Orchard Care Homes.com (3) Limited

Heartlands

Inspection report

50 Broadstone Road
Yardley
Birmingham
B26 2BN
Tel: 0121 786 1212
Website:

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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?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

The inspection took place on 26 and 27 February 2015 and was unannounced. The last inspection carried out on 4 March 2014 was a follow up to check that the provider had implemented actions to improve the service provided. We found that the required action had been taken and the provider was meeting the requirement of the regulation inspected.

The home is registered to provide accommodation and nursing care to up to 76 people. The home is split into four units over two floors; Broadstone and Yardley on the ground floor and Dovecote and Osbourne on the first floor. The home has a third floor that is not in use. Three of the four units provide nursing care to people suffering from advanced dementia and / or other health conditions. The fourth unit provides personal care, without nursing, to people suffering from mild to moderate dementia. On the day of our visits we were told there were 66 people living at the home.

The location is required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'.

Summary of findings

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. The provider registered the service with us in 2011. There has been no registered manager in post from the date of registration. As a result of this breach we issued a fixed penalty fine of £4000. which the provider has paid. An acting manager has been recruited and in post since December 2014. They told us they intended to submit their application to us to become the registered manager of the home. Following our inspection, the acting manager commenced the process to become registered with us.

Although staff were trained to administer people's medicines, we found that suitable arrangements were not in place to ensure that people received their medicines as prescribed.

Some staff involved people in making choices about their day to day needs. However, this was not consistent across all of the four units of the home. Where people did not have the capacity to make certain decisions, due to their dementia, we found that staff did not understand the requirements of the Mental Capacity Act (2005) or the Deprivation of Liberty Safeguards. No formal assessments of people's mental capacity had been completed in line with the requirements of the law. We saw restraints were in place, such as key-coded locked doors to units which meant some people's liberty was deprived but they had no deprivation of liberty safeguard in place. The provider told us that the requirements of the law had been overlooked and they would take action to rectify this oversight.

Some people that we spoke with were able to verbally express to us that they felt safe living at the home and were, overall, happy living there. Relatives told us that overall they were satisfied with the service provided to their family member.

Relatives told us that they felt staff were caring and kind toward their family member and were responsive to their needs. However, during our inspection we found that there was not consistently sufficient and suitable numbers of staff to meet people's needs when required. We observed that this led to delays in some people's needs being met on one of the units.

We found that risks to people had been identified and actions put into place to reduce the risk or harm or injury to them.

Staff told us that they were pleased that the home now had an acting manager in place. Staff said that they were still getting to know the acting manager but overall felt that they were approachable and supportive.

Although systems were in place to monitor and improve the quality of service people received, these were not always effective. We saw that when improvements had been identified as needed, actions were not taken in a timely way.

You can see what action we told the provider to take at the back of the full version of the report.

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?

Requires Improvement

The service was not consistently safe.

Suitable arrangements were not in place to ensure that people received their prescribed medicines.

The service did not always ensure there were suitable numbers of sufficient staff to meet people's needs.

Risks to people were identified and actions put in place to reduce the risk of harm or injury.

Procedures were in place to keep people safe from the risk of abuse. Staff understood their responsibilities in protecting people and knew how to raise concerns if needed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not consistently understand the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People did not always receive the support they required when needed.

Is the service caring?

Good

The service was caring.

People and their relatives told us that staff were kind, caring and polite to them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff were not consistent in involving people about their care on a day to day basis.

People's needs were assessed. Staff worked closely with people's relatives to ask about their family member's preferences.

Relatives told us they knew how to raise their concerns if they needed to and arrangements for listening and responding to complaints were in place.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Although the provider / acting manager had systems in place to monitor the quality of the service provided to people, these were not always efffective. Where actions were identified as needed to make improvements these were not always implemented in a timely way.

Summary of findings

Staff felt supported in their job roles.	

Heartlands

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was unannounced and took place on 26 and 27 February 2015. The inspection team consisted of two inspectors, a pharmacy inspector and an Expert by Experience. This is a person who has experience of using or caring for someone who uses this type of service.

We had received information of concern to us about the home and brought forward our planned inspection date. We had received a whistle-blowing concern and safeguarding concerns about people that lived at the home. The Local Authority had shared their concerns with us about safeguarding incidents at the home. We also reviewed other information we had received since our last inspection. This included notifications received from the provider about deaths, serious injuries and safeguarding alerts. A notification is information about important events which the provider is required to send us by law.

