Elder Homes Cotgrave Limited

Eton Park Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of the service on 29 June 2017. Eton Park Care Centre provides accommodation for persons who require personal care or nursing, for up to a maximum of 76 people. On the day of our inspection 45 people were using the service. Care was provided on residential and nursing floors as well as a dementia unit.

On the day of our inspection there was not a registered manager in place, however an application had been submitted for the new home manager to be registered. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We will continue to monitor application process and will address any delays with the provider.

Staffing numbers on the day of the inspection exceeded those required on the provider's internal dependency assessment. Howver, people, relatives and staff raised concerns about the number of staff working at the home. Staff could identify the potential signs of abuse people could face; however only some knew what external agencies any concerns could be reported to. People's medicines were managed safely; however people's preferred way to receive their medicines was not always recorded within their records. People's medicine administration records were not always correctly completed. Risks to people's safety were continually assessed.

The principles of the Mental Capacity Act (2005), including Deprivation of Liberty Safeguards, had been followed when decisions were made about people's care.

People were supported by staff who completed an induction prior to commencing their role. However, some training was not currently up to date. Staff received supervision of their role, although the frequency, in which staff received this, was inconsistent. Staff felt supported by the deputy manager and the manager.

People were supported to maintain good health in relation to their food and drink. However, the serving of the lunchtime meal was disorganised, with some people waiting too long for their meal and a drink, which did not promote a positive mealtime experience. People's day to day health needs were met by staff and referrals to relevant health services were made where needed.

People and relatives spoke positively about the staff and felt they were kind and caring and supported them or their family member in a respectful and dignified way. Staff responded quickly to people when they showed signs of distress or had become upset, showing genuine warmth and compassion. Staff understood people's needs and listened to and acted upon their views. People felt able to contribute to decisions about their care, although people's care records did not always reflect this. People were provided with information about how they could access independent advocates. People's privacy was maintained and respected. People's friends and relatives were able to visit whenever they wanted to.

People were encouraged to take part in activities. The majority of relatives felt there was enough stimulation for their family members. Before people came to live at the home assessments had been carried out to determine whether their needs could be met. This, in majority of cases led to timely detailed care plans being put in place. The care people received was provided in line with their care plans, although a small number of examples were identified where improvements in this area were needed. People living at the home had person centred care plans in place that recorded their preferences and likes and dislikes. Staff were knowledgeable about people's preferences.

People were provided with the information they needed if they wished to make a complaint and they felt their complaint would be acted on.

The new manager had started to identify and act on areas that required improvement within the home. Quality assurance processes were in place, with roles delegated to senior staff to manage on-going improvements to the home. The manager was well-liked by the people, relatives and staff we spoke, although some people said they would like see more of the manager. People were encouraged to provide feedback about the quality of the service, although formal meetings were rare.

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.

People, relatives and staff raised concerns about the number of staff working at the home.

Staff could identify the potential signs of abuse people could face; however only some knew what external agencies any concerns could be reported to.

People's medicines were managed safely; however people's preferred way to receive their medicines was not always recorded within their records.

People's medicine administration records were not always correctly completed.

Risks to people's safety were continually assessed.

Is the service effective?

Requires Improvement

The service was not consistently effective

People were supported by staff who completed an induction prior to commencing their role. However some training was not currently up to date.

Staff received supervision of their role, although the frequency in which staff received this was inconsistent. Staff felt supported by the deputy manager and the manager.

People were supported to maintain good health in relation to their food and drink. The serving of the lunchtime meal was disorganised, with some people waiting too long for their meal and a drink.

People's day to day health needs were met by staff and referrals to relevant health services were made where needed.

The principles of the Mental Capacity Act (2005), including Deprivation of Liberty Safeguards, had been followed when decisions were made about people's care.

Is the service caring?

Good

The service was caring.

People and relatives spoke positively about the staff and felt they were kind and caring and supported them or their family member in a respectful and dignified way.

Staff responded quickly to people when they showed signs of distress or had become upset, showing genuine warmth and compassion.

Staff understood people's needs and listened to and acted upon their views.

People felt able to contribute to decisions about their care, although people's care records did not always reflect this. People were provided with information about how they could access independent advocates.

