selecting the flooring for their bedroom.

We observed people receiving the support they needed to take their medicines as prescribed. The nurse offered people a drink and gave people time to take their medicines.

There were systems in place to ensure that medicines had been ordered, stored and administered. We noted the recording of receipt of medicines had not been completed fully.

Medicines that were required to be refrigerated were kept appropriately; we saw staff had recorded the date liquid medicines were opened. However we noted gaps in the recording of the fridge temperatures. You can see what action we told the provider to take at the back of the full version of the report.

The manager told us that due to the changes in management they had noted on their arrival at the home in April 2015 that appraisals and supervisions had lapsed. They had however ensured that all staff members had now received supervision over the past two months.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and to report on what we find. We saw that DoLS authorisations had been requested where required.

We saw that where required people were supported to have specialist or modified diets. In addition all staff received training in allergen awareness as part of their mandatory training. This training covered the new legal requirements in food allergies.

We witnessed staff treating people with compassion and kindness. One person said, "Staff here are nice and I get good care", and "Care here is brilliant, the lasses are great". Another told us, "I'm happy here. However another person told us, "I'm sick to death of being here." A relative said, "The staff are great and my [relative] is happy here."

We observed people being asked if they needed anything either to drink or eat. We saw good interactions between staff and people using the service. One care worker was patient and sympathetic to a person who was distressed and needed reassurance.

Staff had access to information about people's needs and preferences including their likes and dislikes. When we asked staff to describe a person's needs they were able to without consulting the person's care plan.

People and relatives told us they were aware of the complaints procedure and knew how to raise concerns. One relative told us she had reported an issue about the way a staff member spoke to a person. They said that they had a meeting with the Regional Manager and the matter was looked into.

The provider had a system in place for rewarding staff, entitled ROCK (Recognition of Care and Kindness). The home had recently started to advertise the scheme by displaying posters. The manager told us they had already received six ROCK nominations from relatives.

We looked at what the provider did to seek people's and relative's views about the quality of the service. The manager said questionnaires are sent out yearly to relatives and people who use the service to gather information. They also said the provider had introduced a system called 'Quality of Life' programme where staff would seek daily feedback about the quality of the service from people.

Summary of findings

We saw the provider had a weekly newsletter called 'Inform' which is sent out to staff via email. It reports on successes of the 'Quality of Life' programme and details the innovations the provider is making in different areas of care. The manager also told us about a training

programme the provider was introducing Care Home Assistant Practitioner (CHAP) this covered technical skills, leadership, communication and innovation development.

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?

The service was not always safe.

We saw that as part of the recruitment process all staff had completed a Disclosure and Barring Service (DBS) check. We also saw the provider carried out reference checking in line with their recruitment policy.

There were sufficient numbers of staff available to meet people's individual needs.

Procedures for managing people's medicines were not safe as records were inconsistent. We noted the recording of receipt of medicines had not been completed fully.

Requires improvement



Is the service effective?

The service was effective.

The provider had a system in place which recorded all staff training and allowed management staff to review compliance against either individual courses or overall per person, or per home.

The staff members we spoke to told us they had received training in MCA and DoLS and they were confident in supporting people who did not have capacity.

We saw evidence in care records of co-operation between care staff and healthcare professionals to ensure people received effective care.

Requires improvement



Is the service caring?

The service was caring.

We saw staff were professional and had a patient and caring attitude that treated people as individuals with dignity and respect.

We observed staff as they went about their duties throughout the service. All staff including administrators, domestic support and cooks were friendly when they interacted with people and their families.

People's privacy was respected. We saw staff knocking on people's doors and waiting for a response before entering.

Good



Is the service responsive?

The service was responsive

People and relatives were involved in planning the care received.

We saw the home displayed each day's activities in the entrance area so people could see what was available to do that day. We saw a chiropodist was present at the home providing nail care and people told us a hairdresser attends once a week.

Good



Summary of findings

People, relatives and staff were able to express their views and give feedback on any issues or concerns. The provider offered different formats for people, relatives and stakeholders to give feedback.

Is the service well-led?

The service was well-led.

The home had gone through a number of changes in management over the past six months. The previous registered manager had left their post in February 2015; a new manager was appointed however they left in March 2015. Since April 2015 a peripatetic manager had been overseeing the service.

We saw the peripatetic manager had made improvements in the quality of care since taking up their post and they were supported to do this by the provider

The provider had a comprehensive system of checks and audits to assess the quality of care provided.