During our inspection we spent time with people on all four units in the home. We spoke and / or spent time with 31 people that lived there. We spoke with 10 relatives, 12 care staff and one agency staff member, five qualified nurses, two housekeeping staff and two chefs. We also spoke with the deputy manager, acting manager and two senior area managers. We observed how people were cared for on two units by using a Short Observational framework for inspection (SOFI) in the communal areas. SOFI is a way of observing people's care to help us understand the experience of people who live there. We also carried out general observations throughout the day. We looked at five people's records and 15 people's medicine records. We also looked at information about staffing, complaints and audits of the home.

Requires Improvement

Is the service safe?

Our findings

Staff told us that qualified nurses administered people's medicines to them on three of the four units. One staff member told us, "Senior carers administer people's medicines to them on the residential unit as there are no nurses but we have completed a medication training course." All of the staff that were responsible for administering people's medicines told us that they had received training. One nurse told us, "I am new here and am working alongside another nurse. I can ask if I am not sure about anything."

We observed parts of two medicine administering rounds on two units. We saw that both nurses administered people's medicine to them in a hygienic non-touch way. Overall, we saw that both nurses encouraged people to take their medicine and stay with them. However, we observed one incidence of one person's medicine being left with them in a communal area. We spoke with the nurse about this and they told us that it was not the policy to leave medicines unattended.

One relative told us, "I observed staff put a sachet of powder in my family member's cup of tea. They did not tell [Person's Name] what this was or what they were doing." We found that where people needed to have their medicines administered, by disguising them, in food or drink the provider had not ensured that the necessary safeguards were in place to administer medicines safely.

We looked at 15 people's Medicine Administration Record (MAR) and found that their diagnosed health conditions were not always being treated appropriately by the use of their medicines. We found that one person had not had any of their prescribed medicines for three days. Another person had not had one of their medicines for 12 days. This was because the provider had not obtained sufficient supplies of their medicines. We found other people did not receive their medicines as prescribed. For example, some people's medicines were not given to them at the frequency / time interval that the person's doctor had prescribed it to be taken. This was particularly evident for medicines that had not been supplied in the monitored dosage system, such as separately boxed medicines.

We looked at records for people who were having the medicinal skin patches applied to their bodies. We found that the provider was making a good record of where the skin patches were being applied. However, the record showed that the skin patches were not always being applied in line with the manufacturer's guidance. This may impact upon the absorption of the medicine through the skin and showed guidance was not being followed in the administration of skin patch medicines.

One person indicated to us, by wincing and pointing, that they were in pain. Their relative told us, "We have been waiting for the GP to prescribe something more effective for the pain relief for [Person's Name]. It can take some time. One nurse told us, "Sometimes the GP seems to take a long time when we ask for things." We did not see evidence that the provider was following up requests made to the GP.

We found that the information available to staff for the administration of 'when required' medicines, such as pain relieving medicines, was either not available or was not detailed. Staff we spoke with could not tell us 'when required' medicines should be given. One nurse demonstrated to us that they were unaware of when to and how to use one person's prescribed emergency medicine. We identified this as a risk because staff did not the information they needed to refer to.

We saw that people did not have any 'pain assessment' in place so that staff knew what signs to look for to assess people's level of pain. This meant that staff did not always have the information they needed to ensure that the medicines were given in a timely and consistent way.

We looked at the medicine refrigerator temperature records and found that the temperature monitoring was not effective in ensuring medicines were being stored at the correct temperature. For example, we saw one medicine refrigerator displayed a low temperature of minus 14 which was not in accordance with the storage temperature guidance and may affect the effectiveness of the medicines. We found that the maximum and minimum temperatures of the refrigerator were not being monitored on a daily basis.

We found that the provider had not protected people against the risks associated with the unsafe use and management of medicines. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (f) and (g) of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service safe?

People told us that they felt safe living at the home. One person told us, "I feel quite safe living here." One relative told us, "[Person's Name] is kept safe. Staff are always coming and checking they are okay."

Staff told us they understood their responsibilities to keep people safe and protect them from harm and the risks of abuse. Records confirmed that most staff had completed safeguarding training. Staff told us that they were confident about recognising and reporting abuse. One staff member told us, "If I thought someone was being abused, I'd tell the manager straight away." We saw that a poster was displayed in the home to remind staff how to report any concerns that they had about abuse to people. Staff confirmed to us that they would whistle-blow to the Local Authority or Care Quality Commission if they thought their concerns were not being listened to. Since our last inspection, we have received a whistle-blowing concern that has been investigated. One senior area manager told us, "The appropriate staff disciplinary action has been taken following the investigation."