People's privacy was maintained and respected. People's friends and relatives were able to visit whenever they wanted to.

Is the service responsive?

Good

The service was responsive.

People were encouraged to take part in activities. The majority of relatives felt there was enough stimulation for their family members.

Before people came to live at the home assessments had been carried out to determine whether their needs could be met. This, in majority of cases led to timely detailed care plans being put in place.

The care people received was provided in line with their care plans, although a small number of examples were identified where improvements in this area were needed.

People living at the home had person centred care plans in place that recorded their preferences and likes and dislikes. Staff were knowledgeable about people's preferences.

People were provided with the information they needed if they wished to make a complaint and they felt their complaint would be acted on.

Is the service well-led?

Good

The service was well-led.

Although the new manager had started to identify and act on areas that required improvement, further work was needed to ensure these were addressed and the improvements sustained.

Quality assurance processes were in place, with roles delegated to senior staff to manage on-going improvements to the home.

The manager was well-liked by the people, relatives and staff we spoke, although some people said they would like see more of the manager.

People were encouraged to provide feedback about the quality of the service, although formal meetings were rare.

Eton Park Care Centre

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 checked 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 comprehensive inspection was carried out on the 29 June 2017 by one inspector, a specialist advisor, who was a nurse 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 information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies. This included the local authority who commissioned services from the provider.

During the inspection we spoke with eight people living at the home, three relatives, the cook, four members of the care staff, two nurses, the deputy manager, the manager and a representative of the provider.

We looked at care records relating to six people living at the home as well as medicine records for others. We reviewed other records relevant to the running of the service such as, staff recruitment records, quality assurance audits, training information for care staff, staff duty rotas, meeting minutes and arrangements for managing complaints.

Requires Improvement

Is the service safe?

Our findings

People and their relatives had mixed views in relation to the number of staff available to support them or their family members. One person said, "I think they seem fine in number." A relative said, "They seem to be staffed ok on this floor (nursing floor)."

However, others felt more staff were needed. One person said, "I had a long wait for my breakfast today." Another person said, "They need more permanent, stable staff, it feels like they're very short at the moment. Two left at the same time recently." A third person said, "They seem rushed at times and don't stop to chat." Other relatives felt more staff were needed. One relative said, "It's the perennial problem at nights especially when agency are used, and if a fire breaks out, I worry about so few staff." Another relative said, "If they're short, I help out. I feed [family member] lunch most days and help hand things round. But the quality of the regular staff is so good, they hide the shortage well. Staff levels are low. It's retention which is the problem."

The staff we spoke with felt more staff were required, especially on the nursing and dementia floors within the home. They told us these issues had been raised with the previous management but as of yet, nothing had been done to address this. One member of staff said, "The majority of people upstairs need two staff to support them to get up, to go to the toilet and also need staff support with eating and drinking. We don't always get our breaks because we are so busy." Another staff member said, "The numbers are manageable, but we could do with one more member of staff upstairs."

We reviewed the provider's assessment of how the number of staff needed to support people safely and effectively was calculated. We noted the number of staff working on the day of the inspection exceeded the number recorded on this assessment. However, records showed all 11 of the people on the dementia unit and 14 of the 16 people on the nursing floor had been assessed as being at 'high risk'. Two of the 11 people living on the dementia unit also received continuous supervision (one to one support) at times throughout the day. Our observations showed that although staff managed with the numbers in these two areas, during times when meals were not being served, there was limited time for meaningful interactions with people. We were also told that nurses regularly left their nursing role to support care staff with day to day caring activities.

We raised these concerns the manager and a representative of the provider. We received different views from both. The manager felt more staff were needed, especially on the nursing floor and dementia unit. However, the representative of the provider felt sufficient numbers of staff were in place. This conflicting analysis could pose a risk to the safety of the people living at home that people would not be supported safely.

Safe recruitment procedures were in place. Checks on staff suitability to carry out their role before they commenced work were carried out. This included checks to establish whether a potential member of staff had a criminal record, whether they had sufficient references and proof of identity. This reduced the risk of people receiving care and support from unsuitable staff.

