

Hallmark Care Homes (Wimbledon) Limited

Kew House

Inspection report

58 Spencer Hill Road
Wimbledon
London
SW19 4EL

Tel: 020 8971 0190

Website: www.hallmarkcarehomes.co.uk

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Ratings

Overall rating for this service

Requires Improvement



Is the service safe?

Requires Improvement



Is the service effective?

Requires Improvement



Is the service caring?

Requires Improvement



Is the service responsive?

Good



Is the service well-led?

Requires Improvement



Overall summary

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, and to pilot a new inspection process being introduced by the Care Quality Commission which looks at the overall quality of the service.

The last inspection was carried out in August 2013. At that time we found that all legal requirements were met in the areas in which we looked.

Kew House is registered as a care home for up to 81 adults. It provides accommodation for people who require personal care and nursing. At the time of the inspection there were 71 people living at the home.

There was no registered manager in post and there had been several unregistered managers at the home since the previous registered manager had left over a year ago. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

The home was divided into three floors. The top floor, provided care to people with high nursing needs. The middle floor, provided nursing care to people with dementia while the ground floor, provided care to people who had lower levels of support needs.

We found that medicines management in the home was not safe, and people did not always get their medicines as prescribed. This meant that the service was not meeting the regulation in relation to the management of medicines. The action we have asked the provider to take can be found at the end of the full version of this report.

We found that there were not enough staff employed in the home to meet people's needs. This meant that the provider was not meeting the regulation in relation to staffing. The action we have asked the provider to take can be found at the back of the full version of this report. Soon after the inspection the provider confirmed they had permanently increased staff numbers in response to our findings.

Staff had a good understanding of how to identify abuse or neglect, and knew how to respond appropriately to this to keep people safe. There were policies and procedures in place to make sure people were safe.

Staff had a good understanding of the Mental Capacity Act 2005 and their responsibilities under this, with clear policies in place. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). People's rights in relation to this were therefore properly recognised, respected and promoted.

Recruitment procedures were robust, with procedures in place to ensure that only people who were deemed suitable worked within the home. There was an induction

programme for new staff which prepared them well to do their role. Staff were provided with a range of training to help them to carry out their roles. Although staff did not receive regular support and supervision, the provider was putting systems in place to improve this.

People had care plans in place which reflected their assessed needs. Staff had a good knowledge and understanding of people's individual needs and preferences. People were supported effectively with their health needs. The home supported people who were at risk of malnutrition and dehydration, and those with specialist needs related to their diet. Referrals were made promptly to specialists, and guidance from them was followed effectively.

The feedback from people regarding whether they were treated with kindness and compassion in their day to day care was mixed. However, we observed that staff cared for people in a person-centred, rather than a task-based way, and we saw that people were treated with dignity and respect. Relatives were able to visit without restriction.

Equipment in the home was well maintained and fit for purpose. The design, layout, environment and signage in the home support people to maintain their independence and minimised risks.

People using the service, relatives and staff were encouraged to give feedback on the service. People knew how to make complaints and there was an effective complaints management system in place.

The home carried out regular audits to monitor the quality and health and safety of the service and to plan improvements.

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. Medicines management in the home was not safe, and people did not always get their medicines as prescribed.

We found that there were not enough staff employed in the home to meet people's needs. However, soon after the inspection the home confirmed they had permanently increased staff numbers in response to our findings.

Staff had a good understanding of how to identify abuse or neglect, and knew how to respond appropriately to this to keep people safe.

Staff had a good understanding of the Mental Capacity Act 2005 and their responsibilities under this, with clear policies in place. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). People's rights in relation to this were therefore properly recognised, respected and promoted.

Recruitment procedures were robust, with procedures in place to ensure that only people who were deemed suitable worked within the home. There was an induction programme for new staff which prepared them well to do their role. Equipment used to support people was well maintained and fit for purpose.

Requires Improvement



Is the service effective?

The service was not always effective as staff did not receive regular support and supervision across the home.