While staff were trained in protecting people from the risk of abuse and the provider had processes in place to protect people, an incidence of neglect had been upheld following an investigation by the Local Authority.

One staff member told us, "We can look at people's care records and read their risk assessments. I try to always read those for new people or if I've been on leave see if anything has changed for people." We observed that staff took action to reduce the risk of injury to people. For example, we observed one person spill their drink and a staff member immediately cleaned the spillage to prevent people from slipping. Of the five sets of care records looked at we saw that risks had been identified in all of them and actions identified to reduce the risk of harm or injury. It was not evident from people's care records whether they had been involved in managing their own risks and people we spoke with were unable to recall this detail.

We spoke with staff on duty that had been trained in first aid and asked them to tell us the first aid action they would take, for example, if a person was choking or had a fall. We asked about these scenarios as people's care records identified these as risks to their safety and wellbeing. Staff were able to tell us the safe first aid action in the event of a fall but some were unclear on the safe action to take in the event of a person choking. However, staff told us that they would call 999 for further assistance. One staff member told us, "Once the person was alright, we'd make sure we recorded what had happened."

People and their relatives expressed different thoughts to us when we asked them if they thought there was enough staff on duty to meet their needs and maintain their safety. One person told us, "I am generally satisfied with everything but just get a bit fed up having to wait for staff sometimes. I can't walk and need staff to help me but have to wait for someone to be free to help me." One relative told us, "I would like to see a few more carers, especially at mealtimes." Most staff felt that there were not always sufficient numbers of staff on shift to keep people safe and meet their needs in a timely way. One staff member told us, "We have been working with three care staff instead of four. We try to manage, but it does cause delays to people. It is also not as safe as most people need two carers to help them." On another unit we also observed that there was one nurse and three carers on shift. The deputy manager explained to us that there would usually be four carers but as there were two empty beds on the unit, carer numbers were lower. The deputy manager told us, "Other staff in the home help out when needed." We observed that staff on the unit, at times such as supporting people with drinks or with personal care, were not sufficient in number to meet their needs and we did not observe other staff assisting at times when needed.

We discussed staffing levels with the acting manager and two area senior managers. They told us that agency staff would be used when needed to ensure sufficient staff allocation to each unit. The acting manager said, "People are assessed for their dependency levels but this is something I am updating." On day two of our visit, staff on two units told us that they had a fourth carer on shift. One staff member told us, "It is much better today. We've had difficult times managing with three carers recently due to staff absences. It is safer for people and we can ensure people's needs are met." Another staff member told us, "We have an agency staff member on our unit today. This means we do not have to rush to do things with people."

Recently employed staff members told us that they were aware that pre-employment checks were completed on them by the provider. One staff member told us, "I know that I had to wait to start my job here as the checks were being completed." We looked at four new staff records and

Requires Improvement

Is the service safe?

saw that all pre-employment checks had or were being undertaken as required. However, we saw one record where the staff member had commenced their employment before their checks were completed. We spoke with the provider's human resources department about this and they explained to us that they would allow staff to commence their induction and training and work under supervision. We saw, and the staff member confirmed to us, that they were working unsupervised. We discussed this with the deputy and acting managers and they told us that they were unaware of this. The acting manager told us, "There seems to have been some missed communication. We will ensure we follow our company policy and staff that start before all checks are completed will work under supervision."

The provider had suitable disciplinary processes in place and these were followed when unsafe practices or inappropriate conduct was found. The acting manager told us, "Where we find evidence of staff not following training and policies, we will take the appropriate action."

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. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty to keep them safe. CQC is required by law to monitor the operation on the DoLS and to report on what we find.

We saw that a key code was needed to gain exit from the front door of the home. We also saw that to gain entry and exit from three of the four units a key code was needed. One staff member told us, "The three nursing units are all locked to make sure people are safe." Another staff member told us, "We can't let people out of the unit." During our visit, some people on the residential unit and some people on two of the three nursing units told us they wanted to leave. None of the people had access to any of the key coded doors and were unable, for example, to access fresh air in the garden. One staff member told us, "People are dependent upon staff taking them into the garden area. It would be nice to get people out more and when the weather is better, hopefully we can do."