People told us they were happy with the way they were supported with taking their medicines by the permanent staff. One person said, "They bring me my tablets and wait with me." Another person said, "They bring them (tablets) to you and I can take them later when I'm ready. They trust me." A relative said, "[My family member] has [condition] and they seem to have their own set times for [my family member] to have them."

However we did receive some concerns regarding when agency staff were involved with administering medicines. One person told us an agency member of staff did not give them their medicines in the way they wanted them and that they were 'dismissive' when they raised concerns with them. A relative said, "An agency staff member gave [my family member] the wrong dosage recently. It got sorted out." We were advised by the representative of the provider that immediate action was taken to address this with the appropriate authorities, including the CQC being notified.

Medicines were stored safely in locked cupboards and trolleys within a locked room. A refrigerator used to store medicines on the first floor was unlocked but it was situated within the locked medicines room. The temperature of the rooms and the refrigerators used to store medicines were recorded daily. We observed the administration of medicines by employed staff and saw they were administered safely and staff stayed with people when needed, until they had taken their medicines.

Medicines administration records (MAR) contained a photograph of each person to aid identification and recorded their allergies. They also stated whether each person was complicit with taking their medicines and if not, procedures were in place for the medicines to be given covertly. This is medicine which is hidden, usually in food. When medicines were given covertly there was evidence of consultation with the person's GP and, in most cases, the pharmacist. We did note that people's records did not always contain information about how they liked to take their medicines which could mean people received their medicines in a way that was not their preferred choice.

When handwritten entries had been made on people's MAR there were not always two signatures to indicate they had been checked by a second person for accuracy of transcription. We also saw there were some gaps in the three people's MAR which suggested the medicine was not given, or the person administering the medicine did not sign the MAR. This could lead to medicines being given twice. When we checked one of the medicines we found the tablet was not in the pack suggesting the person was given their medicine, but the record was not signed.

Protocols were in place to provide additional information about medicines which were prescribed to be given only as required to enable them to be administered consistently and in line with the prescriber's intentions. Competency checks were carried out to assess staff member's on-going ability to administer medicines safely.

People and relatives told us they or their family members felt safe at the home. One person said, "I do feel safe, we're protected well." Another person said, "You know it's a safe place as there's no strangers around." A relative said, "I'm happy [family member] is safe enough. I see nothing that concerns me greatly." Another relative said, "I've no real concerns about [my family member] being safe."

Staff were aware of the signs of abuse and how to reduce the risk of people experiencing avoidable harm. They told us if they had any concerns about a person's well-being they would report this to the senior staff on duty or the manager. Whilst some staff understood the process for reporting concerns to external agencies such as the CQC or local safeguarding teams, some were not aware. However, records showed that when incidents had occurred the provider had ensured that the local authority safeguarding team as well as

the CQC were notified without delay.

People were supported by staff who had an understanding of the whistleblowing process and there was a whistleblowing policy in place. Whistleblowers are employees, who become aware of inappropriate activities taking place in a business either through witnessing the behaviour or being told about it.

Risk assessments were completed to assess risks to people's health and safety such as nutritional risk, choking, falls and development of pressure ulcers. They were reviewed monthly. Care plans provided information for staff about actions to reduce these risks and staff were knowledgeable about how to support people safely.

Regular servicing of equipment such as hoists, walking aids, gas installations, fire safety and prevention equipment were carried out, with specially trained external professionals used to service the more complex equipment such as lifts.

People told us staff used equipment such as hoists safely when supporting them with transferring around the home. One person said, "I'm hoisted all the time now and the staff are very good. I've had no bangs or falls." Staff told us they had the equipment available to support people safely and effectively. Some staff did raise a concern that if new equipment was needed, the process for ordering a replacement could sometimes mean there was a delay. However, staff also said, if an item could be fixed internally, normally by the maintenance person, this was done promptly.

We did note that for two people the setting for their mattress, used to reduce the risk of pressure sores developing was not set to the correct level. We also noted that the documentation used to record when staff repositioned people, who could not do so for themselves, was not always appropriately completed. The accurate recording of the repositioning is important in ensuring that people are repositioned at the appropriate times and to a new position, to reduce the risk of pressure sores forming. The manager told us they felt the pressure care management at the home was good as people did not currently have pressure sores at the home, but they also acknowledged that records must be completed accurately to reflect this.