People who used the service had care plans in place which reflected their assessed needs. Staff had a good knowledge and understanding of people's individual needs and preferences. People were supported effectively with their health needs. Staff were provided with adequate training to help them to carry out their roles.

The home supported people who were at risk of malnutrition and dehydration, and those with specialist needs related to food well. Referrals were made promptly to specialists, and guidance from them was followed effectively.

Requires Improvement



Is the service caring?

Parts of the service were caring. The feedback from people who used the service regarding whether they were treated with kindness and compassion in their day to day care was mixed, although we saw that staff cared for people in a person-centred, rather than a task-based way and people were treated with dignity and respect. Relatives were able to visit without restriction.

Requires Improvement



Summary of findings

Is the service responsive?

The service was responsive. People who used the service, relatives and staff were encouraged to give feedback on the service. People knew how to make complaints and there was an effective complaints management system in place, with most complaints being responded to promptly. People had access to a range of activities, although some people on the nursing floor were not provided with enough things to do.

Good



Is the service well-led?

The service was not well-led. There was no registered manager in post. There had been several unregistered managers working at the home since the previous registered manager left.

People using the service, relatives and staff were encouraged to give feedback on the service. The home carried out regular audits to monitor the quality and health and safety of the service and to plan improvements.

Requires Improvement



Kew House

Detailed findings

Background to this inspection

We visited Kew House on 16 July 2014. The inspection team consisted of an inspector, an expert by experience, a registered nurse, who acted as a specialist, and a pharmacist inspector. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We looked at some areas of the building, including people's bedrooms and the communal areas. We also spent time looking at records, which included people's care records, and records relating to the management of the home.

Before our inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed this, as well as other information we held about the service and the provider.

This included any notifications that had been received from the home, safeguarding referrals, complaints and any other information from members of the public. We spoke with the local safeguarding team, a commissioner of the service and a dietician.

On the day of our inspection, we spoke with 17 people who lived at Kew House, ten relatives who were visiting the home, the regional director, the provider's dementia specialist and eight members of the staff team. We also spoke with a GP.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Is the service safe?

Our findings

There were some omissions in medicines recording administration and when we checked stocks we were not always able to confirm medicines had been given as prescribed. Our stock checks also showed that some medicines had not been given, but were signed as given. One antibiotic was given twice a day as prescribed on one day only of the course and daily on the other days. For another medicine we could not be sure whether a dose of two tablets three times a day was being given correctly.

The provider had policies and procedures in place to manage medicines safely and report medicines errors. However, we saw that there was no policy to manage anticoagulants, medicines which reduce the ability of the blood to clot, safely. Several people were prescribed anticoagulants and on two floors we were not able to reconcile stock balances with the dose recorded. Two people had no stock of a particular strength of their tablets and there was evidence that nurses and care workers were using medicine belonging to another person to make up the dose. This meant that there were inappropriate arrangements in place for ensuring people had sufficient quantities of medicines in stock, and that people were only administered medicines prescribed for them.

We found a policy was in place for medicines to be used 'when required' or 'PRN' and written guidance was available to enable staff to administer these medicines correctly. Most of these protocols were for pain relief and laxatives. In one unit we saw that people were sometimes also prescribed medicines to calm their mood, but there were no protocols in place for these medicines.

These issues were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the provider to take can be found at the back of this report.

We saw evidence of people's current medicines on their Medicines Administration Records (MAR) and saw that there were records of medicines received into the home. We found people's allergy status was recorded to prevent inappropriate prescribing. Medicines prescribed as a variable dose, such as one or two, were all recorded accurately. There were separate charts for creams and patches so that the place for application was appropriate and could be accurately recorded.

Although most people were unable to manage their own medicines two people were being supported to self-administer their own medicines. Risk assessments had been written and secure storage for their medicines had been provided in their room and were in use by the two people.

We heard from staff that there were meetings being held with the GP practice and supplying pharmacist to improve the management of medicines and ease the storage and stock required by the home. We also heard about the training planned on medicines management and saw the dates on a notice board alerting staff to the forthcoming training.

