

# Monarch Healthcare Limited

## Clifton Manor Nursing Home

### Inspection report

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Nottingham,  
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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?	Good	●
Is the service well-led?	Requires improvement	●

### Overall summary

This inspection took place on 30 November 2015 and was unannounced. There were no breaches of legal requirements at our previous inspection in November 2014, but we did ask the provider to make some improvements to the service.

Clifton Manor Nursing Home provides accommodation and nursing care for up to 30 people who have nursing or dementia care needs. There were 29 people living there at the time of our inspection.

There was no registered manager at the service; a manager is required to register with us by law. 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 our last inspection in November 2014 we found that improvements were required in relation to a registered

# Summary of findings

manager. Management and safe storing of medicines, activities reflecting people's needs and monitoring the quality of the service provided. At this inspection we found that the provider had made some improvements.

People felt safe and well looked after by the staff who cared for them. Risk management had improved and risks were managed more safely. There were mixed comments about the number of staff on duty. Staff were not always deployed appropriately. Recruitment processes were robust and appropriate to ensure staff were safe to work with older people. Medicines were safely managed.

People gave positive feedback about the staff skills and knowledge to do their job. Staff had a good understanding of people's needs. The requirements of the Mental Capacity Act (2005) were adhered to. People were supported to have sufficient to eat and drink. People were supported to maintain good health and wellbeing and this was supported by having access to healthcare services.

People experienced a positive caring relationship with the staff who supported them. People were involved in making decisions about their needs and felt they were given choices and preferences. People were treated with dignity and respect at all times. Staff interaction was not always of a good enough standard, but this had been identified by the service and they were in the process of addressing the issue.

People participated and were supported to follow their individual interests and social activities, but work was required to improve the consistency and quality of activities available. People's feedback was positive about the care they received, but staff were not consistently responsive to people's personalised needs. Systems were in place for people to share their views and experiences. Complaints and incidents were monitored to ensure the service minimised reoccurrence.

The manager of the service was not registered with CQC at the time of our visit. We received positive feedback from people, their relatives and staff on the approachability of the manager and how they felt supported by them. Improvements had been made in regards to the quality monitoring of the service. There had been a number of issues addressed since our last inspection, however to ensure this was consistent further

monitoring was required. Management had discussed shortfalls and concerns in staff meetings to try and address some of the issues we had identified. The vision and values of the home were positive.

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# 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 consistently safe.

Staff were not always deployed appropriately as people raised concerns and said their presence was sometimes limited.

The provider took appropriate action to recruit staff with the right skills and followed clear disciplinary procedures to ensure people were kept safe.

People were able to take informed risks and these were managed by staff.

People received their medicines as prescribed and in a timely manner. Medicines were stored safely.

We found people felt safe living in the home. Their relatives were confident people were safe and knew how to raise any concerns. Safeguarding issues were reported and investigated appropriately.

Requires improvement



### Is the service effective?

The service was effective.

People felt their needs were met by staff that were knowledgeable and skilled to ensure they received effective care.

The provider was following the requirements set out for the MCA and DOLs and acted legally in people's best interests if they did not have the mental capacity for particular decisions.

People were supported to have a balanced diet that promoted healthy eating and drinking.

People had access to other health care professionals and were referred if staff had concerns about the person's health.

Good



### Is the service caring?

The service was caring.

People were involved in decisions about their care needs.

People were treated with kindness and compassion and their privacy and dignity was respected.

People experienced a positive caring relationship from staff who supported them.

Good



### Is the service responsive?

The service was responsive.

People were supported to follow their individual interests and social activities.

Good



# Summary of findings

People received personalised care and their preferences were responded to.  
People and their relatives were encouraged to share their experiences and raise concerns if needed.

## Is the service well-led?

The service was not consistently well-led.

There was no registered manager at the home, but the person in charge was reported to be open and approachable.

People were encouraged to be actively involved with the service.

The provider had systems to assess and effectively monitor the quality of the service they provided.

**Requires improvement**



# Clifton Manor 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.

This inspection took place on 30 November 2015 and was unannounced. The inspection team consisted of three inspectors, one specialist advisor which we used to monitor the homes falls management 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.

Before the inspection we reviewed the information we held about the home. This information included notifications. A notification is information about important events which the provider is required to send to us by law. We contacted commissioners of the service to obtain their views on the service and how it was currently run.

During our inspection we spoke with eight people living at the home, six relatives, one nurse, one agency nurse, six care staff, one senior care staff member and the manager. We reviewed ten care records, five staff files, observed care and reviewed other records relating to the management of the home.