Regular assessments of the environment people lived in were conducted to ensure that people were safe. We noted some rooms, such as the sluice, which had labels on stating they should be locked, were not locked, which could pose a risk to people's safety in the entered these rooms. People had individualised personal emergency evacuation plans in place that enabled staff to ensure, in an emergency, they were able to evacuate people in a safe and timely manner. These were regularly reviewed to ensure they met people's current needs.

When accidents and incidents had occurred the manager ensured these were investigated thoroughly. Guidance was also provided from a representative of the provider where needed. Agreed actions were in place and these were regularly reviewed to ensure the possibility of reoccurrence was reduced.

Requires Improvement

Is the service effective?

Our findings

The feedback from people and relatives in relation to the quality of the food and drink provided for them or their family members was, in the majority of cases, positive. One person said, "It's not bad at all. There's usually a choice at lunch." Another person said, "It's fantastic food, it's like a hotel. I've put weight on which is good as I was too thin. We get two to three choices each time." A relative said, "The food is basic, but an adequate standard."

Prior to lunch being served people were offered a choice of what they would like. We then observed lunch being served in two of three dining areas. We noted people were able to eat their meals together in the dining rooms, the conservatory, in the lounges or in their bedrooms. However, we noted in both dining areas the serving of the lunchtime meal was disorganised with people waiting long periods of times for their meals, drinks or for assistance with eating their meals. For example, on the nursing floor people were not offered a drink until at least ten minutes after their main meal was served. On the ground floor, only a hot drink was offered and this took almost an hour to serve all of the people waiting for a drink. We also noted the hot drinks were served from non-thermal jugs/teapots which had been sat on the serving trolley for over an hour and were being served intermittently when staff had finished supporting people. These drinks could have been cold and we did not see staff check this.

On both floors support for people who required assistance with eating was provided, but this, again was disorganised, with staff members regularly leaving the person they were supporting to do other things which meant they were not supported in a dignified way. We saw one person had their meal placed in front of them and had to wait 20 minutes for a staff member to come and support them with eating. We also noted two people who received their meals in their bedrooms did not receive them until after 2.00pm. This disorganised approach meant many people's plates were left with large parts of their meals uneaten which could have an impact on their health.

We noted that whilst hot drinks were offered throughout the day, we saw no evidence of soft drinks or water being readily available in the lounges, bedrooms or at lunch time. We asked people and their relatives for their views on the drinks that were available for them and how readily available they were. One person said, "They bring me cups of tea. Although I don't have a jug or drink in my room." Another person said, "We've just got to ask if we're thirsty" A third person said, "They bring us hot drinks quite often." A relative said, "I don't think [my family member] drinks enough as they need encouraging and reminding, plus they sleep a lot. I get [my family member] to drink when I'm here, which is most days." Another relative said, "It's all hot drinks in the day. Cold drinks are around on a hot day though."

People and their relatives felt the staff supported them effectively. One person said, "I find them excellent." Another person said, "Most of them manage me well and know me." A third person said, "I find them very capable, I ask and straight away they see to it." A relative said, "The existing staff are the capable ones. They're better at handling [my family member] than me." Another relative said, "They do a fantastic job."

Staff received an induction, with new staff undertaking the care certificate training. The care certificate is a

set of minimum standards that can be covered as part of induction training of new care workers. Following their induction staff received an on-going training programme designed to equip them with the skills needed to support people effectively. However records showed some of the training in key areas was out of date. For example, 13 of the 44 staff required refresher training for the safe moving and handling of people and 17 of the 44 staff required refresher training for the safeguarding of adults. After the inspection we were advised by the representative of the provider that the gaps in training were being addressed and refresher courses were booked for staff that needed them.

Staff told us if they had any concerns about their role they would discuss these first with the deputy manager and then with the registered manager. One staff member said, "I feel supported by the new manager. She is doing an absolutely brilliant job and her door is always open." We saw staff received supervision of their work; however the frequency of this varied. The manager, after the inspection, forwarded us a schedule which showed the frequency with which staff would be receiving their supervisions over the coming year. The records showed staff would receive at least one supervision every three months, with senior staff held accountable for ensuring they were completed. This new approach would ensure that staff performance was regularly monitored providing people with effective care from competent staff.