People, relatives and staff said the manager was approachable and made themselves available to speak with if they had any concerns.

Requires improvement



Manor Park 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 took place on 11 June 2015 and was unannounced. A further visit was carried out on 16 June 2015.

The inspection team consisted of two adult social care inspectors, one inspection manager, a specialist advisor in nursing care 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.

Prior to the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events of incidents the provider is legally required to let us know about.

Before we visited the service we contacted the local authority commissioners, local authority safeguarding, the local area's infection prevention and control lead and clinical commissioning group.

During the inspection we met with 12 people who used the service. We spoke with eight staff members including the regional manager, the peripatetic manager, senior care staff and care staff.

We looked at eight people's care records and seven staff files including recruitment information. We reviewed medicine records and supervision and training logs as well as records relating to the management of the service.

We carried out an observation using 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 undertook general observations of how staff interacted with people as they went about their work.

We looked around the home, visited people's bedrooms with their permission and spent time with people in the communal areas.

Is the service safe?

Our findings

We observed people receiving the support they needed to take their medicines as prescribed. The nurse offered people a drink and gave people time to take their medication.

There were systems in place to ensure that medicines had been ordered, stored and administered correctly. However we noted the recording of receipt of medicines had not always been completed fully. The senior care worker told us that she had experienced problems with the fragmented/late delivery of medicines from the chemist. We saw one person did not have part of their medicines for the day available. The senior care worker made every effort to secure the correct medicines and contacted both the GP and chemist involved. Before leaving the home they confirmed they had obtained a prescription and were getting the medicines immediately.

Medicines that were required to be refrigerated were kept appropriately; we saw staff had recorded the date liquid medicines were opened. However we noted gaps in the recording of the fridge temperatures.

We examined the management of controlled drugs. Staff used a controlled drugs register to record the receipt, administration and return of any controlled drugs. The register did not accurately record the stock of controlled drugs in the home. On the first day of our inspection we noted the controlled drugs cabinet contained medicines which were not in use. On our second day the nurse told us they had contacted Boots to get the medicines removed and disposed of appropriately. We observed this take place with staff double checking the medicines and recording details in the control drugs book.

On the first day of our inspection we found one person's medicines had not been signed for and the medicine for that day was not in the pre filled medicine administration card. We spoke to the manager who informed us she had spoken to the nurse on duty for that day who had confirmed that she had given the medicine and would be in to sign the chart later that day. We found medication audits were not being conducted.

Medicines were not handled safely because records relating to medicine were not completed correctly placing people at risk of medicine errors.

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke to told us they felt safe at Manor Park Care Home. One person said, "It's a lovely home, of course I feel safe." Another person said, "They will do absolutely anything for you, the most important thing is that whenever I need them, there is always someone there for you. I never have to wait."

Staff we spoke to told us they were confident in safeguarding and identifying possible areas for abuse. We noted all staff members had received training in safeguarding vulnerable adults, of which the training included identifying different types of abuse. Staff we spoke to could describe the different types of abuse and what they would look out for. We noted safeguarding referrals had been made to the local authority where required.

The manager told us they submitted a weekly return to the regional manager and included within this was the safeguarding log. We noted that since the manager started in April 2015 there had been four safeguarding entries. For each safeguarding record we saw appropriate information was recorded, including the people involved and whether any further action was required. We noted if action was required then the weekly log was updated so a running history of the concern was available.

We examined the accident and incident records. The manager showed us how the information was stored electronically within the services own system called Datix. We saw information was collected, including types of incidents and times they occurred. We asked the manager if an analysis was carried out to identify any trends or contributory factors which may require investigation. They advised the information was recorded against the person who used the service. We asked the manager how many accidents had occurred in the last 12 months. They attempted to retrieve the information from the system but were unsuccessful. They advised us that at each point an accident or incident is inputted in to the system they are made aware and would deal with the matter if required.

We noted there was a number of generic risk assessments available in the providers care plan templates, such as falls and moving and handling, however if anyone had any specific areas that were a risk this was documented also. The risk assessments viewed during our visit were thorough

Is the service safe?

and contained information required for people to know the exact process to follow to minimise the risk. For example we noted one person had a moving and handling risk assessment. We saw that the risks were broken down to individual tasks such as transfer from a bed to a chair. The person needed the support of a hoist and we saw clear descriptions were documented, for example what coloured loops were required for the each area on the sling to ensure a safe transfer. We saw that where risks were identified detailed care plans were available for staff on what was required. For example, a risk assessment of choking was complete and the care plan detailed exactly what to look out for and what staff should do if they suspected the person was choking. Importantly it also covered the steps they should take to prevent choking from occurring for that person.

