Haydn-Barlow Care Limited

Holmfield Nursing Home

Inspection report

291 Watling Street
Nuneaton
Warwickshire
CV11 6BQ

Tel: 02476345502

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 9 and 10 August 2016. The visit was unannounced on 9 August 2016 and we informed the provider we would return on 10 August 2016.

Holmfield nursing home provides accommodation, nursing and personal care and support for up to 22 older people living with physical frailty due to older age and complex health conditions. At the time of the inspection 21 people lived at the home. The home has two floors; with a communal lounge and dining area on the ground floor.

The home is required to have 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 and associated Regulations about how the service is run. At the time of our previous inspection in January 2016, there was a new manager who was not yet registered with us. This manager became registered with us in March 2016.

When we inspected the home in January 2016 we identified breaches in the regulations relating to safe care and treatment and good governance of the home. We rated the home as 'inadequate' and placed the home in 'special measures,' which meant we kept the service under review. We served a warning notice on the provider because the quality of the care the provider has responsibility for, fell below what is legally required. We told them improvement must be made by 10 June 2016. At this inspection visit, we looked to see if the requirements of the warning notices had been met and found they had. Improvements had been made, however some further improvement was still required. Following our inspection feedback to the provider and registered manager, the provider informed us how further improvements would be implemented and gave us timescales for some of these.

People told us they felt safe living at the home. Staff knew how to protect people from the risk of abuse because they had been trained to safeguard people and knew what to do if they had a concern.

People felt there were not enough staff on shift and we found sufficient numbers of staff were not always available to meet people's needs in a timely way that promoted their safety. Risks to people were assessed to reduce the risk of harm or injury, however, actions staff should take were not always shared with them which meant risks to people were not always minimised.

People had their prescribed medicines available to them and were supported to take these by trained staff. Some information about medicines was not kept by staff as needed and checks on the safe temperature storage of medicines in the medicine fridge were not effective.

Staff had received training to give them the knowledge and skills to care for and support people. People felt staff had the skills they needed to care for them. Staff worked within the principles of the Mental Capacity

Act 2005 and Deprivation of Liberty Safeguards. People were offered choices of what they wanted to eat and drink. People were referred to healthcare professionals when needed and staff followed their guidance to maintain people's health and wellbeing.

People told us staff were kind and had a caring approach toward them and involved them in day to day decisions about their care, although at times staff told us they felt rushed. People had limited opportunities to be involved in their care planning

Some planned social activities were offered to people, however there were periods of time when activities were not offered and staff were not always available to respond to people because they were busy with other tasks. People were not always able to gain staff attention because call bell cords were not accessible in communal areas of the home. Staff felt care was often task led at the home.

Improvements had been made in the governance of the home, although some further improvement was required. Systems and processes were in place to monitor the quality of the service, although where actions were identified as needed to make improvement, these had not always been implemented. The clinical lead nurse role had not yet been fully developed as effective support to the registered manager or in undertaking the competency assessments for nurses.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Improvements had been made to the safe care and treatment of people. However, further improvement was required.

People were protected from the risk of abuse because staff had been trained to safeguard people and knew what to do if they had a concern. People felt there were not enough staff to consistently meet their needs. Sufficient numbers of staff were not always available to meet people's needs in a timely way that promoted their safety.

People were assessed to reduce the risk of harm or injury, however, actions staff needed to take to reduce the risks were not always shared with them. This meant risks to people were not always minimised. People had their prescribed medicines available to them and were supported to take these by trained staff. Staff did not always record essential information about some medicines and temperature checks on the safe storage of medicines in the medicine fridge were not effective.

Is the service effective?

Good

The service was effective.

Staff were trained and people felt staff had the skills they needed to care for them and provide support when needed. Staff worked within the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. People were offered choices of what they wanted to eat and drink. People were referred to healthcare professionals when needed.

Is the service caring?

Good

The service was caring.

People told us staff were kind and had a caring approach that promoted their privacy and dignity. People felt involved in the day to day decisions about their care and their views about some issues were sought.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Improvements had been made to the responsiveness of meeting people's needs. However, further improvement was required.