# Is the service safe?

## Our findings

During our previous inspection we found the provider needed to make some improvements to how they managed risk for people. We found that not all the records related to risk had been fully completed. There were gaps and inconsistencies in some of the records, such as, falls risk assessments were left blank. Skin integrity assessments had been partially completed.

During this visit we found improvements had been made. People who took informed risks were managed more safely. We looked at care plans for five people who were at risk of falls. We found all records were completed and identified the potential risk. One person was at quite significant risk of having falls and a comprehensive falls prevention plan was in place. Another person had been assessed as a risk to others, as they sometimes had aggressive outbursts. We saw that triggers to these outbursts were identified and methods to de-escalate a difficult situation were clearly recorded. This ensured staff were aware and could manage any risks involved for this person and others. Another person had use of equipment, including a room sensor and sensor mat, to alert staff to when the person was out of bed. The person was at risk of falling when leaving their bedroom. Staff told us the equipment worked well as when staff heard the alarm they would attend the person's needs and make sure they were safe.

Assessments of risks to people's health and safety were carried out and we saw examples of these in the care plans we viewed. All the records we checked contained risk assessments, which outlined any potential dangers and risks, and looked at ways to minimise these dangers in order to keep people safe. For example people at risk of skin ulcers had regular intervention from tissue viability nurses and the use of appropriate equipment, such as, pressure relieving mattress, to minimise the risk of their skin breaking down and causing any injuries.

The internal and external environment was in a good state of repair and we found there was a record of regular checks and audits of equipment and services.

During our previous inspection we found the provider needed to make some improvements to how they

managed medicines. People did not always receive their medicines in a timely manner. The clinic room was left unlocked. The medicine trolleys were not secured to the wall when not in use.

During this visit we found improvements had been made. The service had implemented a new electronic system that was easier to monitor and minimised any errors when staff were administering medicines. The medication administration records (MAR) that we looked at included a picture of the person the medicines were for. Any allergies were clearly identified and it was clear when medicines had been discontinued. Where medicines were time critical the system did not allow medicines to be administered until the correct time. There had been a change to the clinical room and the room and medicine trolleys were now kept secure.

People told us their medicines were administered by staff. No one raised any concern that they didn't get their medicines on time. Staff and records we saw confirmed staff had received relevant medicine training and competency tests.

We saw recorded in care plans detailed information for when a person required their medicines covertly. This meant the person had their medicines concealed or disguised in their food with full support of a GP. There were instructions for staff how they should do this. This told us they were managing this process correctly.

We found where PRN 'as required' or variable doses of medicines were prescribed there were no protocols advising staff of when and why to give the medicine, but there was information recorded on the MAR chart. We also found when creams or eye drops were prescribed there were no protocols to advise staff which eye they should administer the drops in. We spoke with the nurse and they said they would address this.

Staff were not always deployed appropriately to ensure people received efficient and safe care.

People gave us mixed views about being supported by sufficient numbers of staff. One person told us the response to the call button when they required assistance from staff was prompt, but the follow up call was not. This meant when the person first requested assistance staff were prompt to answer the call bell. However if a person required further assistance with their same call this person felt there was a delay till staff came back to them. One

## Is the service safe?

person commented that it was understandable that staff needed time to 'hand over' at the shift change, so minor delays were not a problem. A third person said, "The staff can't be everywhere. Sometimes in the lounge there will be no staff around for up to an hour at a time." Another person said, "Staff are brilliant, but they're run off their feet." They also commented that the lounge area often had no staff. However, three other people we spoke with did not raise any concerns about the staff numbers.

We also spoke with three relatives and one commented there were fewer staff at weekends. Two more relatives felt there was not enough staff at the home. Staff told us there were enough staff, but sometimes if people were sick or absent it could be hard to cover the shortfalls. During our visit we noted there were times when staff did not appear to be present in some areas of the home where people were. There was a risk people would be left for long periods and may not be able to call for assistance, as there was no system in place for them to call for support.

The manager told us they based staff numbers on people's needs, but there was no evidence to demonstrate how this was assessed.