We found there were not enough staff to safeguard the health, safety and welfare of people even though, as staff told us, staffing levels had been increased across the home in March. We spoke with three people using the service and while one person felt that staffing had improved as some agency staff had been recruited to become permanent staff; two other people felt that there were still not enough staff on duty. One person told us there were delays in being supported to use the toilet because of, "...staff being very busy not because of staff being lazy." Another person commented on there often being delays in receiving medicines as there was only one nurse.

In the information we requested before our inspection the provider had told us that there were eight vacancies across the home. During this inspection the regional director told us that 15 new staff members had been recruited and would start work soon. We looked at staff rotas over the last four weeks, which showed the staffing levels at the home. The provider told us that any shifts, which could not be filled by employed staff, were filled by agency workers. As there was only one nurse each on the nursing and dementia floors as standard, this meant that there was no nursing support when they went for breaks. This meant that people who required nursing support may not always have been able to receive it promptly. A comment made in the recent relative's survey was that there should be a review of, "...staffing levels during staff breaks. Evening handover [around] 8pm needs more thorough and better organisation."

These issues were a breach of Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, the action we have asked the provider to take can be found at the back of this report.

Is the service safe?

People told us that they felt safe. We spoke with three people on one floor and all said they felt safe and happy. One person told us, "I felt very anxious about moving into here after living in my house for 40 years, I now feel that this is my home and that my belongings are well looked after."

Staff with told us they had received training in safeguarding adults. Staff understood what abuse was and how to respond appropriately if they suspected that people were being abused.

We spoke with the local safeguarding team about incidents which had been investigated in recent times. They told us about two current safeguarding allegations which were being investigated. The provider had already notified us of these events as required by law. We also spoke with the local commissioning team who had no current concerns about the service.

The home had policies and procedures in place to ensure that they complied with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The organisation's dementia specialist told us, and we saw records to show, that they were reviewing all people within the home to see if any applications to deprive people of their liberty under DoLS were required. We saw records to show that one application had been made so far and the dementia specialist told us that they were due to make others shortly. Staff we spoke with showed a good understanding of their responsibilities in relation to these. The local authority told us that the service had been in regular contact with them regarding the on-going DoLS assessments.

People were protected by a safe recruitment system. We looked at three staff files and saw they contained photographic identification, evidence of criminal records checks, references including at least one from the most recent employers and application forms. Staff told us that they received an induction when they commenced employment at the home. This included a period of shadowing more experienced staff prior to working alone.

They told us the induction had made them feel confident about their ability to carry out their duties. A volunteer with told us the same recruitment processes had been followed before they could start work at the home. We only saw them with another member of staff in the home, and the volunteer confirmed that they were supervised in the home at all times. This meant that appropriate recruitment checks and induction procedures were being followed.

We found that the service had followed clear staff disciplinary procedures when it had identified unsafe practice. The regional director gave us examples of disciplinary action which had been taken, where necessary, to protect people from harm.

We checked the equipment for helping people to transfer and saw that this was appropriate, working and safe to use. We observed two transfers with a full hoist and saw that both times it was used correctly with two carers and the correct size sling. We saw that each person who used a hoist had individually named slings for their sole use. Staff told us they had received training on how to use the hoists correctly and records confirmed this.

Records also showed that risk assessments had been completed with the individual concerned and their representative, if appropriate, for a range of activities. These identified hazards that people might face and provided guidance upon how staff should support people to manage risks. For example the use of the call bell, moving and handling, falls, nutrition and choking. These were regularly reviewed.

Systems were in place to prevent people from falling, particularly while in bed. Training records showed that staff had received training in the use of bed rails. We looked at care records and saw that bed rail assessments had been completed for all those who had bed rails in place. We checked some bed rails and found them to be in good order. Staff explained that they encouraged people to wear appropriate footwear to reduce falls when walking around the home.

Is the service effective?

