Four Seasons Homes No 6 Limited

Wyndthorpe Gardens

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

Wyndthorpe Gardens Care Home is a two storey care home situated in Dunsville, Doncaster and provides a service for 38 older people. There were 34 people living at the home when we visited. We carried out a routine inspection of the service in August 2013 and did not identify any concerns.

This inspection took place on 21 and 23 October 2014 and was unannounced. The first day of the inspection was unannounced. This meant that the provider did not know when we were inspecting the service.

There was 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 2008 and associated Regulations about how the service is run.

We received contradictory information and opinions from people and their relatives about the service. While everyone said they were very happy with the service, particularly with the caring attitude of the staff, some also raised a number of concerns. In addition, our own observations and the records we looked at did not always match the positive descriptions some people gave us.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in

Summary of findings

that there were not always sufficient numbers of skilled and experienced staff to meet people's needs. Staff we spoke with told us it was difficult to meet everyone's needs at key times, such as mealtimes. They said the number of agency staff used added to the pressure they were under. We saw people left unattended who displayed behaviours that challenged others. These issues indicated that the service had not been well led as there was not always evidence that the provider effectively assessed and monitored the quality of service provided. You can see what action we told the provider to take at the back of the full version of the report.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. Although we saw information that best interest meetings had taken place for some people who lacked the capacity to make decisions, this was not the case for all important decisions made on behalf of people who did not have the capacity to decide for themselves. There were not always evidence that staff worked within the Mental Capacity Act 2005 Code of Practice.

Although people told us about activities they had enjoyed, during the time of our inspection there were not enough meaningful activities for people, either as a group or to meet their individual needs.

People's relatives expressed concern about the laundry arrangements and that people's beds were not made until the afternoon. The registered manager had not been consistent in how they had recorded and responded to people's complaints and the process for monitoring the quality of care was not effective; as it had not picked up some of the problems we found, so had not led to the necessary improvements being made.

People's health care needs were assessed and they had good access to healthcare services, such as GPs and district nurses and we found that medicines were managed safely. Most people enjoyed the food and they spoke very highly of the care staff.

Staff were recruited in a safe way and understood their role in safeguarding people from abuse. They were seen to be caring in their approach and treated people with respect.

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?

Inadequate

The service was not always safe as there here were not always enough staff to meet people's needs.

Staff had received training in safeguarding and knew how to report any concerns regarding abuse or possible abuse and staff were recruited in a safe way as thorough pre-employment checks were done before they started work.

Is the service effective?

Requires Improvement

The service was not always effective. Best interests meetings had not always been undertaken or recorded when someone lacked the capacity to make an important decision and it was not always clear whether people's relatives had the legal authority to make decisions on people's behalf.

People had a choice about what they wanted to eat and most people enjoyed the food.

People's health care needs were met and they were referred to health care specialists if there were any concerns about their health.

Staff had up-to-date training and supervision.

Is the service caring?

Good

The service was caring. People and their relatives spoke very highly of the staff and were very positive about the care people received from staff and this was supported by some of our observations.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs. Whereas people's care plans were up-to-date and people's needs and preferences for their physical care were met, staff were not able to be responsive to people's emotional and social needs at all times. There were some activities available for people to engage in and some people really liked getting out into the garden. However, we saw there were long periods when the more quiet people were without stimulation or engagement.

People's relatives told us they had concerns about the laundry and not all the complaints that people told us about had been recorded. It was also unclear if some of the complaints, which had been recorded, had been resolved.

Is the service well-led?

Requires Improvement

The service was not well led. Some people's relatives and staff expressed little confidence in the way the home had been managed in recent months and systems for monitoring quality were not always effective.

Wyndthorpe Gardens

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 inspection took place on 21 and 23 October and was unannounced.

The inspection team was made up of a lead inspector, one other adult social care inspector and an expert by experience, who had experience of older people's care services. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection, we reviewed information we held about the service, which included incident notifications they had sent us. We contacted Doncaster Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We obtained information from Doncaster Council who commission services from the provider. They told us they had visited recently and had identified some areas that needed improvement. They shared the action plan that had been put in place for the provider to improve in these areas.

During the visit we spoke with 12 people who used the service, seven people's relatives and visitors, three nurses, nine care staff, the deputy manager and the regional manager. We observed care and support in communal areas and also looked at the kitchen and 10 people's bedrooms. We reviewed a range of records about people's care and how the home was managed. These included the care plans for eight people, 15 people's medication records, the training and induction records for all staff employed, the recruitment records for four staff, the complaints records and quality assurance audits. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

Before the inspection we received information from members of Doncaster Council's safeguarding adults authority and contracts team. They had identified concerns about the numbers of staff available, particularly in the downstairs communal living areas.