Social activities were planned for and took place. People said staff responded to them but said staff were busy and often rushed, which meant waiting for staff to be available to respond to their individual needs. Care was not always personalised to individual needs but was task led. People were not always able to gain staff attention because call bell cords were not accessible in communal areas of the home.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Improvements had been made in the governance of the home, however, some further improvement was required. Quality assurance systems and processes were in place to monitor the service. However, where actions were identified as needed to make improvement, these had not always been implemented.

Holmfield 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 took place on 8 and 9 August 2016. The visit was unannounced on 8 August 2016 and we told the provider we would return on 9 August 2016. The inspection team consisted of one inspector, a pharmacist inspector and an expert by experience on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. One inspector returned on the second day to complete the inspection. We gave feedback to the registered provider and registered manager about where further improvement was required on the second day and they told us how and when these improvements would be implemented.

The provider had not completed a provider information return (PIR) because they had not received a request from us. 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. During our inspection, we gave the provider an opportunity to supply us with key information, which we then took into account during our inspection visit.

We reviewed the information we held about the service. This included information shared with us by the local authority and statutory notifications received from the provider. A statutory notification is information about important events which the provider is required to send us by law. The registered manager had kept us informed about events we needed to be told about.

Some people living at the home were not able to tell us about how they were cared for due to living with complex health care conditions. We spent time with them and observed the care and support they received from staff.

We spoke with ten people who lived at the home and eight relatives. We spoke with six care staff, one nurse, one cook, one domestic housekeeper, one activities staff, the clinical lead nurse, the registered manager, the area manager and registered provider. We also spoke with three visiting healthcare professionals.

We reviewed a range of records, these included care records for four people, their weight check records and nutritional information and 10 people's medicine administration records. We reviewed staff training and quality assurance audits and minutes of meetings.

Requires Improvement

Is the service safe?

Our findings

When we inspected the home in January 2016 we identified breaches in the regulation relating to safe care and treatment of people. We found the provider did not manage people's medicines in a safe and proper way. At this inspection visit, we looked to see if the requirements of the warning notice served on the provider had been met and found they had. We found, overall, improvement had been made but some further improvement was required.

We looked at 10 people's medicine and care records and found people received their medicines as prescribed. Nursing staff who were trained to handle and administer medicines safely, kept records of medicines received into the home; that were given to people and of medicines disposed of. We found no gaps on the medicine administration records (MARs) and where people had not had their medicines as directed by their GP, reasons were recorded. One nurse told us that topical items such as creams, were administered by care staff, when people received personal care. Records showed creams and ointments were applied by the care staff in line with the prescription instructions and people's care plan.

People were protected against the risk of being given medicines that they were allergic to because any allergies were recorded on their MARs. Some people had medicines that required them to have blood tests to make sure their dosage remained safe for them. We found these people's blood tests were carried out on time and showed that people were getting these medicines correctly. On the first day of our inspection visit, the phlebotomist was visiting people at the home. They told us, "I generally come to this home on a weekly basis and haven't had any concerns about the people I've visited."

Some people were prescribed medicines on a 'when required' basis and had detailed information to tell staff how and when to administer these medicines. This meant they were given consistently and in a way that met people's individual needs.

On the first day of our inspection visit, we observed people being given their medicines by the nurse on duty. The nurse was frequently interrupted by care staff, all with genuine concerns that required the attention of the nurse. However, these interruptions resulted in some (8.00am) morning medicines not being given until 11.30am. This meant some people had waited a long time since the last dose of their medicines, such as pain relief, and presented a risk that some people being given their next dose too soon. On the second day of our visit, we saw the morning medicines had been completed at 11.00am. The nurse told us, "I try to prioritise 'time specific' medicines like giving people their insulin. The care staff only interrupt me when they need guidance about someone, or when I might need to check someone." We discussed the length of time it took for the nurse to administer medicines to people with the registered manager. They told us, "Some of the issues the care staff might have brought directly to me if I was not currently involved with the inspection team, but I agree it might be an area for developing what the senior carer can deal with to support the nurse, whenever possible, so they are not taken away from administering medicines."

Improvement had been made to ensure medicines were stored safely, however further improvements were required. Some medicines, such as insulin, required cool storage in a medicines fridge. We found fridge

temperatures logged by nurses, showed the fridge had been operating out of the correct temperature range. This meant that the medicines stored in it may not have been safe for use. We discussed this with the registered manager who told us they would obtain a fresh supply of medicines to replace those in the fridge. The provider told us, "I will put up a sign on the medicines fridge to remind nurses to check the fridge temperature is within the desired range and to take the required action, if they find any problem."