Of all the care staff on duty spoken with, only one nurse was able to tell us about the requirements of the MCA and DoLS. They told us, "I have only recently started working here so I have not been involved in any assessments or referrals. But, as this is a locked unit I would expect people to have a DoLS in place but I have not seen any in the care plans I have read so far." We spoke with another nurse about a further locked unit in the home and they told us, "I had not thought of the key coded door as a possible deprivation of people's liberty." While training records showed us that most staff had completed MCA and DoLS training, most care staff could not tell us about the requirements. We found that care staff were unable to relate their training to protecting people's rights in their everyday work.

We saw that most people may have lacked mental capacity due to their advanced dementia. We saw people had a generic mental capacity assessment in their care record but this was not about any specific decision. We saw one person's generic mental capacity assessment recorded they did not have mental capacity but this lacked any further detail and was not about a specific decision. We discussed this with the acting manager. They told us, "The form should be more detailed and dated. It is the company policy for people to have a generic mental capacity assessment. But, to my knowledge no one has had a referral for a mental capacity assessment about a specific decision."

We found that no one had a DoLS in place. We discussed this with the acting manager. They agreed with us and said, "To my knowledge no one has a DoLS in place and no referrals had been submitted. This is an area where training is planned for. Some staff have completed training but not really understood it." One senior area manager told us, "This requirement has been overlooked. We will ensure that this is addressed urgently. We agree that DoLS referrals should have been made for people." This showed us that the requirements of the MCA and DoLS were not understood.

This meant that people could not be assured they would be provided with care only where they had provided valid consent or where this was in a person's best interests. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All of the staff told us they felt that the training provided was good and they felt they had the skills and knowledge to carry out their roles. One staff member told us, "The training is really good here." Another staff member told us, "A lot of training is offered but I am on shift so have not attended a lot." One relative told us, "I feel that staff do have the training to meet my family member's needs."

Staff told us that they felt they would benefit from diabetes training. The acting manager told us that this was planned for and four staff members were to become diabetes 'champions' and support other staff to meet people's diabetic care needs. However, at the time of our visit this had not yet been implemented and we found a few staff members did not have the knowledge they needed to effectively support people that lived with diabetes. We found that this had impacted upon people that lived at the home and there remained a risk to people with this condition.

Since our last inspection of the home, we were told there had been several new staff members. We spoke with three new staff members and they told us that they had been

Is the service effective?

interviewed and were offered an induction. One nurse staff member told us, "I have had a very good induction. I do not feel it is rushed. I am working alongside another nurse for another two or three weeks." However, we saw that, at times, another staff member on their induction was not always able to work alongside and shadow the more experienced staff member they were on shift with. One staff member told us, "It would be better for the new staff member to be working with me throughout the shift, but this has not always been possible when we are short staffed." Staff told us that this was because there were three carers on the shift instead of four. We saw that a further staff member on their induction was not being supervised as planned for.

We spoke with two chefs at the home. They told us, and showed us examples of information that was shared with them about peoples' food likes and dislikes. One staff member told us, "Most people's relatives complete the information for them when they move here." We saw that the kitchen was well-stocked with food. We were told that a rolling four weekly menu was offered to people but alternatives could be provided if needed, for example if a person did not like something.

One staff member told us, "We complete a 'tick list' of what choice people want." We saw most people were suffering from advanced dementia and asked staff how people's choice of drink and meal was determined. One staff member told us, "We base it on what we know people will like. But, if a person needs a soft or puree meal there is only the one choice offered." No one, in any of the four units, told us that they were given a choice at mealtimes. One person told us, "The food is okay, but you have no choice." We observed a lunchtime meal in three units and saw that choices were not always given to people.

Overall, people told us that they enjoyed the meals and we saw that they had enough to eat. One staff member told us, "We do put a small portion on people's plates as too much can put some people off their meal." Two people in Osborne unit said, 'It's nice.' We saw that they ate all of their meal but were not offered another portion. One staff member told us, "Sometimes a few people might ask for seconds but usually there is only enough food sent for one portion each." However, on Broadstone unit we observed one person was offered an extra portion.

We saw that some people did not always receive the support identified in their care records that they needed during their meal. In Osborne unit, we saw three people had their hot meals placed in front of them but were not offered support. We observed one person waited 20 minutes before being supported to eat. In Broadstone unit, we observed one person was not eating. We asked staff about this and saw they then gave support for a short time and then removed the plate of food. We saw other people ate slowly and were given the time they needed to eat their meal.