Our observations showed there were not enough staff to meet the needs of the people who used the service, for instance, here were several periods during mealtimes when people were left unattended and were therefore, left vulnerable. We also saw an incident in the downstairs communal area, when one person spilled a hot drink in their lap. There were no staff in the room at the time. We alerted staff to this. On this occasion the person was unharmed.

Most people who used the service and most relatives and visitors we spoke with described the service as safe and praised the staff highly. However, most relatives we spoke with and one person who used the service also told us there were staff shortages, which had an impact of this on people's care and support. For example, one person's visitor said, "Several times there has been just one staff member on duty upstairs. Surely that's not right given the number of residents up here and their needs." Another visitor told us, "Part of staffing problem is the variability of staff with some going off sick and being replaced by agency staff, who don't know the residents."

We asked nine staff if they thought there were enough staff to meet people's needs. Five of the nine told us they struggled to meet people's needs at key times because there were not enough staff. The others said there were usually enough staff to meet people's needs. They said there were busy times, but there were also quieter times, when they could spend time with people.

People's care plans and risk assessments included information for staff about any behaviour people may have exhibited that was challenging to the service. This included how to manage people's behaviour. However, our observations showed there were not enough staff to supervise people adequately and to intervene in a timely way. For instance, we saw an incident in the small ground floor lounge. One person was exhibiting behaviour that showed they were distressed. It took approximately seven minutes for a staff member to respond, by which time the person had become very upset, had caused minor physical harm to themselves and posed a risk to others.

Three visitors were concerned about the number of agency staff used in the home. Five of the nine staff we spoke with told us that agency staff were used regularly and this sometimes had a negative effect on the standard of care provided to people. One staff member said that when agency staff were new and unfamiliar with people and their needs, this contributed to the pressure on the permanent, experienced staff. They said this was particularly the case at key times, such as when people were getting up and at mealtimes.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (Staffing).

We looked at the staff rotas. This showed there were usually two qualified nurses on duty in the daytime and one nurse at night. Agency nurses provided covered around 50% of the time. There were usually five care staff on duty during the daytime and four at night. There were several occasions when bank staff and care staff from agencies were used. The regional manager told us they were recruiting to vacant posts.

The registered manager had not been at work for a short period and was not likely to return within the next two weeks. The deputy manager was covering in their absence and was working more supernumerary hours to fulfil her management role. However, the deputy manager said she was so busy trying to cover for the registered manager and that she was not able to do her own work. She told us this resulted in several tasks not being done or being delayed.

We looked at recruitment records of four staff members and spoke with three staff about their recruitment experiences. Checks had been completed before staff worked unsupervised and these were clearly recorded. The checks included taking up written references, identification check, and a Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

The recruitment system included applicants completing a written application form with a full employment history

Inadequate

Is the service safe?

and a face to face interview, to help make sure people were suitable to work with vulnerable people. We saw that interview notes were kept on each staff member's records to show that the recruitment process tested each candidate's suitability for the role they had applied for.

The deputy manager showed us around the home. For the most part it was suitable for people's needs. However, we saw three people's en-suite toilets had toilet roll holders attached to the rear wall above the low level cistern. These were difficult to reach. This caused difficulties for people in routinely cleaning themselves and posed a risk of people twisting and falling. As this risk had not been previously identified no risk assessments were in place.

The home was well presented and decorated and smelled and looked clean. Staff had training in infection prevention and control. However, we saw one incident when one member of staff did not adhere to best practice when dealing with body fluids and did not wash their hands when dealing with food.

The care staff we spoke with showed they understood their role in safeguarding people from abuse. They described signs which might indicate possible abuse or neglect. They understood the procedure to follow to pass on concerns to senior staff. They said they had read the whistle blowing policy and would use it if they felt there was a need. The staff training records showed staff had received safeguarding training and updates and the staff we spoke with confirmed this.

One person who used the service told us they had been abused by other people who used the service. Discussion with staff and mangers and the records we saw showed the care staff were aware of the person's concerns, and had responded and supported the person appropriately.

Safeguarding incidents had been referred to the local authority safeguarding team and notified to the Care Quality Commission appropriately. One person's relative said, "My wife is very safe in this home. I have absolute confidence in the staff."