Our findings

Staff did not have regular supervision. The regional director told us that this was something they were aware of, and they were putting structures in place regarding this, such as providing the nurses with supervision training. Records showed that two weeks before our inspection there had been group supervisions with the nursing and care teams across the home to outline the purpose and importance of supervisions. We spoke with the two nurses on duty and both confirmed that they did not supervise care workers, although both line managed around seven staff each. One told us they had not been able to carry out any supervisions at all this year and had raised their concerns about this with management. Another told us they did not supervise staff at all and they would not have time to do so given their workload. Care workers told us they did not receive regular supervision. However, staff we spoke with told us they felt well supported. The regional director told us that annual appraisals were due in October and all staff would take part in these.

These issues were a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The action we have asked the provider to take can be found at the back of this report.

People were supported by staff who had the necessary skills and knowledge to meet people's assessed needs, preference and choices. We spoke with three people who felt that staff had a good understanding of their individual needs. We looked at five care plans and saw they reflected people's assessed needs. They covered a range of areas such as nutrition, mobility, dexterity, falls and communication. Some care plans gave examples of how to read the facial expressions of people who were non-verbal to identify certain types of issues, such as incontinence or pain. Staff we spoke with were knowledgeable about the people they cared for and were able to tell us in detail about their preferences and health needs.

Staff had effective inductions and training. Staff told us their induction was thorough and prepared them well to do the job. As part of this induction they got to know people, their preference and choices, read care plans, shadowed other staff and completed a range of e-learning within the first six months, for example, in safeguarding adults. Staff

spoke positively about the training, they told us, and we saw records to show, they were offered a range of training, in topics such as bed rail safety, fire awareness, first aid, food hygiene and infection control.

Some staff commented they found the dementia training was particularly good. We spoke with the organisation's dementia specialist. They told us that they had written a draft dementia strategy and it had been agreed that dementia training would take place annually for all staff, including domestic and catering staff so that they would understand the needs of people with dementia better and how their role impacts them. We were told that there would be dementia champions in place soon who would learn to supervise and act as a role-model to others.

People found mealtimes pleasurable, and their food was served at an appropriate temperature. We saw that mealtimes were unrushed and the delivery of meals was organised and calm. Staff supported people in a timely and professional manner. We observed that people were supported to eat with staff who sat at the same level as them, talked with them in a respectful way and stayed with them for the duration of the meal. Food was delivered to people whilst it was hot and we saw that it was well presented. Portion size appeared appropriate and additional food was offered. We saw that meals were provided in the dining rooms or in people's own rooms if they requested this. We spoke with four people after they had had their meals in their rooms and all told us they had been given their preferred choice and the food was tasty and hot.

People's identified nutritional needs were monitored and managed. Staff were knowledgeable about people's nutrition, dietary needs and preferences. For example, they could tell us who was a vegetarian and who required their food to be soft, blended or cut into small portions. Staff were aware of which people required their liquids to be thickened to reduce the risk of choking, and were consistent in telling us how much thickener was required.

People were involved in decisions about their nutrition and hydration needs. We saw that people were given a choice of meals at the point they were served, and people confirmed that they were always given choice. People said they had regular meetings in which they were involved in menu choices and encouraged to feedback on meal quality.

Is the service effective?

People had enough to drink through the day. We saw that drinks were readily available and that staff encouraged people to drink during our visit, as it was a hot day. We observed staff checking with each other to ensure people were adequately hydrated.

People, especially those with complex needs, were effectively assessed to identify the risks associated with nutrition and hydration. Records showed that staff monitored people's weight monthly and looked for any patterns of weight loss. When people were not well enough to be weighed, staff used an alternative assessment, called "Mid-Upper Arm Circumference (MUAC)" to monitor their weight. Staff told us, and we saw records to show, that, on the nursing unit, each person had a "Malnutrition Universal Screening Tool (MUST)" assessment which was reviewed regularly. We looked at the assessments for four people and saw that this tool had been used effectively and appropriate action had been taken where concerns had been identified. We saw that food and fluid charts were completed by staff to monitor whether people were receiving enough fluids.