At the time of our inspection there were two nurses, one senior care worker and seven care workers on duty. One care worker had phoned in sick on the day of our first visit; however staff members told us they were able to deliver the care required with the staff members on duty. One staff member said, "We work well as a team, we support each other. We just all want the best for the residents."

We reviewed the rotas for a three week period and noted that staffing numbers were consistent. The provider had a staffing tool called CHES (Care Home Equation for Safe Staffing), which was used to calculate the required staffing level based upon a dependency score for each resident. We noted that as part of the calculation and number of considerations were made, which included people's capacity, mobility, medication requirements and behaviours. The manager told us that they used the CHES tool as a minimum staffing level and they believed there was flexibility. They told us there was certain times where they used local intelligence and increased the staffing numbers, the rotas we viewed confirmed this. For example, we noted an increase in numbers on weekend night shifts.

During our visit we noticed call bells were answered in a timely manner. During our observations we noted no times whereby people were waiting for support or not receiving the care that was required. The manager told us they currently had two vacancies for nursing staff. We noted that any shifts that required cover were covered by the homes staff members, bank staff or agency staff that were specific to the provider. The manager advised that this meant they

could ensure staff members were suitably trained and would provide good quality care. One person we spoke to said, "I never have to wait. None of us do. There is always people around if you need them." One relative said, "There is always staff around when I visit, I certainly haven't seen anyone wait."

We saw that as part of the recruitment process all staff had completed a Disclosure and Barring Service (DBS) check. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults. The manager told us that although they had completed DBS checks during recruitment of staff members, they had not completed three yearly updates as required by the Local Authority. However, at the time of our inspection we noted they had been working through this and a large portion of the staff now had a recent DBS check and further staff members had sent there's off. We also saw the provider carried out reference checking in line with their recruitment policy.

We noted the provider kept a log of all the nursing staff it employed and their PIN for professional registration. We saw that for each nursing staff member the provider had previously checked the status of the individual's registration and had noted when their PIN was due to expire so they could ensure it was renewed appropriately.

The manager advised they were in the process of refurbishing areas of the home. We noted two rooms had already been refurbished. The manager advised that people were included in decisions in relation to the refurbishment, such as selecting the flooring for their bedroom. The manager had recently sought funding to also refurbish a number of communal areas and bathrooms.

We observed the emergency procedures in place including personal emergency evacuation plans (PEEPS) for people who used the service. These were held centrally in the office and within individual care plans. We saw it detailed action to be taken in the event of an emergency and was accessible to staff. This meant the provider had suitable plans to keep people safe in an emergency.

Is the service effective?

Our findings

People told us they felt staff had the right skills and experience to support them. One person said, “All of the staff are brilliant, you couldn’t fault the girls.” Another person said, “[staff member] is brilliant, they will just do anything for you, they always know what to say and do to keep us entertained.”

The provider had a system in place which recorded all staff training and allowed management staff to review compliance against either individual courses or overall per person, or per home. We noted there were 17 courses deemed as mandatory by the provider, which included areas such as infection control, safeguarding, moving and handling and equality and diversity. Staff told us that dementia training was also mandatory for all staff members. We noted a large portion of the training was eLearning; however there were a number of face to face elements such as moving and handling, resident experience and Mental Capacity Act 2005.

We saw the majority of staff were up to date with all of their mandatory training. Out of 57 staff members, 10 staff members had some courses that had expired in March 2015 (the provider requires all staff to complete the training every 12 months), therefore they were required to complete updates. Staff told us there were also additional training opportunities available. One staff member said, “There are other courses on the system we can access, like more medication training.” We noted the provider offered a number of areas of additional training which was option for staff and included areas such as anaphylaxis, basic life support, palliative care and pressure ulcer prevention.

One staff member told us about the additional training they had been supported to complete. They said, “I did my Level 2 and 3 in Health and Social Care and now I’ve done a diploma in Dementia Care. They have really supported me to learn and to keep it up to date as well as the dementia research changes all the time.”