Some people had their medicines through patches applied to their skin. We found that nursing staff were not keeping records to ensure that the manufacturer's guidance to apply skin patches to different parts of the body was followed. This meant there was a risk of skin irritation being caused to people and people not receiving their medicine effectively.

Some people, due to their health condition, required 'tube' (gastrostomy) feeding to provide essential nutrition that is normally provided by eating and drinking. Medicines were also administered through this tube directly into their stomach. Some people living at the home had either a percutaneous endoscopic gastrostomy (PEG) or a radiological inserted gastrostomy (RIG). We found there was no care plan or information for nursing staff to refer to, if needed, to tell them how to give people their medicines safely through a PEG or RIG. The nurse we spoke with was able to describe the safe technique to us. However, there was only one nurse on duty each shift at the home and, on occasions, agency nurses were used and did not have information available to refer to. On the second day of our inspection visit, the registered manager showed us guidance they had sought and put into one person's care plan. They told us they would ensure people's care records contained the guidance required.

On our January 2016 inspection, we found risks to the health and safety of people receiving care and treatment had not always been assessed and reasonable steps to mitigate risks had not always been taken by the provider. On this inspection visit, we found improvement had, overall, been made. For example, where people had bed rails on their bed to maintain their safety, risks of injury and entrapment had been assessed and bed rail cover bumpers were used to reduce these risks. However, we found actions to reduce the risk of harm to people had not always been communicated to staff. For example, some people living at the home had severe respiratory illnesses and the use of aerosols had been assessed as a potential risk to their wellbeing. However, this information was not made available to cleaning staff, who were supplied with aerosol cleaning products to use in communal areas and people's bedrooms. We discussed this with the registered manager and they agreed this had been an oversight. They told us they would take immediate action and replace the aerosol products with a suitable alternative.

Risks to people's skin becoming sore or damaged were assessed and staff used equipment, such as special pressure reliving cushions, for people when required. One staff member told us, "If we are helping a person with personal care and we notice their skin is red or sore, we tell the nurse to check it. If creams are prescribed, we put these on to people's skin but the nurses do any dressings that are needed." The registered manager understood when they had to inform us about any pressure areas people had, and this had been done. The registered manager told us, "One person was admitted to the home with a pressure area and we are continuing with the specialist treatment of this that was commenced in hospital." The nurse told us, "The technique being used is new to me, it is vacuum therapy to remove fluid from the wound and we are being trained on how to change dressings when this technique is being used." Detailed records, including dated and signed photographs, were kept about pressure areas or skin wounds so that nurses had the information they needed to check on the progress or deterioration of the person's skin and were able to take the action needed.

During our January 2016 inspection, staff had told us they felt they did not have enough staff on shift to safely meet people's needs. On this inspection visit, staff told us they continued to feel there were not

enough staff on either the day or night shifts to safely meet or respond to people's needs. One staff member said, "People's needs are quite high, 17 of the 21 people, need two staff to safely support them to move and with some personal care tasks." One person told us, "All of the staff are great here, they do a brilliant job but the only problem is there are not enough of them." Another person told us, "The staff here are brilliant, but there are not enough of them to us."

In June 2016, the provider had asked relatives, as a part of their annual quality feedback survey, if they thought there were enough staff on each shift and 93% had stated 'no'. One relative told us, "The staff are very good, but there does not seem to be many of them." The provider informed us they had recruited an activities staff member in February 2016, to work 30 hours a week. However, we found this had not resolved issues, as care staff continued to undertake non-care tasks in the kitchen and laundry. We observed staff were busy with tasks and this meant there were periods of time when communal areas were not always staffed to ensure people's safety. For example, we saw one person, who was assessed as being at risk of falling, stand up numerous times and another person was sliding forward in their armchair and needed support from staff to help them reposition themselves safely. We discussed this with the provider and they told us that since our last inspection, they had recruited an activities staff member but care staff had continued to undertake non care tasks, as a part of their role. The provider added that they would take immediate action to recruit an additional staff member to undertake the non-care tasks on a daily basis.