We discussed with the manager the use of a dependency tool to identify how many staff were required to meet people's needs. They told us they were not aware of and did not use any tools to determine how many staff were required to support people. Although we found there was a dependency tool in the home's policies, this was not currently being used to determine how many staff were required on a daily basis. The manager told us they felt the staffing numbers were right for the number of people living in the home. They told us staff covered any shortfalls and they had flexibility to increase staffing, should they need to. We discussed the number of vacancies at the time of our inspection. The manager confirmed they had successfully recruited a number of nurses and in turn reduced the number of agency staff used. We looked at staff rotas and found that on some occasions there were less staff on duty than the staffing levels the provider had identified as being necessary.

Safe recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service. The files contained all relevant information and appropriate checks had been carried out before staff members started work. The manager told us they were actively recruiting nurses. They said that in the interim they used agency and bank nurses, however where possible they tried to use the same staff to ensure continuity. We also saw that the service followed clear staff disciplinary procedures when necessary.

Three people told us they felt safe in the home. One person told us they had never heard any shouting or seen any inappropriate behaviour. Relatives we spoke with felt their family members were safe. One relative said, "When I go home I feel [my family member] is safe; [staff] contact me if there are any problems." People were confident to raise concerns; they told us they would speak with the manager if they had any concerns regarding their safety. One relative told us about an incident their relation had with another person living at the home. They said they were encouraged to raise concerns about safety, which they did and staff responded.

We spoke with two staff. Both were aware of safeguarding adult's policies and procedures. They both confirmed they had received training in this area. One staff member said, "If I saw anything, [abuse or harm,] I would report it straight away." A second member of staff told us they were fully confident that incidents between people who used the service could always be prevented. Staff talked about different types of abuse and knew how to report internally and externally.

We found safeguarding incidents forms were completed. The service kept a safeguarding log, which included body maps of injuries and appropriate reports to the local authority and CQC.



# Is the service effective?

## Our findings

People received care from staff who were knowledgeable and skilled to carry out their roles and responsibilities. People gave positive feedback about their care and support. Relatives of people felt that staff mostly had a good understanding of their relations needs. One relative told us, “[Staff] are good: they understand [my family member’s] needs.”

Staff told us they felt they received enough training. One staff member confirmed they received sufficient training. They said, “In fact sometimes too much training.” We discussed with staff the training they had attended. One staff member said they wanted to do more training in passive restraint. This means to use of a lap belt to hold a person in place, such as in a wheel chair or specialist chair. We saw the dementia outreach team (DOT) had provided some training in this area and further training was booked. The manager had a system in place that identified training staff had attended and when they required any updates.

Staff told us they received supervision that they found useful and supportive. The manager confirmed supervision had taken place every six to eight weeks. However, no appraisals had taken place to date, but the manager had dates booked and we saw a copy of the plan in place. We looked at staff files and saw appraisals had taken place historically and had provided a useful review of each staff member’s performance, knowledge and skills.

Some staff talked about undertaking an induction when they first started working at the home. One staff member told us they had completed a checklist, shadowed other experienced staff for a week and completed relevant training and workbooks to make sure they were fully inducted into the home. The manager told us two staff had recently completed the Care Certificate. The Care Certificate is a nationally recognised qualification regarded as best practice for the induction of new healthcare assistants and care workers. It also offers existing staff opportunities to refresh or improve their skills.

People were asked their permission before staff undertook any tasks. For example, we heard staff asking for a person’s approval before they removed an item that was used to cover their clothes when they had finished eating their meal.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The requirements of the Mental Capacity Act (2005) were adhered to in that when a person lacked the capacity to make some decisions for themselves a mental capacity assessment and best interest documentation had been completed.

Some staff showed good understanding of the MCA. For example one staff member said, “If someone had full capacity and then made a decision, we have to respect that decision.” Another staff member told us, “If a person lacks capacity, we should talk to a relative and try and understand what the person would have wanted.” They knew that the nurse completed a capacity assessment and talked about best interest decisions. One staff member said, “We encourage people to eat and realise a best interest decision may be needed if a person is cared for in bed, regarding turning them if they are always on their back.”

We spoke with the manager who told us they had made some DoLS referrals, but a number of applications submitted had not been authorised to date. We saw when DoLS were required and in place, they informed CQC. They said they were confident staff had a good understanding of behaviours of people and worked well with the dementia outreach team. However, they had discovered there were some issues around the MCA and best interests therefore had arranged further training for staff.

People were supported to have sufficient to eat and drink. People told us the food was good and they got plenty to choose from. One person told us that staff asked people what they would like to eat on a daily basis. We saw choices were offered and pictures were available on the

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noticeboard, but no printed menus were seen. The manager told us these were being printed at the time of our visit. Relatives we spoke with were satisfied that the food was appetising. One relative said, "I have noticed my relation had a healthy appetite and this had resulted in staff taking action to ensure they do not put on too much weight." There were plenty of drinks, snacks and fruit if people wanted them. We also found peoples cultural and religious needs were catered for, for example, if a person was unable to eat a type of meat due to their religion alternatives were offered.