The manager told us that due to the changes in management they had noted on their arrival at the home in April 2015 that appraisals and supervisions had lapsed. They had however ensured that all staff members had now

received supervision over the past two months. They had also set up a co-worker system so staff members had a clear hierarchy structure and senior care staff and nursing staff could support the supervision and appraisal system.

The manager advised that none of the staff members had received an appraisal in the past 12 months; however we noted that a number of appraisals had only expired in May 2015. Now all staff had received a first supervision under the new management, the manager was working on a plan for appraisals. The manager had worked with the senior staff members and they were starting the appraisal process and recording their conversations. The manager was then going to meet each staff member and review their documented conversations and finalise each appraisal.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and to report on what we find. We saw that DoLS authorisations had been requested where required. The manager advised, “Every resident that needed a DoLS have been submitted. We are just chasing the Local Authority for some of the paperwork to confirm it’s been authorised. We’ve had verbal confirmation though.”

The staff members were spoke to told us they had received training in MCA and DoLS and they were confident in supporting people who did not have capacity. We noted that where required ‘best interest’ decisions had been made, and the person’s loved ones had been involved wherever possible. We saw that where people did not have capacity the care plans were detailed and identified which tasks they did not have capacity to make decisions about and who should be involved, such as the social worker, doctor etc. We also saw that where people didn’t have capacity to make decisions it was clear why, for example that they couldn’t retain the information or understand the options to make a decision. We saw that in some people’s care plans it was clear that they could make decisions regarding non-complex decisions day to day but as they had fluctuating capacity would need support with more complex options.

Staff told us how they supported people to make decisions on a daily basis. One person said, “Sometimes I can’t be bothered to make a decision so they give me options and I

Is the service effective?

pick one, either way they always say is this okay". One staff member we spoke to said, "We try and involve people in as much as we can, there are so many choices each day, like what do they want to wear, what do they want to do."

We observed the lunch time meal during our visit and noted that this was a pleasant dining experience and most people ate all of their food provided. We saw a number of people had a second portion, especially on the pudding. We noted there wasn't a good choice in terms of the meals available that day; however people told us if they did not want the food that was offered they could always ask for something else. One person we spoke to said, "Sometimes you just don't fancy it, the food is always lovely but the other day I just didn't want it so they made me a sandwich instead." We saw that on a visit two people didn't want the pudding that was available, therefore staff offered them alternatives and they each had yoghurt instead.

We noted each dining room had a large menu board which detailed the menu for the day. There was three dining rooms in the home and we noted that the menu was not up to date in all cases. We noted that unless you went into the dining room you would not know the options for the day as the menus were not displayed in the hallway,

reception or in communal areas. We noted this may restrict people who were not mobile knowing the menu in advance, also it meant the menu was not clearly visible to any visiting family members.

We saw that where required people were supported to have specialist or modified diets. In addition all staff received training in allergen awareness as part of their mandatory training. This training covered the new legal requirements in food allergies.

When looking at people's care documentation we noted that any dietary requirements were clearly noted, for example one person required a soft diet and this was clearly described. One person we spoke to said, "The puddings here are always lovely, all of the food is really. I would recommend it."

During our visit one person was repeatedly sliding themselves out of the bed. We saw that the staff were proactive and arranged for a physiotherapist to come and complete a new assessment that day so that appropriate equipment could be set up to minimise the risk of harm.

We saw evidence in care records of cooperation between care staff and healthcare professionals to ensure people received effective care. For example, one person had been referred to the Falls team following an increase in falls.

Is the service caring?

Our findings

We spoke to 16 people who used the service and they all spoke highly of the care they received. We witnessed staff treating people with compassion and kindness. One person said, “Staff here are nice and I get good care”, and “Care here is brilliant, the lasses are great”. Another told us, “I’m happy here.” However another person told us, “I’m sick to death of being here.” A relative said, “The staff are great and my [relative] is happy here.”

The home had a nice calm atmosphere. People seemed happy and comfortable with staff and other people who used the service. We saw care workers sat with people and chatted about their local town as they watched a video together showing different areas of their town in the 1970s.

We observed people being asked if they needed anything either to drink or eat. We saw good interactions between staff and people using the service. One care worker was patient and sympathetic to a person who was distressed and needed reassurance. We saw staff popping into people’s rooms to see if they were okay or if they needed a drink. We noted staff knocked on people’s doors before entering rooms and were heard to speak respectfully and pleasantly to people.