We found that following our last inspection visit, fire door holders had been put into place to improve and promote fire safety within the home. The nurse told us the safe action they would take in the event of a fire and people had personal emergency evacuation plans (PEEPS). PEEPS provide staff and the emergency services with information about what support each person wold need to evacuate the home in an emergency. During our inspection visit, the provider purchased special 'evacuation mats' that could be used to transfer people, in an emergency situation. The registered manager said, "I will update people's PEEPS, now that we have the evacuation mats and make sure they contain all the information needed." The nurse and clinical lead nurse informed us they were first aid trained and felt confident in dealing with any accident, such as a person having a fall.

People told us they felt safe at the home because it was secure and staff were there to help them. One person told us, "The staff give me confidence in feeling safe here." People were protected from the risks of abuse because staff attended training in how to safeguard people. One staff member said, "I would recognise abuse and report it to the manager. If I felt it was ignored, I'd report to social services or the CQC." The registered manager informed us that if any concerns were identified to them, they would act on these and refer any allegations of abuse to the local safeguarding team and to CQC.

Good

Is the service effective?

Our findings

At our last inspection, we found improvement was needed to effectively meet the needs of people living at the home. Staff training had not always been effective and they had a limited knowledge of the Mental Capacity Act. Choices about food and drink had not consistently been offered to people. On this inspection we found improvement had been made and further improvement was planned for.

People felt staff had the skills they needed to effectively care for them. One person said, "The staff are excellent, they couldn't be better." One relative said, "The staff are exemplary here and have the skills they need."

Staff told us improvement had been made to the training they received. One staff member said, "We now have some taught face to face training sessions, for example on mental capacity, which is good. We still use the learning booklets for some topics, but I'd say training is better now." The registered manager told us that in addition to staff completing training booklets, they also had some topics, such as first aid, that were brought in from a qualified trainer and also some in house training such as moving and handling from staff that had completed a train the trainer qualification.

We observed the care and support people received from care staff and found they had the skills and knowledge they needed. We discussed with the registered manager, the plans for on-going training for the staff including the nurses. They informed us some staff had completed training booklets and these were due to be checked to ensure staff had understood the training they had received. Other taught training sessions were being planned for to refresh staff skills. More specialist training was now provided to nurses, such as diabetes care and tissue (skin) care. The registered manager told us, "Since the last inspection, we've had more training for the nurses. The provider is also supportive of further training being arranged for nurses and we have planned sessions for end of life care and a Parkinson's disease awareness session."

Staff told us they had completed training on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 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 take particular decisions, any made on their behalf must be in their 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 application procedures for this in care homes are called the Deprivation of Liberty Safeguards.

We observed staff worked within the principles of the Act and whilst not all care staff could explain how the MCA impacted on their job roles, we saw they asked people's consent before undertaking care tasks. One staff member told us, "I tell people what is happening, we never force people to do things." People's care records showed consideration had been given to their mental capacity and the registered manager and clinical lead nurse could tell us when they would refer a person for a 'best interests' decision in line with the Act.

The registered manager informed us they had made DoLS referrals for three people. People were not restricted by staff if they wanted to go out and we saw one person go outside the front of the home. This person told us they wanted to see what was happening, as a delivery was being made.

At our previous inspection, we could not be sure people were always offered sufficient food and drink to meet their needs. At this inspection visit, we found improvement had been made. People told us they enjoyed the food and staff offered them alternatives if they did not like something. One person told us, "They fill me up and I get plenty to drink as well." One relative told us, "Staff support my family member to eat their meals and they have put on some weight." We observed staff offered people choices and the cook showed us information they had about people's preferences. This was detailed and informed staff about any special diets people required, such as diabetic or soft food diets. The cook informed us, "I have information about how to fortify (increase the calories) in people's meals and I add cream, butter, cheese or milk powder." Individual risks of malnourishment and dehydration had been assessed and staff knew which people required support with eating and drinking.

Staff told us they had set times to offer a choice of drinks to people from the 'tea trolley round.' However, we found some people did not always have drinks accessible to them. We discussed this with the registered manager and the importance of people being able to take frequent sips of water or squash when they wanted to. The registered manager said they would ensure jugs of juice and beakers were made accessible to people, in addition to the set time for drinks offered.