We found that medicines were managed and stored safely. We reviewed 15 people's medication administration records (MAR) and observed part of the morning administration of medicines. We observed the nurse give medicines to six people. The home used a monitored dosage system. This meant that tablets were dispensed by the pharmacy in separate 28 day, 'bubble' packs. Each person's medicine record included information about any allergies they had and photographic identification.

The nurse told us that medicines were given to people as they were ready for them and that most people came into the dining room for breakfast between 09.30 and 10.30 in the morning. We saw that the nurse provided a drink for each person and was patient, gently encouraging people to take their medicines.

There was an effective system of ordering medication This ensured the correct medicines were always available for people. Medicines that were no longer required were listed and disposed of appropriately.

Information about medicines was available along with a copy of the medication policy. The nurse and care assistant we spoke with had received medication training and they confirmed they had updates. We saw an up to date record of staff who administered medications.

One person was given their medication covertly. However, there was no evidence of the involvement of a pharmacist. Pharmacists have expertise about which medicines can be safely crushed, what kind of food or drink is suitable and can suggest alternative medicines, such as liquids or patches which might be more suitable. As required (PRN) prescriptions included indications for use, such as 'for pain'. However, for they did not include details of how people expressed pain for people who relied on non-verbal communication.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including balancing autonomy and protection in relation to consent or refusal of care or treatment. We spoke with a nurse on duty and they understood the importance of the Mental Capacity Act in protecting people and the importance of involving people in making decisions.

Everyone whose file we saw included a mental capacity assessment. However, some people's assessments were not clear about people's capacity to make decisions or how staff should support people to make and communicate their decisions.

There was evidence in two people's files that they lacked the capacity to make a particular decision in their own best interest. Meetings had been held to establish what the person would want. However, this was not the case for everyone. The deputy manager told us about one person, who had been assessed by a physiotherapist because they had a number of falls. The physiotherapist had recommended the use of specialist equipment to help minimise the risk of the person being injured. However, a close relative was not in agreement with its use. This meant it was not used. We looked at this person's records. We saw no evidence that the person's capacity was assessed in relation to this particular decision and no record as to whether their relative had any legal right to make decisions on the person's behalf. We saw no evidence that a best interest meeting had been undertaken.

One person was given their medication covertly. We saw a letter of authorisation for this from the person's GP. However, there was no related assessment of the person's capacity about this particular decision and no evidence that the best interest process had been followed.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Mental Capacity Act 2005 includes decisions about depriving people of their liberty so that if a person lacks capacity they get the care and treatment they need where there is no less restrictive way of achieving this. The Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to do so. As Wyndthorpe Gardens is registered as a care home, CQC is required by law to monitor the operation of the DoLS, and to report on what we find.

Two people were subject to a DoLS authorisation at the time of the inspection. The records we saw showed that correct procedures had been followed to make sure people's rights were protected. The regional manager was aware there had been recent guidance about the way the Deprivation of Liberty Safeguards were interpreted, widening their definition. They told us the provider, Four Seasons, had been proactive and had discussed what action services should take to make sure they met the key requirements of the Mental Capacity Act 2005 and were following a plan of action to put these into practice.

The staff we spoke with confirmed they were up-to-date with their mandatory (required) training. The training monitoring record we looked at confirmed this. Staff informed us they received one-to-one supervision and an annual appraisal, but this was not always as regular as it should be. The deputy manager told us that some staff's one-to-one supervision meetings had fallen behind during the summer months, but they had made concerted efforts to get this back on track and were now up to date. The records we saw confirmed this.

All the people we spoke with who used the service and their visitors said they would recommend this home to others. One person who used the service said, "It's alright here. It's safe, nice, quiet and the foods alright too. The staff are good, they're all good. I'd recommend this place."

People's preferences were reflected in their care plans, such as 'my favourite foods.' and staff were familiar with what food people liked and disliked. Some people told us they particularly liked the food, while others said it was not of a high standard. One person's visitor said, "The food here is great." Another visitor said, "I know the food's a bit repetitive, you're always going to get that in a home, but overall the quality is good and there's always enough of it for folk."

For most people, the experience at mealtimes was a pleasant one. There was gentle music playing and most people sat together at tables for four, so they could socialise. Some people liked 'finger food' and this had been taken into consideration when meals were prepared. Others needed support to eat and drink and we saw that

staff supported them in a discreet and gentle way. Most people did not have independent access to snacks and finger food throughout the day, although drinks and snacks were served mid morning and afternoon.