The manager told us that some of the staff had completed relevant external qualifications in adult social care. Records viewed showed the numbers of staff who had completed these qualifications was quite low, with just ten staff having completed them. The continued professional development of staff ensures the care they provide people is effective and in line with current best practice guidelines.

People's care records included detailed guidance for staff to enable them to communicate effectively with people. Due to the wide ranging needs of the people living at the home, with some people living with dementia, staff were required to use a variety of different methods to communicate and engage with people. Throughout the inspection we saw staff doing so effectively. We saw staff support people who presented behaviours that may challenge and observed a staff member react to one particularly challenging situation, calmly and with patience.

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 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. We checked whether the service was working within the principles of the MCA.

When people could not make some decisions for themselves, mental capacity assessments and best interest decisions were completed. For example, we saw these for the use of bed rails to prevent a person from falling out of bed, and the covert administration of a person's medicines.

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 (DoLS). We looked at the documentation for two people and found staff adhered to the terms of the DoLS. Some people also had documentation which stated they did not wish to be resuscitated if their conditions worsened. Documentation for the ones we reviewed had been completed correctly.

Staff displayed a good knowledge of MCA and DOLS and were able to give good examples of its application. One staff member said, "I know the people here so well, so I know what decisions they can and cannot make for themselves." Observations of staff showed that they always asked for people's consent before carrying

out care or support tasks and explained what they were doing and why.

People and their relatives told us they or their family members had access to external healthcare professionals when needed. One person said, "The optician has been in now and then and I have the chiropodist quite often." Another person said, "I go out to the optician but have the chiropodist when he's here. A relative said, "[My family member] had sores on their feet before but they've healed now. The chiropodist keeps an eye on it. The doctor also does occasional checks on their [name of condition]."

People's care records contained evidence of the input of a range of professionals when it was required. For example we saw the use of speech and language therapists, dieticians and a tissue viability nurse had been requested.

Good

Is the service caring?

Our findings

People and their relatives told us they thought the staff were kind and caring and that they liked them. One person said. "I find them quite a cheerful lot." Another person said, "They're extremely kind." A third person said, "They're a wonderful lot here. We lark about." A fourth person said, "I've not a bad word to say against them. Always helpful and kind." A relative told us staff were "very kind" to their family member.

We observed staff interact with people throughout the inspection. We saw they were patient, warm, compassionate and friendly and it was clear people had a positive relationship with the staff who supported them. We observed staff respond quickly to people when they showed signs of distress. For example, one staff member calmed a person who had become anxious and agitated by sitting next to them on a sofa, putting an arm round them and stroking their hand whilst chatting calmly about their family. This reassuring approach ensured the person's demeanour quickly changed to a much more positive state. We also saw staff transfer people to the dining room in an unhurried manner, gently encouraging them to stand and walking with them with an arm around them for support where needed. People responded positively to this encouraging approach.

People were supported by staff who had a good understanding of what was important to them. People told us they felt able to make decisions about their care and felt the staff respected their views and acted on their opinions. One person said, "They listen. If I've any worries they do something about it." Another person said, "I still do my own affairs and see my care plan, often I add something to it with them so it's kept up to date."

We noted in people's care records there was a space at the end of each care plan for people to sign and say they had agreed to the decisions made about their care within each plan. A lot of these documents were left unsigned with little or no explanation why. We raised this with the manager. They told us they acknowledged more needed to be done to ensure people's views were accurately recorded, however, they did also feel that feel that people's views were verbally requested and acted on.

People's life history was recorded which enabled staff to have a good understanding of the person and what was important to them. Staff we spoke with demonstrated a good understanding of people's character and treated everyone as individuals. They were aware of people's likes and dislikes and how this could affect the care they provided. People's care records showed their religious and cultural needs had been discussed with them and support was in place from staff if they wished to incorporate these into their life. A monthly church service was available for people if they wished to worship.

Information was available for people about how they could access and receive support from an independent advocate to make decisions where needed. Advocates support and represent people who do not have family or friends to advocate for them at times when important decisions are being made about their health or social care.