People told us if they felt poorly they told staff and felt they would ask the doctor to visit them. One staff member told us, "Whenever people say they feel poorly, we tell the nurse. If someone has been sick, we always tell the nurse. They will get the doctor if needed or phone them for advice." On the second day of our inspection visit, the nurse told us, "Four people are not feeling very well today, I've contacted the GP and am waiting for them to phone me back." One staff member told us, "Today, one person has ambulance transport arranged for their hospital appointment, and the manager has arranged for one staff member to support them."

We spoke with a visiting dietician and speech and language therapist and they both told us they felt staff followed guidance given, referrals were made to them when needed and overall they had 'no concerns' about the home.

People told us and their care records confirmed that they received home visits from chiropodists, opticians and dentists and were supported to maintain their wellbeing.

Good

Is the service caring?

Our findings

At our last inspection, we found improvement was needed in how people were cared for at the home because staff had felt they were too rushed. On this inspection we found improvement had been made and further improvement was planned for.

People made positive comments to us about the staff. One person told us, "I can't fault the staff at all. They are always kind to me." Another person said, "The staff look after me, they are very kind and caring to me." One relative told us, "Staff are very caring, I have no concerns at all." Another relative said, "As far as possible, all the staff are caring. They are a bit rushed and they could do with more staff, but the ones they have are certainly caring and kind."

We observed some kind and friendly interactions between staff and people living in the home. One staff member told us, "A lot of the staff have worked here for many years, we get to know people well and develop good relationships with them. Some people become like an extended family." Another staff member said, "We all do our best, we do care about people and would like a bit more time so we are not task focused but have time to just be with people when they want that."

People living at the home felt involved in decisions about their day to day care. One person told us, "If I didn't want to get up, I could stay in bed." Another person told us, "I spend time where I want to, staff ask me and I'll say the lounge or I want to stay in my bedroom." People could not recall being involved in their care plan, however, people's care records showed they or their relatives were involved in care planning when they had moved into the home. One relative told us, "My family member has recently moved here. We have given information about their likes and dislikes."

The activities staff member told us they had asked people about what they enjoyed doing and how they liked to spend their time. One person told us, "The new girl (activities staff member) asked me what I'd like to do during the daytime. I said bingo and quizzes and we have those occasionally, like today. We even have prizes." One relative told us, "The activities staff member has managed to encourage my family member to get involved in creative art, which they never liked before. This was a way to encourage my relative to get involved in planning what they would like to do."

People told us they felt respected by staff and that their privacy and dignity was maintained. One person said, "Staff knock on my bedroom door and tell me who they are. I tell them they don't need to knock, but they always do." During our inspection visit, we observed staff knocked on bedroom doors before entering. We saw one person's dignity was promoted when staff supported this person to transfer, using a hoist, when they placed a blanket over their legs.

The registered manager told us further improvement was planned for to ensure people's privacy and dignity was maintained when healthcare professionals visited. They told us, "Most healthcare professionals visit at appropriate times when care staff can support people, for example, if they need to be helped to their bedroom or private area. But, we've had a few experiences when it has not been an appropriate time. I'm

planning to introduce 'protected times' which will mean healthcare professionals visit at agreed times when staff are available to give support to people, which will make sure visits take place in private."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, we found improvement was needed to ensure staff effectively responded to people's individual needs. Care records were not sufficiently detailed and did not give staff the information they needed to respond to people's needs. We found call bell cords were not available for people to use in communal areas to attract staff attention if needed. People told us there were not enough activities offered to them. On this inspection we found some improvement had been made, but further improvement was required.

People told us that, overall, staff responded to their needs. One person told us, "The staff are very good and come when they can, sometimes I have to wait." Another person said, "You have to wait for staff, but they get around to me in the end. They are very good, but rushed at times." A further person told us, "Last week, I pressed my buzzer for staff as I needed help to get to the toilet. But, the staff couldn't come straight away as they were busy, and I had an accident because I couldn't hang on."

Staff told us they felt people's needs were met, but this felt 'task led' rather than the personalised care they would prefer to give to people. One staff member told us, "A lot of things have improved since the last inspection we had, but I still feel care is a bit institutionalised and everything is task led." Another staff member said, "If we didn't have to do the laundry and prepare the teatime meal and clear away, we would have more time to do our caring role which is what I feel we should be focusing on. Some people want us to just be with them and talk with them, but it is this we don't have time for."