We spoke with the chef. They told us, "Any residents with special dietary needs are catered for." The deputy manager told us that if anyone wanted a vegetarian option it would be provided and added to the menu.

Staff members told us the quality of food was variable. The regional manager explained this was an area identified for improvement and extra support was to be provided by a member of the regional management team to support kitchen staff with improvement.

We looked at care plans for eight people. All had pre-admission assessment by a qualified nurse. The assessments included people's mobility, nutrition and their skin integrity.

Risk assessments and care plans were in place for people with special nutritional and dietary needs. We also noted that external healthcare professionals were involved in the development of some people's nutritional plans. People had their weight checked each month to monitor for any fluctuation.

We could see that records were maintained of consultations with healthcare professionals, such as people's GPs, district nurses, continence advisor and urology specialist nurse. People were referred to specialists if there were concerns about their health. For example, we saw from the care records that one person was referred to a speech and language therapist (SALT) as there were concerns about how they swallowed food and drink.

People had access to a safe and private garden and this was greatly appreciated by some. One person said, "I'm happy here. I like to go outside for walks in the garden." Another visitor said there was a sense of freedom. They added, "The back of the home is beautiful with lovely views. On sunny days it's lovely to go outside with (the person) and just enjoy the warmth, greenery and fresh air. (The person) loves being outdoors and walking around the garden. The man who cuts the grass does a lovely job too." Another person's relative echoed these comments saying, "My dad absolutely loves it here. He loves walking and the gardens here are beautiful. Most days you'll find him taking little strolls around the gardens." Another comment was, "It's off the main road, you don't get any uninvited visitors coming round here and the staff make sure the front of the home looks lovely. I saw a handyman a while ago repainting all the garden pots white. The home has got a new handyman and he's worked wonders.

The bedrooms and shared areas were light and airy and, although the chairs were not arranged in clusters in the downstairs lounge, there were smaller rooms where we saw people chatting and spending quiet time together and areas where people could sit with their visitors.

The signs, such as those for people's rooms, toilets and bathrooms were clear and people had boxes outside their rooms with pictures and other items that they liked and identified with. This helped people to identify their rooms.

Several of the corridors and landings had been turned into 'memory walks' and 'memory gardens' with photographs, paintings and objects to touch, such as paper flowers. There was memorabilia and pictures, primarily from the 1940's and 50's. However, there was little reference to life of the 1960's or later, for the younger people who used the service.

The home was suitable for people who used wheelchairs and there was a lift to the first floor and other adaptations, such as handrails, which helped to meet people's needs and promote their independence.

One person's visitor told us, "They've re-carpeted everywhere, put down new clean wooden flooring and lots of new furniture. In fact I think they've replaced the chairs in the lounge/dining rooms twice since then. It looks and smells nice now."

Good

Is the service caring?

Our findings

All the people we spoke with who used the service and their relatives and visitors described staff as kind, caring and compassionate. Each visitor said the staff were in the top three best things about the home and often the top one. One person said, "My carer really looks after me." Another told us, "They really look after you here. They're good girls here."

The staff completed a comprehensive assessment of needs and risks covering all aspects of mental health and physical health. The process included the preferences of the person. This then informed the care planning process, so people had care plans that included their preferences. The deputy manager told us people could have access to an independent advocacy service if they needed an advocate to speak up for them and we saw that the contact details for local advocacy services were displayed in the home.

The plans included what was important to people and how staff should support them to maintain their privacy and dignity. The care plans we saw included people's religious and spiritual beliefs. People's dignity was upheld. Staff explained to us how they ensured each person's privacy when undertaking their personal care in the person's bedroom or in a bathroom.

People told us they made decisions about their lives and made choices every day. This included what they wanted to eat and what clothes they wanted to wear. People had chosen what they wanted to bring into the home to furnish their bedrooms. They had brought their ornaments and photographs of family and friends or other pictures for their walls. This personalised their space and supported people to orientate themselves. The brochure said that bedrooms could be redecorated in a colour chosen by the person, prior to them moving in and we saw a bedroom was being re-decorated in readiness for a new person.

The SOFI observation we carried out showed us there were positive interactions between the three people we observed and the staff who supported them. The staff showed patience, gave people lots of encouragement and had respectful and positive attitudes. They asked people how they were and if they wanted or needed anything. We saw one person put their arms around a staff member and say, "I love you." The staff member smiled and accepted the hug willingly. They warmly put their arms around the person and replied, "I love you too."