People had access to dietary and nutritional specialists as their assessed needs indicated. Staff told us how people who were at risk of malnutrition or dehydration were referred to a dietician for specialist support. We spoke with a dietician who told us that the home was good at optimising people's food with normal dietary inputs such as butter, sugar and cream. One person told us that staff encouraged them on a daily basis to have dessert to help boost their calorie intake as they did not like the supplement drinks they had been prescribed. The dietician said they recalled there being a high calorie menu available and homemade nourishing drinks and snacks between meals and we observed this.

People who had difficulties swallowing were referred to a speech and language therapist (SALT). We reviewed the SALT guidelines for two people and saw that they required a pureed diet and thickened fluid. We observed that this was correctly given at lunchtime and staff ensured the people were in the correct position before supporting them to eat to reduce the risk of choking. The nurse also checked on this throughout the mealtime. We saw that both people had appropriate choking risk assessments in their care

plans. We observed staff raise concerns with a nurse about a person's eating and drinking. We later checked the records and saw that these concerns had been appropriately recorded and actioned.

Where people were assessed as needing to intake food directly into their stomach via a PEG feed we saw that specific advice from dieticians were followed. We saw that advice around how to support the person into an appropriate position was followed. Staff we spoke with had a good knowledge of the risks of aspiration due to PEG feeding, the signs of infection and when antibiotics would be required.

When people's needs changed, referrals were made quickly to relevant health services. We saw that a medical emergency was dealt with promptly and effectively. Staff told us, and records showed, that other people had been promptly referred to dieticians, physiotherapists and to the end of life team as appropriate. We saw that any changes in conditions and the advice obtained had been documented in care plans. One person told us how they had requested a consultation with an particular external specialist and this had been actioned to their satisfaction.

People's day to day health needs were met, for example, pressure sore management was effective. Staff told us how they regularly checked people's pressure areas, and we saw that body maps were used to record the locations of any pressure sores found. We saw records to show that assessments of risk were carried out monthly. Staff told us they were trained to complete these and showed a good level of understanding around them. We saw that where issues were identified, the necessary action was taken. We reviewed the arrangements in place for four people who had been assessed as at high risk of pressure sores and saw that they had the correct pressure-relieving mattresses in place. Where people required assistance to change position while in bed we saw that charts were in place for this to be recorded. We observed staff reposition one person and saw that this was done in a safe, caring manner. Staff had a good understanding of individual needs of clients in regards to their limitations to position themselves and how long the client should sit out in their chair for.

We saw that the home had measures in place to avoid people being admitted to hospital, as far as possible. Records showed that for some people there were

Is the service effective?

treatment plans developed between the home, a specialist physiotherapist and the GP to prevent hospital admissions. Records showed that communication between the teams was regular and effective.

People's needs were met and their independence promoted through the use of signage, decoration and other environmental adaptations. The kitchen-dining areas on each floor had facilities for people to prepare their own meals with support. Safety adaptations had been made so that people had full access to the kitchen-dining areas at all times. All corridors and doorways across the home were wheelchair accessible. The home was at the end of a refurbishment programme at the time of our visit and people told us that the overall feel of the home was "luxury". We saw that best practice in dementia care had been followed with contrasting colours used to indicate doors and no busy patterns on carpets to avoid visual disturbances. On the dementia floor there was

reminiscence room with objects from previous eras placed to prompt memory. We saw new rummage boxes along the corridor which staff told us would soon be filled with items to stimulate those looking through them.

There was a range of communal areas on each floor and people had appropriate space for activities and to see their visitors. We saw that there were other facilities such as a cinema and a massage/ hairdressing salon. We were told that a massage was included each week in the fees. Each room had an en-suite wet-room to allow people to maintain their independence as far as possible. There were bathrooms on each floor which were all spacious with sufficient room for wheelchair and hoists to be used.

Each floor had a garden area. Staff told us how people using the service were supported to maintain the plants there. There was a garden to the front of the home and we saw people choosing to sit outside throughout the day. The reception area had a juice dispenser and facilities for people to freely make hot drinks, with seating.

Is the service caring?