One relative told us, “When my [relative] came in here the GP told me to prepare for the worst and they have now been here for three years during which time they have been bedfast. The best reference I can give the home is that my [relative] has never had a bedsore and is always clean and tidy. If I have any issues I raise them with the staff and they are sorted straight away”.

We observed staff as they went about their duties throughout the service. All staff including administrators, domestic support and cooks were friendly when they interacted with people and their families. We observed a relative being offered a cup of tea while waiting to take their relative out. The care worker took time to chat with the relative and enquired after other family members. It was clear from conversations and interactions staff knew the people they cared for as individuals.

We saw people were asked if they wished to take part in activities. Staff would encourage people to get involved but did not pressure them to take part if they declined. Staff offered other pastimes for people to engage in. We saw staff accompanying people to the garden area and enjoy sometime in the sunshine.

During the morning medication round a person who was restricted to bed asked for some company, the nurse immediately ensured a care worker sat with the person. Throughout the morning we noted staff popping in and chatting, sat watching television and reading with the person.

We saw rooms on the ground floor had people’s life stories displayed on their doors, which is useful in helping staff to know the person better. We noted on the first floor there was an absence of life stories however on the second day of our inspection the manager had the information ready to be fixed to each door. We saw people’s rooms were personalised and some had ‘memory boxes’.

Over the mealtime we carried out observations. We saw staff acting in a kind and supportive manner, asking people if they had enough and enquiring if they needed assistance or more to eat or drink. However, we noted one care worker wiped the hands and mouth of a person without asking which the person objected to, telling the care worker they would do it themselves.

We noted that staff were respectful in protecting people’s dignity. We saw staff always ensured toilet doors or bedroom doors were closed when delivering personal care. Staff understood the importance of maintaining people’s dignity. One care worker told us, “I always ask the person first if they would like some help and explain what I’m doing.”

Where people had no family or personal representative we saw the home provided information about advocacy services. We saw posters detailing the support available on notice boards. The manager told us currently no person using the service required the support of an advocate.

Is the service responsive?

Our findings

People were keen to tell us about the activities that were on-going at the home. One person said, “[staff member] takes us out in the car, we’ve been to the park, [staff member] will do anything to make us residents happy.” Another person said, “I really like gardening so I helped do the garden. All the residents love the staff, especially [staff member]; they do lots of different things and keeps us busy.”

We noted a full time activities organiser was in post and a programme of activities was on display. The activities programme was displayed in the reception area, it listed 1:1 individual games for the morning and keep fit and basketball for the afternoon. We observed people take part in a game of short basketball with people taking turns to put a ball through a hoop in the centre of the floor.

One person told us, “I don’t like going in the lounge, when [staff member] gets the time we are going to the park for a walk and a cup of tea.” It was confirmed by people and visitors that some people went to the park once a week for an outing and a coffee.

We observed people doing exercises with a ball, playing skittles and dominos. The domino session was well received with both male and female residents playing and with staff and people engaging in ‘banter’ with each other. One person told us, “This is a good activity and I usually win. I used to play this many years ago”.

On the day of our inspection a chiropodist was present at the home providing nail care for those who wanted it. People told us a hairdresser attends once a week. Staff told us a singer is brought in every few weeks and pet therapy is organised twice a year. It was also pointed out there was a pet rabbit in the garden area and people could see that if they wished.

Staff had access to information about people’s needs and preferences including their likes and dislikes. Staff told us they knew about people’s preferences from talking with them. For example, this included details about people’s dietary choices, what activities they like to take part in and what time they like to get up or go to bed.

When we asked staff to describe a person’s needs they were able to without consulting the person’s care plan. People’s care plans we viewed contained comprehensive information about them and how they wanted to be cared for. We saw a photograph of the person, a care plan assessment which outlined the person’s needs and a consent to care form which described the person’s goal, ‘to maintain their lifestyle’. Each care plan covered personal hygiene, nutrition; mobility; communication and medication. We noted in the mobility section there was detailed information on how to use the hoist for the person with clear directions for a care worker to follow.

We saw monthly reviews were carried out from April 2015 when the new manager had taken up the post, however prior to that date there was no evidence reviews had been conducted. The manager told us the provider was introducing a new format of care plans. One care worker said, “The new system is better to follow and easier to record details on.” This meant staff had access to up to date information about how people should be supported and cared for.