The staff we spoke with were thoughtful about people's feelings and wellbeing and the staff we observed and spoke with knew people well, including their personal histories. They understood the way people communicated and this helped them to meet people's individual needs. For instance, we saw that most staff on communicated with the people who used the service effectively by using different ways of enhancing communication. This included touch, ensuring they were at eye level with people who were seated, and altering the level and tone of their voice appropriately for those who were hard of hearing.

One person's relative said, "The standards of care from the staff here are very high…they are devoted to and giving my wife the very best of care." Another relative said, "The staff are so loving… I know there are lots of other relatives and families not here today who feel just the same as I do about the staff."

The relatives we spoke with said the home had an open access visiting policy and that they were always made to feel welcome any time of the day or night. One visitor we spoke with said of the staff, "They're all so friendly" and another told us, "The staff really look after people here. I've been to lots of homes and here they make the relatives so welcome. I can come and go as I like, so I really get to see what the place is really like. No matter what time of day or night I come I can tell the staff have really looked after (the person)." One visitor praised the quality of care given by one particular staff member. They were particularly appreciative of this staff member's vigilance and persistence on behalf of her relative when they were ill.

Staff knew the likes and dislikes of each individual person and their preferences in relation to their care and support. People's care plans set out how they wanted to be cared for and what was important to them. People's plans showed they were supported with those tasks that they may not be able to achieve on their own, for example personal care tasks or daily living activities. On one occasion we saw a staff member assisting one person to eat their lunch. They had a visitor who was also sitting close to them and supporting this activity. The staff member was patient, gentle, encouraging and caring, so the person enjoyed the food and the caring experience.

Good

Is the service caring?

Most people's bedrooms we saw were personalised with family photographs, ornaments and paintings and people's care plans included a personalised 'Life Story' and included people's preferences. We asked three staff about the personal interests, health and hobbies of three particular people. The three staff spoke fluently about each person and in some detail about their needs and their lives. One staff member told us they had worked with people for several years and had got to know them well. We saw two staff in the upstairs lounge carefully and gently use a mechanical hoist to help move a person from an armchair to their wheelchair. The staff spoke to and reassured the person throughout the process and the person chatted happily with the staff.

Requires Improvement

Is the service responsive?

Our findings

A copy of the complaints procedure was available for people in the communal areas. When we asked people whether they knew who to complain to, most said they would complain to the staff.

The record of complaints we saw reflected that one person's relative had made complaints about the laundry. However, several family members we spoke with told us they had raised concerns about this. They said there had been some improvement in recent months, but there were still issues. For instance, one relative told us what had originally been six pairs of socks, were now six single socks. They showed us a drawer, containing a number of single socks, saying, "I'm forever having to buy extra socks."

One relative added "I can tell you that this laundry thing upsets the staff too. They don't say anything to us relatives of course, but I just know they are as upset as me about it." They showed us their family member's wardrobe and were surprised when it did not contain other people's clothes, saying, "Well at least that's a change. Some improvement at last."

We saw records of four complaints received from people who used the service and their relatives, in the last six months. Whilst two records included correspondence, which showed that the concerns had been properly investigated and responded to in accordance with the complaints procedure, this was not always the case. Additionally, the separate monitoring record of complaints kept by the provider had not been properly completed. This made it unclear if two of the complaints had been investigated or resolved.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (Complaints).

We looked at care plans for eight people. All had a pre-admission assessment and included the person's medical history, medication and risks. People's needs assessments included their psychological and emotional needs, personal hygiene, dressing, sexuality, communication, behaviour and cognition. If people had any wounds or pressure sores these were assessed and people had a care plan in place. If the person needed to be lifted using a hoist their care plan included the correct sling size. The needs assessments had been reviewed monthly.

We saw evidence that staff responded to changes in people's behaviour, needs and health in a timely way. For instance, staff told us that one person's behaviour had changed, in that they refused to take their medication, or to eat or drink and had lost weight. They were referred to GP and dietician They were diagnosed as having an illness, which was treated with prescribed medication and their appetite had returned. We saw this was clearly recorded in their care plan.

Most relatives thought the home provided sufficient opportunities for people to go on outings. They told us about a singer who had visited the day before, a trip to the Yorkshire Wild Life Centre and a forthcoming visit to Whitby for fish and chips. We noticed that about people's names were on the list for the Whitby trip, together with accompanying relatives and staff. Other visitors also mentioned the home organising a summer fair, raffles and a Halloween event. One person said, "They also make birthday cakes for us."