Staff were knowledgeable about what people ate and drank. One staff member told us they calculated how much fluid people should have and where required they implemented a food and fluid chart. Kitchen staff had a list of people's dietary requirements, such as, diabetic, vegetarian, pureed or soft food. The list was colour coded for clarity and enabled staff to see at a glance if a person required a special diet. Care staff we spoke with understood what diets people required and why. This showed people's nutritional needs were understood. We found when a person was not eating properly and lost weight the service contacted a dietician, took advice and monitored the person's food intake. We observed the lunch period and found people received their food in a timely manner. We saw sufficient staff who offered drinks and supported people with their meals where they required assistance.

People were supported to maintain good health and wellbeing and this was facilitated by having access to healthcare services. People told us if they required a doctor they attended promptly. We looked at five care records for people with complex needs. We found when people needed support from other healthcare professionals they received appropriate support. Where a person required intervention from the Tissue Viability Service (TVS), there were clear records to show this did happen. However, we saw body charts used by the home, which identified on the person's body where the injury was and details of the sore were out of date. They did not match current information for the integrity of the person's skin. This meant staff may not provide appropriate and effective care. Where people were living with a condition of diabetes, and staff were finding it difficult to control due to people's level of dementia, they were following guidance from the relevant professionals to ensure these people received effective care and support.

We saw appropriate pressure relieving equipment was in place when required and there was a record of position changes one to two hourly during the night along with checks for incontinence for those people at risk of skin damage.

# Is the service caring?

## Our findings

People experienced a positive caring relationship with the staff who supported them. People told us staff were, polite, friendly and helpful. Relatives we spoke with told us staff were caring. One said, “Staff are kind; there’s just not enough of them.” They also said, “Staff look out for [my family member], they have a laugh together.” Two other relatives felt the staff interacted well with people. One told us, “[Staff] are interactive, they don’t just walk away.” The relative went on to describe how staff spent time sitting with people.

We observed some staff sitting down with people and spending time with them. One staff member told us, “If it was my parent, I would expect them to be treated and cared for in a way I would like them to be treated.” Staff told us when people had difficulty communicating they consulted with people’s family to find out what the person’s wish would have been. Another member of staff described how they communicated with people living with dementia. They said, “I speak slower, clearer, pick my words carefully and I don’t stand over people.” Other staff described how they used different techniques, such as eye movement, facial expressions and body language to help them communicate with people who were not verbally able to express themselves.

We observed most staff engaging positively with the people. For example, one staff member noticed a person had a bad back, and the staff member spontaneously went to rub the person to comfort them. A second staff member was noted to be very calm and caring whilst looking after a person who became distressed. We saw staff responded to people when they showed distress or discomfort. They provided reassurance and support to people who became anxious or who were confused. However, we did see some staff who were task orientated, for example when one person requested a drink the staff member responded to them in a brief fashion, not making eye contact or facing the person when they spoke to them. Another member of staff, while supporting a person to eat, did not attempt to engage in conversation with the person. We also observed a staff member while supporting a person to eat was looking around the room and watching what was on the TV rather than engaging with the person. We found other issues of a similar nature had previously been noted by the manager as they had discussed staff interactions with

people at team meetings. The manager told us they were in the process of addressing this issue. They said they would discuss with individual staff in their supervision and arrange further training.

People were actively involved in making decisions about their care. People felt they were given choices. One person said, “We are given a choice of food we would like to eat. Another person said, “I choose what time I go to bed.”

Most people we spoke with were unfamiliar with the concept of a care plan, but described how their needs were met and that discussions with staff had taken place. One relative had not heard of a care plan, but told us they were consulted on their relative’s ongoing care. Another relative said, “I have seen [my family member’s] care plan and attended meetings.” We saw relative and resident meetings had taken place and people and their families were able to voice their views. The manager told us they had an open door policy and had daily discussions with people and their families. They had received feedback from meetings held such as, “The atmosphere of the home is much better and more comfortable. Staff morale is reported as good.”

We looked at ten care plans and found personalised information about the way people wanted care to be delivered.