Our findings

People were involved as partners in their own care as much as they were able to do so. Staff supported and involved them in planning and making decisions about their care, treatment and support. We observed staff discussing people's care with them and being asked about their choices for the day. People's care plans showed they had been reviewed and discussed in consultation with the people themselves. Also, those who mattered to people were also encouraged to make their views known about their care, treatment and support. One relative told us, "They have just done a new care plan for [my relative], I have given my comments."

Four people using the service made positive comments such as, "[The staff] are very good here. Everybody is very friendly and helpful. All of the staff, the handyman and the ladies. If someone needs something it's never too much trouble." Another person said, "These girls work very hard. I appreciate what they do. They're very kind. There's nothing they won't do for you... Someone just helped me walk around the garden and it was lovely." One person told us how staff would sit with them at night time to comfort them when they felt anxious.

However, not all people felt they were treated with kindness and compassion in their day to day care. One person told us, "They [the staff] need to be kinder and take things more slowly... You are relieved to see certain faces." We spoke with four relatives and one told us, "One great thing is some of the carers; they're fantastic." Another relative confirmed that they would recommend the home to their own mother. Another person said, "Some of the

carers could be gentler and communicate more. Some of the carers are very compassionate and some are not." We discussed this feedback with the regional director so they could take appropriate action.

We saw that staff cared for people in a person centred, rather than a task-based way. For example, one care worker told us that people were always asked when they wanted to get up, and this was respected. Another care worker told us, "Even if people don't speak you can have eye contact and touch, and relationships can grow." The dementia specialist told us that the home was accessing an external programme "Ladder to the Moon" which challenged staff to get out of the habit of doing only task orientated care and work more therapeutically. One staff member told us of some games they had learnt on dementia training which they told us people enjoyed and it stimulated their memories.

People were treated with dignity and respect and had the privacy they needed. We saw staff knocking before entering people's bedrooms on all floors. One staff member told us, "We must knock, it's their home!" People using the service also commented positively on this practice. We observed that when people were supported to leave rooms to go to the toilet this was done in a dignified manner. People were supported to dress appropriately as necessary. Staff told us, and we heard, that they addressed people formally unless the person had said they preferred their first name to be used. Such preferences were documented in their care plans.

The relatives we spoke with told us that they could visit without undue restriction.

Is the service responsive?

Our findings

People had access to activities that were important and relevant to them and were protected from social isolation. We saw that the activities people liked to do were listed in their care plans and staff told us they tried to cater for these preferences. One person told us, “They provide lots of activities which are good. We have a knitting club”. We observed a range of activities taking place in the home, such as baking with the home’s “lifestyle assistant”, and a sing-along. Staff told us that group activities were arranged most days and we saw an activity programme for the current week. This programme listed four or five activities each day, such as “Bastille Day French Cuisine” afternoon board games and brain exercises. Staff also told us that several staff had been trained by an external company to lead fun group-based exercise classes, such as chair cheerleading and chair aerobics, to improve mobility, social interaction and mental stimulation.

Staff told us that each week people were offered beauty therapy as part of their care package and we saw this listed on the activity programme. One relative told us, “I asked them to do [my relatives] nails and they did”. A recent relative survey showed that 69% of respondents rated their family member’s activities as “excellent” or “good”. The same survey showed that 100% of responder’s agreed that their family member was able to pursue their interests and hobbies if they chose to do so.

However, during our inspection we did not see any group activities taking place on the nursing floor. Although we did see people from this floor being supported to do some, but not all, activities elsewhere in the home. One person on this floor told us they got lonely. They also said they would like to go to the coffee shop every day to watch the world go by, although there were not enough staff to facilitate this. Another person said that, at times, they also felt lonely as they were not offered enough activities.

People, their relatives and friends were encouraged to provide feedback. Staff told us, and records showed, that there were monthly meetings for people using the service on each floor and regular relatives meetings. Minutes of these meetings showed that suggestions were encouraged, and responses were given to queries raised, with actions noted. We saw records to show that dining room committees had recently been set up on each floor for people to express their views on the dining service, to make suggestions and complaints. Records showed that people’s suggestions had been noted and actioned, such as, “cream with puddings, less cakes, more veal, strawberries’ and raspberries” and positive comments had been made such as, “Quality and food choice is good, requests are being made, can see the difference in new menus”.