During the inspection we were told resident/relative meetings are not held very often because of poor attendance and one had not been held for a while. The manager told us the provider had a policy to ensure that daily feedback is gained and staff have a daily walk around the services to collect feedback. We saw in the reception entrance a feedback point with a touch screen for people to access. The manager advised all visitors and external professionals are constantly encouraged to use the facility and give feedback. They said any negative comments are immediately emailed to the manager for them to action.

People and relatives told us they were aware of the complaints procedure and knew how to raise concerns. One relative told us they had reported an issue about the way a staff member spoke to a person. They said that they had a meeting with the Regional Manager and the matter was looked into. The manager advised us complaints were recorded electrically and one had been received in the last 12 months. We saw that a complaints policy and procedure was in place.

Is the service well-led?

Our findings

The home had gone through a number of changes in management over the past six months. The previous registered manager had left their post in February 2015; a new manager was appointed however they left in March 2015. Since April 2015 a peripatetic manager had been overseeing the service. The regional manager told us they had been interviewing for the managers post the week of our inspection, however they were not aware as to whether anyone had been appointed during our visit. The home also had a vacancy for a deputy manager which was currently being advertised.

Visitors could not recall having completed any surveys about care received in the home although one visitor did state, "I am concerned about the change in managers which is not a good thing." Despite the changes in management we noted a positive atmosphere amongst staff on duty during our inspection. One staff member we spoke to said, "I've worked here for six years and I love it. We've had some management changes but we are a good team so it hasn't rocked us."

The manager showed us an aid memoir which was produced by the provider. This was a calendar of all the mandatory audits and checks that were required and their frequency. We noted since the manager had started in April 2015 they had worked on ensuring all of the providers standard audit systems were in place and understood and recognised by staff members. When we spoke to the manager about a permanent manager being recruited, we asked about how they could ensure consistency, they said, "All of the processes are set up now; we have companywide system to ensure the quality is right. I've spent time with people on what they are and why they are done so it's now just a case of following the process."

The provider had a system in place for rewarding staff, entitled ROCK (Recognition of Care and Kindness). The home had recently started to advertise the scheme by displaying posters. The manager told us they had already received six ROCK nominations from relatives. We viewed the nominations and noted some of the comments included, 'Always available if you have any questions regarding what's happening to keep residents occupied,' '[staff member] is thinking ahead for the welfare of the

residents regarding activities and fundraising events' and 'He is respectful of their individual needs and always caring and cooperative and his cheerful and positive attitude with residents and relatives is very welcoming'.

The manager submitted a weekly return to the regional manager as part of the quality monitoring program, as well as safeguarding incidents, the weekly return also included sickness and any staff absence, disciplinary, investigations, grievances and suspensions. The manager said this made sure all regional managers were aware of what was going on in the home, but also so the managers could access support if needed.

We looked at what the provider did to seek people's and relative's views about the quality of the service. The manager said questionnaires were sent out yearly to relatives and people who use the service to gather information. They also said the provider had introduced a system, 'Quality of Life' programme where staff would seek daily feedback about the quality of the service from people. Following recent feedback a full review of all entertainment was carried out.

We saw the provider had a weekly newsletter 'Inform' which is sent out to staff via email. It reports on successes of the Quality of Life programme and details the innovations the provider is making in different areas of care. The manager also told us about a training programme the provider was introducing Care Home Assistant Practitioner (CHAP) this covered technical skills, leadership, communication and innovation development.

On the first day of our inspection we found the nurse's office which contained personal and medical in confidence information, such as care plans and details of hospital appointments was unlocked. We brought this to the attention of the manager. When we revisited the service on a second day we found this door was securely locked and there was a notice on the door to remind staff that it should be locked at all times. The manager told us that arrangements had been put in place for confidential information to be disposed of appropriately.

We saw a staff meeting had been held in April 2015 and the manager said it was well attended. They also said a separate nurse's meeting was held. We viewed the meeting minutes and saw issues covered included Nursing Midwifery Council (NMC) codes of conduct, handovers and

Is the service well-led?

supervisions and CQC standards. A number staff confirmed that they had attended and welcomed the opportunity to get together. The manager said they intended to have the team meeting every other two month.

The provider has notified the Care Quality Commission of all significant events which have occurred in line with their

legal responsibilities. The manager was also proactive in communicating with the inspector of the service, advising them of current situations prior to notifications being made.

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 Medicines were not handled safely because records relating to medication were not completed correctly placing people at risk of medication errors. Regulation 12(2)(g) the proper and safe management of medicines