There were details displayed on the noticeboard in the home about how people could access an advocacy service. Advocacy services use trained professionals to support, enable and empower people to express their views. We also found this referred to in the service user guide. The manager told us no one used an advocate. Staff we spoke with were not aware of advocacy services and why someone may need an outside person to speak on their behalf. This meant that there was a risk that people may miss the opportunity to be fully supported or understand information shared with them.

People told us they were treated with dignity and respect by staff. We observed people being encouraged by staff to be independent where possible. We saw staff take people to private areas to support them with their personal care.

Staff described how they respected people’s wishes and protected their privacy. One staff member said, “I always knock on the door, and ask if they want a wash. I also ensure towels are used to protect their privacy when washing someone.” We observed staff knocking on people’s doors before they entered or, if the door was open, they

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knocked to highlight to the person they were entering the room. Care records we looked at contained a care plan for maintaining a person's privacy and dignity, identifying and providing them with choices.

We observed people visiting their friends and family during our inspection. The manager told us there was no restricted time for people to visit.

# Is the service responsive?

## Our findings

During our previous inspection we found the provider needed to make some improvements to how they monitored and reviewed people's needs. During this visit we found improvements had been made. Care plans we looked at contained relevant information to support staff respond to people needs. For example, one person had a history of aggressive outbursts and there was detailed information in the care plan that identified triggers and things/ words to avoid, such as, how staff asked the person specific questions. This meant staff had access to helpful information to ensure they provided appropriate support to this person.

During our previous inspection we also found the provider needed to make some improvements to how they provided activities to ensure they reflected people's hobbies and interests. Although there were no activities taking place during this inspection we did find that some improvements had been implemented. Two of the relatives we spoke with told us that their relations had recently been on trips. One relative told us their family member had recently enjoyed a trip to the goose fair. Another relative confirmed their relation had been on a shopping trip, but they felt that there still needed to be, "More for people to do."

Staff told us there was a dedicated member of staff responsible for activities, but they were not available on the day of our inspection. We looked at three care plans that identified one person liked their nails painted and make up done. Another person liked going out with their family. A third person liked to go to the shops to fetch a paper. We found each person had completed these activities on some occasions. We noted a number of activities on the noticeboard for am and pm each day, for example, Monday am colouring. During our inspection there was no one participating in the planned activities for that day, or in any other organised activities. During our inspection we observed the TV was on loudly all day even though people did not appear to be watching it. No other activities were taking place. This showed us the service was not consistently responding to people needs for social and leisure activities.

People's feedback about the service was good, but we found staff were not always consistently responsive to their personalised needs. One person told us staff initially responded to the call button promptly, but if they required

further assistance to the call the follow up was slow. They gave an example of when they asked for a specific drink. They said, "I had waited over an hour for them to complete my request." We asked the manager if they monitored staff response times to call bells. They told us there was a system in place, but this was not audited in any way to check if it was effective. We spoke with staff about how swiftly they responded when call bells sounded. One staff member said, "We always respond to the call bells. They told us people only waited two to three minutes no more." Another staff member said, "Sometimes the call bells ring for four or five minutes, but that's not often." They went on to say, "Staff run to answer the call bells. The response to calls could be improved. It tends to be when staff is unavailable and people may have to wait five or ten minutes."

People were involved in identifying their needs, choices and preferences and these were usually accommodated. The service involved families and friends in decisions about care that was provided. One relative said their relation responded better to female staff and this was respected. They also confirmed that staff asked their family member about their preferences and choices. Staff showed they knew about people's individual preferences. For example, one staff member described to us that one person liked a certain cream in specific areas on their body and a choice of particular nighties. However, relatives told us the service was not always responsive to their family member's needs. One relative said, "[My family member] has always liked to be clean shaven, but sometimes when I visit they have not had a shave." Another relative, told us about a minor concern, which they felt the response was unsatisfactory when their relation requested a certain piece of fruit, but was told by staff they didn't have any.

People were able to get up and go to bed when they wanted. They were able to do things independently and, when required, staff supported them. We observed a staff member responding to one person immediately when they felt breathless. We heard another person complaining of back ache and a staff member was attentive and responded by massaging the person's painful area to ease the pain and discomfort.

Systems were in place for people to share their experiences, raise a concern or complaint.

People and their relatives told us that they would raise concerns informally with staff or managers. They told us

## Is the service responsive?

they would be confident that they would get an appropriate response, especially since the new manager had been appointed. Staff we spoke with knew how to respond to a complaint. They said, "We would listen to what people had to say and ask them about their expectations. Then we would inform the senior or the manager." Staff told us that they had received feedback on complaints, but gave no examples of changes that had been made due to any concerns raised. The manager told us they had a complaint log in place. We saw complaints were monitored regular to ensure lessons were learned to keep concerns to the minimum.