People told us they were encouraged to do things for themselves and staff supported them to remain independent wherever possible. One person said, "I'm limited what I can do but they let me try." Another

person said, "They let me wash myself in the shower and encourage me to try." We observed examples where independence was encouraged, such as, when people were mobilising around the home.

People told us staff respected their privacy and treated them with dignity. One person said, "They usually knock before peeping in. They close the curtains when I need privacy" Another person said, "They knock even with my door being open. They always close my curtains even when I say don't bother, as it's only the squirrels that can see me!" A third person said, "I've got nice privacy in my room. They're [staff] always polite to me." We noted a board was in place where people, relatives and staff had been asked to record, 'What dignity means to me'.

There was sufficient private space throughout the home if people wished to be alone, or to spend time with family and friends.

We observed staff talking with people in a dignified and respectful manner. When staff discussed people's personal care needs, they did so discreetly ensuring their privacy was maintained. We noted people's care records were handled in a way that did place people's privacy at risk. However, we did observe one occasion where a person's care record had been left on a table in a lounge unattended, which meant people could have accessed this personal information.

Relatives told us they were able to visit their family members whenever they wanted to. One relative said, One relative said, "I can come 24 hours a day to suit me." Another relative said, "It's an 'open door' for visiting times. I've got the front door code to use" A third relative said, "We're not tied to set hours, which is really important."

Good

Is the service responsive?

Our findings

Pre-admission assessments were completed to identify people's health and support needs when they first arrived at the home. When people came to live at the home more detailed care plans were then put in place. We saw these care plans were in place within a reasonable period of time. We did note there had been a delay in the implementation of care planning documentation for one person who had lived at the home for three weeks prior to the inspection. This could mean care could be provided for the person that did not meet her needs. We raised this with the manager who told us this would be addressed immediately, however they assured us this person received the care they needed. Where care plans were in place they were detailed and reviewed monthly.

We checked to see whether the care and support required for people, as written within their care plans, was being provided by staff. We found in the majority of cases they were. Staff responded to people's needs and people received the care and support they needed.

People told us they felt their personalised care needs and preferences were respected by staff and acted on. One person said, "I do feel they care for me the way I like and will make sure they do things to their best." Another person said, "I like the way they provide personal care."

People's care records contained a variety of person centred documents which showed discussions had been held with them about the things that were important to them, their likes and dislikes and personal preferences. Documents such as, 'This is me' provided additional details about peoples' life history and personal interests. We noted peoples' choice of male or female care staff when support was needed with personal care had been recorded. People told us that in the majority of cases their wishes in this area were respected. One person said, "I'm used to either but usually I get a fella for bathing." Another person said, "I don't mind one of the males but I told the others (males), 'No'. Now I have the girls."

The staff we spoke with had a good understanding of people's preferences and wishes and we observed staff using this information in their day to day role when supporting people.

People told us the staff who provided activities within the home encouraged participation and the provision of entertainment was good. One person said, "They're very good. I'm always asked if I want to join in. It's marvellous how they keep us going." Another person said, "They ask if there's anything I want to do, so I may join in things if appropriate. I can sit out on the balcony or in the garden. They do occasional outings but I've not been." A third person said, "There's enough for me to do. I join in things if I can, though there's not something on every day. We watch TV or I go for a walk round. I've been on several trips out from here." A relative said, "A brilliant young team. I see them do bingo, quizzes, one-to-one reading and hand massages. They realised low key things work better like cookie making, art and craft, rather than the big events like film nights, loud music acts."

We did receive some concerns from two. Some relatives that not enough activity and stimulation was provided for people. One relative said, "I'm disappointed there aren't more outings for them. We take [my

family member] out in the garden at weekends. The fruit and veg they're growing is super. The newer activity staff do their best; it used to be excellent with the people before them." Another relative said, "[My family member] doesn't do anything. The physio suggested exercise but they just sit and sleep."

We saw activities were taking place throughout the home. Baking, bingo and reminiscence with family photo albums were some of the activities taking place on the residential floor. Within the dementia unit, we saw activities appropriate for people living with dementia were taking place. We observed one person engaging in activity with a member of staff and they were fully involved and responding well to the staff member.