People’s concerns and complaints were encouraged, explored and responded to in good time. People using the service and their relatives told us they knew how to complain and believed their complaints would be dealt with appropriately. We saw information about how to complain displayed in the communal areas and in the service users’ guide. One relative told us they had made a formal complaint and were satisfied with the way it was handled. We heard how management discussed the concern at length with them, spending time listening to the issues, and had taken action as agreed. The relative told us that the situation was “better but not resolved”. The recent relative’s survey showed that 79% rated the response time to any concerns raised as excellent to average.

Concerns and complaints were used as an opportunity for learning or improvement. We looked at the complaints log and saw that complaints had been appropriately recorded. We saw an investigative report carried out by the regional director regarding one recent complaint, which showed the issues had been considered in depth. The report included an action plan as to how changes would be made to certain processes to improve them in light of the complaint. The regional director told us how they regularly analysed the complaints to look for patterns.

Is the service well-led?

Our findings

There was no registered manager in post and communication with the home showed that several unregistered managers had led the home since the previous registered manager left.

A person at the local authority safeguarding team told us they were concerned about the high turnover of managers, and that they were not sure who the manager was currently. They commented that the service needed a period of stability. The March 2014 relatives and residents' meetings stated that, "Relatives were concerned that there is poor communication when it comes to team members/managers leaving and starting." One relative told us that there were a lot of managers in the home, and they were not sure what role each played.

Staff felt the organisation was well led, but that they required greater individual support to develop. Staff we spoke with felt there was not enough direction or supervision to monitor staff and develop skills.

Several people using the service and relatives commented that there was a high turnover of staff. One person said, "They need to retain their good staff. Some of them are very sweet. They need to nurture staff." Another said, "The staff turnover quite often. There are many agency staff." The regional director told us how less staff were leaving compared to last year. Records showed that five staff had left between April and June, compared to eight in the same period the previous year. The regional director told us that all staff who left were offered an exit interview, although no patterns had been identified as to why people were leaving.

The service had a system to manage and report accidents and incidents, and systems were in place to continually review these. The regional director explained, and we saw, how an information log of significant areas such as weights, accidents, incidents, pressure ulcer care, feedback, audits and was kept up to date. They told us how, they were able

to monitor trends in these areas, and these trends were monitored by the company centrally as well as at the service level. They said how recently this system had identified a person who was having frequent falls and the reasons for this were being investigated.

We saw records to show that an, ongoing, action plan for the home was in place. Records listed areas targeted for improvement, who was responsible for each action, the timescale for completion as well as the date completion was met. Recent actions included assessing who had bed rails and how they were managed and to ensure that personal protective equipment (PPE) was used in the laundry.

Robust quality assurance systems were in place and these were used to identify and action areas for improvement. Records showed that a range of monthly audits were in place such as for care plans, which identified issues including whether there was an up to date care plan and related document for each assessed need for individuals, and whether care plans and daily records used respectful language when referring to people. There was also a monthly health and safety audit in place, as well as audits of all domestic and catering issues. We saw that inspection visits by senior management took place regularly. These looked at many areas including cleanliness and infection control, privacy and dignity, fire drills, exploring the team's knowledge of care plans. However, the medicine audits did not pick up the issues we found. The audits we saw were not in sufficient detail to ensure the safe administration of medicines to people.

The service had appropriate data management systems in place. All documentation we requested during our inspection was readily located and passed to us. We saw that the computer systems contained accessible information such as records of all meetings involving people using the service, staff and relatives; the various audits; accidents and incidents, complaints and safeguarding incidents.

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
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People who used the service were not protected against the risks associated with the unsafe use and management of medicines, by means of making appropriate arrangements for the safe administration of medicines used for the purpose of the regulated activity. Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on regulated activity. Regulation 22

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place to ensure that staff were appropriately supported to enable them to deliver care and treatment to people safely and to an appropriate standard through receiving appropriate supervision. Regulation 23(1)(a)