We observed staff were busy undertaking care and non-care duties, and whilst they attempted to respond to people's needs, we observed this did not always happen when people requested or needed support. For example, one person told us they wanted to use the toilet and another person told us they were waiting to ask staff to take them to their bedroom.

At our last inspection, we had identified to the provider and registered manager that people in the lounge or dining area were not able to gain staff attention or support because there were no call bell cords available to them. One person told us, "We have to wait or shout for staff." We found no improvement had been made to this and discussed this with the registered manager and provider. They told us action to improve this had not yet been implemented and said immediate action would now be taken to arrange for a call bell point to be put into the dining area and a cord would be attached for people to use. The provider added the call bell point in the lounge, which we identified was broken, would be repaired, and a further one would be installed so people could gain staff attention when needed.

At our last inspection, people had told us not enough activities were offered to them. On this inspection visit, we found improvement had been made with the recruitment of an activities staff member. One person told us, "We have a bingo session and I've won some prizes, I enjoyed that." Another person said, "I like the arts and crafts the new girl does, it's good." We observed the activities staff member asked people which DVD they would like on in the communal lounge. We saw activities were offered to people during the morning and early afternoon but there was limited opportunity for people from mid-afternoon onwards. We

discussed this with the provider and they told us, "When the [Staff name] started here, they asked people what they would like to do and also the times they would prefer and this is how we have planned their hours to respond to people's requests. Many people like to spend time in their bedroom relaxing or watching television after lunchtime." Most people confirmed that after lunch they preferred to 'do their own thing'. However, some people remained in the lounge and dining room and had limited opportunity to engage with staff or any activity. We discussed this with the activities staff member and they told us, "I'll create some individual 'rummage boxes' of safe items to leave with people or some other things people can have to do when I am not here."

Improvement had been made to people's care plans which we found were more detailed and gave staff the information they needed to respond to people's needs. For example, when people had health care conditions, such as diabetes, guidance was given to say what an individual's desired blood glucose (sugar) level should be. The nurse told us, "This information is kept with the medicine administration records so it is easily accessible."

People and their relatives could not recall being invited to attend 'resident and relative' meetings. One person told us, "I don't know about any resident meetings" and one relative said, "I'm not aware of any relative meetings." The registered manager told us that one meeting had been planned for since out last inspection in January 2016. The registered manager said, "A meeting was planned for March and a poster was put up near the visitor's signing in and out book. But, no one had attended." We discussed this with them and the provider and how improvement might be made. The registered manager informed us a schedule of meeting dates would be displayed in the home and communicated to relatives using text and email so that every effort was made to encourage feedback from people and their relatives. This would give people the opportunity to give feedback on the quality of the care, and for the provider, or registered manager to act on any issue identified.

People told us they had 'no complaints' about their care. One person said, "If something was wrong, I'd tell the staff. They'd try to sort things out for me." Relatives told us they had no complaints at the time we asked them, but would speak with staff or the manager if needed. The provider's complaints procedure was made available to people and their relatives in the 'service user' guide and the provider's 'Statement of Purpose' booklet. Copies of this booklet were available, in the reception, for people or relatives to take a copy of. The registered manager told us they had received three complaints and these had been responded to in line with the provider's policy and to the complainant's satisfaction.

Requires Improvement

Is the service well-led?

Our findings

When we inspected the home in January 2016 we identified breaches in the regulation relating to governance of the home. We had found the service was not well led. At this inspection visit, we looked to see if the requirements of the warning notice served on the provider had been met and found they had. We found, overall, improvement had been made and some further improvement was required.

On the first day of this inspection, we saw that the provider was not displaying their CQC rating from our January 2016 inspection. It is a regulation, which came into force on 1 April 2015, that says providers must 'conspicuously' and 'legibly' display their CQC rating at their premises and on their website. We discussed this with the registered manager and area manager they told us, "We will ensure that is done straight away." We later saw action had been taken and a poster was displayed to show the rating of the home.

The manager had become registered with us in March 2016 and told us, "Since the last inspection, we have all worked hard to make the improvements that were needed. I've found the provider supportive and generally have daily telephone contact and they visit the home frequently. I am also supported by the regional manager and they also visit often. The three of us have a good positive working relationship."