However, on the two days of our inspection we saw most people sitting, in both the upstairs and downstairs lounges and there was very little stimulation, and no organised, small group activities or hobbies. Periodically, individual staff would talk to people who used the service, sometimes gently touch, hold or walk with them. This was always done in kindly manner and often it was well received by people.

We spoke with the activity coordinator about the activity programme within the home. A copy of the activity programme was displayed in the ground floor corridor. The activity coordinator was not familiar with the listed activities. They told us that, contrary to the listed activity programme, there were no organised activities in the evenings or at weekends. They said they spent more individual time with people. We discussed this with the regional manager who told us the activity coordinator was quite new in post. They went on to say that the way activities were provided was under review

During the late morning we were shown around a number of bedrooms by the deputy manager. We noticed there were no towels in the en-suite areas and that many beds had not been made. Later in the afternoon we met with a relative in his wife's bedroom. They pointed out the bare, unmade rubber covered mattress. Although the dirty towels and bedding had been taken away for cleaning in the morning, they were not happy that clean laundry and bedding was a task scheduled for the afternoons.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. All the people who used the service and their relatives we spoke with knew registered manager's first name and said they saw her around the home. However, most did not speak positively about the leadership at the service.

We looked at the systems used to monitor the quality and safety of the service. The systems in place had not picked up some of the areas of concern we identified, such as the way the Mental Capacity Act 2005 best interests process was applied for some people and not others, and inconsistency in the way complaints were recorded and responded to. This meant these systems were not always effective. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (Assessing and monitoring the quality of service provision).

There were regular, monthly visits undertaken by the regional manager. They looked at all aspects of quality and included talking to people who used the service, staff and visitors. These visits had made the regional manager aware of the concerns people had about the staffing and the laundry. We saw the action plans and evidence of action that had been taken to address any areas identified.

There was a system in place to help manage risks to people who used the service. For example, data regarding accidents was submitted to the provider in a monthly report, actions taken to reduce the risk of accidents re-occurring were monitored by the regional manager and lessons learned were shared with staff.

We looked at a number of audits that were undertaken in the service. These included infection control and maintenance audits, the management of medication, health and safety, and fire safety. We saw evidence that the deputy manager had taken over the task of auditing care plans each month and there was a clear processes to follow to make sure action was taken to rectify any shortfalls in the records.

We asked people and their relatives whether they had been asked to participate in a survey or otherwise offer their views about the home. Not one said they had. However, one relative said the registered manager had organised some meetings with families throughout the year. They remembered attending a meeting in July 2014.

Although people felt they were listened about how they liked their care to be delivered on a day to day basis, two visiting relatives told us they felt they were not listened to. One relative said the meeting they attended in July 2014 was kept short and there was not sufficient time for people to raise all of their points.

One person's relative said, "My relative is safe here and the treatment's OK too." However, they went on to say, "The laundry, changes in staff and empty promises by the management are the downside." Another person's visitor expressed concern about the ability of the registered manager. They said the regional manager was, "trying really hard to sort things."

There were mixed opinions from staff about the support provided for the staff in the home. Half of the staff we spoke with expressed concerns about how the service was run. They felt they were not always supported or listened to.

There was a poster reporting the outcomes of a recent satisfaction survey in the entrance foyer. This was presented in the format 'We asked, You said, We did.' The poster was at or below waist height and in a small font that was very difficult to read. It was not clear when the survey had occurred, how many people responded, in what time frame and with what result. The regional manager told us that a fuller breakdown of the survey outcomes was also available in the front foyer of the home. There was no further information about the survey outcomes in the main part of the home, where people who used the service could see it.

Four Seasons had a clear set of principles and ethics. These included choice, involvement, dignity, respect, equality and independence for people. We spoke with several staff. They said the values of the service were clear and they demonstrated a good understanding of these values.

At the time of the inspection a manager from another, nearby service supported the deputy manager, in the absence of the registered manager. They helped with reviewing the action plan and updated the actions that had been taken. For instance, staff recruitment was taking place and there was on going discussion between managers and staff about how staff could be deployed better, at key

Requires Improvement

Is the service well-led?

times, to make sure people's needs were met. New staff had been employed in the laundry and an improved rota put in place to help address the issues raised by people's relatives.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **There was not always evidence that the provider effectively assessed and monitored the quality of service provided.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **There was not always evidence that the provider was working within the Mental Capacity Act 2005 Code of Practice.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints **There was not always evidence that the provider effectively identified and responded to complaints.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **There were not always sufficient numbers of skilled and experienced staff to meet people's needs.**