Records showed a number of organised activities were provided for people, which were open to family, friends and the local community. For example, preparations were underway for the 'Eton Park Summer Fayre' later in the summer.

People told us when they knew how to make a complaint and when they had done so, they had been acted on appropriately by staff. One person explained how the complaint they made had meant a change in the support they received and they were happy with this. Another person said, "I'd talk to one of the girls if I felt something was wrong. I don't know about official things." Relatives agreed. One relative said, "Small complaints get sorted quickly. I'd know how to escalate things if I wasn't happy." Another relative said, "I complained about an agency carer. It was dealt with instantly."

A complaints policy was in place although was not easily available for people within the home. The manager told us they would rectify this by ensuring the complaints policy was more easily accessible for all. Records showed when complaints were received they were handled appropriately and in line with the provider's complaints policy.

Good

Is the service well-led?

Our findings

At the time of the inspection a registered manager was not yet in place. The current manager told us they started working at the home in April 2017. An application has been submitted to the CQC for the current manager to become registered. The registered manager had an understanding of their role and responsibilities and assured us they were carrying out their role in line with the requirements of registration with the CQC. The manager had ensured that the CQC were notified of any issues that could affect the running of the service or people who used the service.

The manager told us that when they came to the home they identified areas where improvements were needed and showed us an action plan to address these issues. They acknowledged that progress was slow, but they had identified some of the issues that have been highlighted within this report. They told us they had recently introduced daily heads of department meetings, with the cook, housekeeper, nurses, maintenance person and senior care staff, to enable any concerns identified to be dealt with each day. In addition to these meetings, the manager had introduced other quality assurance processes. These included a daily walk around the service to identify any issues, such as poor cleanliness, quality of care or concerns raised by people. They were also in the process of introducing a 'resident of the day' process. They told us this process would enable them or other responsible delegated person, to carry out a thorough review of the person's care needs, their diet, their bedroom and other areas which could place their health and welfare at risk.

We spoke with a representative of the provider who told us regular quality assurance visits were carried out to identify any areas of concern and to offer support to the new manager in order to address any identified areas of improvement.

The manager acknowledged these processes would take time but they were confident the result would be sustained improvement at the home.

Following our previous inspection, we noted the rating for that inspection was on display in the main reception of the home. The provider operated in an open and transparent way ensuring people living at the home, relatives, visitors and healthcare professionals were aware of the home's current CQC rating.

People, relatives and staff were asked for feedback to contribute to the development of the service. A 'manager's surgery' was open Monday to Friday between 10.00am and 3.00pm. This enabled anyone who wished to, to speak with the manager to raise any concerns they had. The manager told us they had an 'open door' policy and welcomed the views of all. There had been one 'residents and relatives' meeting in 2017 and the manager told us they were planning to have more of these meetings in the future. Staff meetings had also taken place, with the most recent one taking place six weeks prior to this inspection. However, we did note the minutes of this meeting had not yet been typed up and made available for staff.

Staff told us they felt able to give their views and the management were available to support them if they needed it. One staff member said, "The new manager is doing absolutely brilliantly and her door is always

open." Staff also told us if they required any support they would normally approach the deputy manager first although the manager was normally available. They said there was an on-call rota out of hours covered by the manager and deputy manager and they told us when they needed to contact them they were available and helpful.

People and their relatives told us they unsure whether meetings had taken place to gain their feedback. One person said, "I don't think enough people have conversation skills to join in properly. I've not seen a meeting take place." Another person said, "I think they have a 'Meet the Manager' on Wednesdays? Although I'm not sure about group meetings." A relative said, "I'm not aware of any meetings for us." Another relative said, "They had one (meeting) and they were going to be quarterly, morning and evenings. But the email never got done to publicise them so meetings didn't happen again."

People and their relatives spoke positively about the new manager. One person said, "I see her once in a while. She's nice enough." Another person said, "I see her a lot and she's really easy to talk with." A relative said, "I get on really well with her now, though she didn't introduce herself initially. She has an open door policy. I'm happier with her now." Another relative said, "We just have catch ups now and then, no formal meetings." However a small number of people did say they would like to see more of the manager. One person said, "I don't often see her here." Another person said, "I rarely see her. I'd talk to one of the carers if I needed advice."