The registered manger informed us that following our previous inspection, the clinical lead nurse had left. However, a nurse had been promoted to the role in March 2016 and the registered manager said, "The new clinical lead nurse has been supporting me in developing the care plans so they contain the clinical information needed about people's health conditions." We found people's care plans had improved, however, we found other aspects of the clinical lead nurse role, such as support for the registered manager, who did not have a clinical nurse background, had not been implemented. For example, in January 2016 we had been told the clinical lead nurse would take a lead role in assessing the clinical competencies of nurses. However, the clinical lead nurse told us, "Support and guidance to the nurses has been given but this is informal and not recorded, I've not done any competency assessments." We discussed this with the registered manager and provider and the provider informed us action would be taken. They told us they would put processes in place to support the clinical lead to take on these responsibilities. They said they would arrange for a pharmacist from their supplying pharmacy to offer guidance and support to the clinical lead nurse. They added they would also formalise clinical support meetings between their business consultant, who has a clinical background, and the clinical lead nurse to ensure best practice, skills and knowledge were assessed by them in their competency assessments of the nurses and recorded for the registered manager.

Overall, improvement had been made to the provider's systems to monitor the quality of the service provided. Where monthly room audits had identified action to improve, these had been completed by the housekeeping staff and signed off as done. Where health and safety checks identified action was needed, this was taken. For example, one water temperature check had revealed the water was too hot and the action taken was to re-set the water valve regulator. However, there was no evidence that a further check had been made to ensure the action taken had resolved the issue.

We looked at the June 2016 infection control audit and found this had identified areas of 'non-compliance' where actions were needed to be taken to improve. The regional manager's comments described actions needed, however there was no recorded evidence of whether these had been implemented or not. The registered manager informed us they believed actions had been implemented to improve, but agreed they needed to record these checks as a part of the audit.

An audit undertaken by a pharmacist, on behalf of the provider, in April 2016 had identified areas for improvement. We found some of these had been implemented such as ensuring any allergies to medicines people had was documented on their medicine records and 'when required' medicines had guidance available for staff to refer to. However, some issues identified in April 2016, had not been improved upon. For example, recording the medicine fridge temperatures to ensure the safe storage of medicines and to report any deviation from the required temperature to the registered manager. We found nurses had recorded minus three degrees celsius, which was too low and may have resulted in medicine such as insulin freezing, but had not taken action to resolve this. A further example was advice had been given to record the expiry dates on all medicines with a short 'shelf-life' such as insulin pens. On the first day of our inspection visit, we found an undated 'on opening' insulin pen for one person that was in hospital.

Improvement had been made to the maintenance of the home. Ground floor window frames had been replaced where needed and the provider informed us first floor window frames in need of replacement would be completed before the end of October 2016. Improvement plans also included the redecoration of the lounge, an improvement to one area of the kitchen to enable effective cleaning to take place and further equipment, including a bain marie for the kitchen was due to be delivered during August 2016. The registered manager told us, "We are making steady progress with the home and the provider is very supportive of things we need."

Staff told us they felt the registered manager was approachable and would listen to them. One staff member said, "The manager is good and seems to get things done." Staff told us they felt supported but would appreciate the opportunity to discuss issues at team meetings and in one to one supervision meetings. One staff member said, "We don't seem to have staff meetings much at all." We discussed this with the registered manager and they told us there had been a few staff meetings and supervision meetings, which were recorded, but not all staff had been involved in these. They informed us they would implement a planned schedule of staff and one to one supervision meetings for staff.

Staff felt, overall, there was a positive culture at the home and that the staff team worked well together. The registered manager said they undertook checks on care staff as a part of their working day and would address any poor care practices they observed, and these checks were recorded so that staff performance was monitored.

Satisfaction surveys had been sent to people and their relatives in June 2016 and analysis identified some areas for improvement. Some actions had not yet been implemented, such as 57% of people had indicated they did not look at the daily menu board near the kitchen. We saw some people would find this difficult to access and action to be taken described that menus would be printed and shared with people, however, no implementation dates for improvements were recorded on the analysis. We found some feedback, such as 28% of people would like other activities did not have any action point. This meant that improvement had been made in seeking feedback from people and their relatives but some further improvement was required to act upon the analysis of this. The provider informed us this was a working document and action was being implemented in stages. They gave us the example of their commitment to recruit a new staff member in light of the response from people and their relatives' feedback about the number of staff on shift.