Guidance on how to make a complaint was displayed in the reception area. There was a clear procedure for staff to follow should a concern be raised. We did not find any information in relation to how to make a complaint in the service guide. This meant people may not receive full information on how to make a complaint or raise a concern.



# Is the service well-led?

## Our findings

During our visit on 11 November 2014 We found there was no registered manager in post, but the manager was in the process of submitting an application. However since our last visit to the home there had been further change in management. There was a new manager in post who had not yet submitted their application. We contacted the provider to ensure there were no further delays in this process. The manager of the home understood their role and responsibility. They told us they were fully supported by senior management to ensure they delivered the care and support required to meet people's needs. The manager told us they were hands on and worked alongside the staff to ensure they got to know and understand the needs of the people the service cared for.

People told us they felt the home had improved since the new manager had been in place. One person said more time was spent getting to know them and not in the office. Relatives of people who used the service told us they found the new manager approachable and helpful. Staff spoke positively in relation to the new manager. One staff member said, "[Manager's name] is fantastic, and if you make an error the manager will take you discreetly to one side and explain how to prevent it happening in future." Another staff member said, "[The manager] talks to you, they are very approachable." Staff received regular feedback in team meeting and shift handovers. Staff told us that the handovers were useful and they had enough information about people on a daily basis.

The manager told us the vision and value of the service was to promote personalised care. They explained a key challenge for the provider was to employ good reliable staff and continue to make sure staff took responsibility for their job role. They discussed their biggest achievement had been to receive a high score in an external medication audit.

We found improvements in audits and quality checks had been made in relation to how medicines were managed. The provider had introduced an electronic system so medicine auditing was made more efficient. Fridge and room temperatures were recorded and were within acceptable limits. The manager told us they also completed a monthly report, which was submitted to the head office for them to monitor progress and improvements. We saw action that had been identified was

followed up appropriately. Staff team meetings discussed where the provider had identified poor recording and relevant charts, such as fluid charts, not being completed consistently. Despite these measures we found that some records were not always completed accurately. The daily notes were completed, but sometimes they did not reflect the care plan. For example one person was supported to have an injury regularly dressed. Intervention from the tissue viability nurse was evident. Dressing records and photographs were in the notes, but the home's body charts of where the injury was were out of date. Information in some of the care files was also out of date and records were misfiled so older records were more prominent at times. This meant new staff could get a false picture of the situation. We felt further monitoring was required to ensure recording processes were consistent. We did find that the care plans we looked at were comprehensive and detailed. We saw plans in place to implement resident of the day, which included updating one care plan per shift and discussing the person and their care needs.

Staff told us they were confident to raise concerns and question the practice of their colleagues if needed. They said they were aware of the whistleblowing policy and knew how to report concerns both internally and externally.

People and their families were actively involved in development of the home and were supported to express their views. For example, meetings for people who used the service took place where relevant changes had been identified these had been implemented. The manager had an open door policy. This meant the manager made themselves available and people or their families could have a discussion with them at any time. Questionnaires were made available for people, their families and other professionals to leave feedback. We saw copies of questionnaires that had been completed. Feedback was positive and complimentary towards the staff and the care they received. For example, "Overall care and facilities very good." One relative commented on a questionnaire that it was difficult when there were no keyworkers to speak to. A keyworker is a named member of staff who has a central role in communication and coordinating the care and support for one person. The manager told us they were implementing keyworkers. Daily discussions took place with each individual with regards to their care needs.

## Is the service well-led?

We asked staff if there was anything they would like improved. One said, “Nothing, we are doing a good job.” Another staff member talked about the people who were in bed or showed behaviours that were challenging to others. They said, “I’d like to spend more time with people.” And they added, “We are like a big family, it wasn’t always like this. I have seen a massive improvement, however we are aware there is some way to go yet.”

Incidents, accidents and complaints were responded to in a timely manner. People and their relatives told us they had

no concerns or complaints about the care provided, but they would know who to speak to if they did. We saw that incident and accident forms were completed. Themes and trends were monitored and action taken when required.

We saw that safeguarding concerns had been responded to appropriately and appropriate notifications were made to us as required.

The service worked well with other health care professionals and outside organisations to make sure they followed good practice. We noted the service followed their legal obligation to make relevant notifications to CQC and other external organisations.