One person told us, "I'd love a cup of tea." We heard staff inform people that the tea trolley would be arriving shortly but did not offer them any other drink. We saw that jugs of squash were made up in each unit, but these were out of reach of people and they did not always have glasses of squash that were accessible to them. We saw that most people were not able to verbally ask staff for a drink. We spoke with staff about this on two of the home's units. One staff member told us, "Some people might knock it over." Another member of staff told us, "Usually we do give out glasses of squash to people." We found that overall people were offered frequent drinks during the day but this in line with set 'drink times' and may not have met everyone's hydration needs.

We saw that risks around malnutrition and dehydration had been identified and recording charts were in place for people identified as at risk. However, we saw that people were not always offered drinks as planned for. At 11.20am we saw one person's drink chart showed that they had not been offered a drink since 8.00am. We spoke with staff about this and they agreed that they had not yet offered the person a drink. They told us that they were on their way around to people with drinks but due to people's support levels needed it meant delays had occurred. Accessible drinks and frequent prompting of drinks would reduce the risks of dehydration.

One nurse told us, "We refer people to the GP if they are unwell. Sometimes it can be a bit frustrating as the GP can take time in getting back to us. So, there are times we need to chase up the GP." People's care records that we looked at showed they had access to and support from dieticians, speech and language therapists, dentists, opticians and chiropodists.

One person told us, "I have lost my dentures here. It is hard to eat without them but the dentist is making me some more." Another person told us, "I've got some new dentures, but they are too big and I don't feel I can ask the

Requires Improvement

Is the service effective?

carers for the dentist to come back." This showed us that access to healthcare services were in place, though the effectiveness of the services was not always discussed with people to see if they were happy with, for example, their new dentures.

One care record we looked at showed that staff had sought advice and guidance from a person's GP, when they had been concerned about the person's healthcare condition. However, the guidance given by the GP had not effectively been followed. We discussed this with the deputy manager and they told us, "Clearer monitoring should have taken place and been recorded. I will ask the manager to investigate further."

Good

Is the service caring?

Our findings

People told us that staff were kind to them. One person told us, “The staff are very good, I can’t speak highly enough of them, they are lovely.” Another person said, “I’m definitely happy here. I’m looked after.” Relatives told us that they felt staff were kind and acted compassionately toward their family member.

Our observations of staff interactions with people showed us that staff cared about the people they supported and showed them kindness and treated them as individuals. For example, we saw one staff member bend down so that they were at the same level as the person before they spoke to them. We observed they did not rush the person but gave them time to respond.

We saw that people were dressed in individual styles of clothing that reflected their age and gender. Overall, we saw that people looked clean and nicely presented with tidy and combed hair. However, we did see that a few people had long finger nails with dirt on them.

We saw that bedrooms were well presented and pleasant. One staff member told us, “People can bring their own things for their bedrooms if they wish to. It’s nice if they do, so that we can talk to them about their family or things they have done.” This gave people the opportunity to personalise their bedroom and for staff to talk with them about their particular interests.

People were unable to recall whether they had been involved in making decisions about their care and support at the home. Some relatives told us that they had been asked for information about their family member, such as their favourite meals. We saw that some people’s care records reflected people’s and / or their relative’s involvement.

Staff spoken with told us that they maintained people’s privacy by ensuring they knocked on bedroom doors and waited before entering. One staff member told us, “I do knock and tell the person that I am coming into their room.” Another staff member told us, “If I am helping a person with personal care, I always close the bedroom door and curtains.” Overall, we observed people’s privacy and dignity was maintained. We did observe one incident when a person was hoisted but staff did not place a blanket over the person’s legs to maintain their dignity. We saw that staff later pulled the person’s skirt back into position. A blanket cover would ensure dignity is maintained for people.

Relatives told us that they were involved in their family member’s care planning. One relative told us, “Staff have asked me about my family member’s likes and dislikes. So far, I’m impressed with the care and that they are listening to what I tell them.”

All of the relatives spoken with told us that they could keep in touch with staff at the home and ask about their family member when they needed to. One relative told us, “They don’t like relatives to visit at mealtimes much, but I can understand that. Otherwise we visit when we wish to.” We did not see any information about restrictions on visiting and staff told us relatives could visit whenever they wished to.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us that they were asked about their family member's care and support needs. We saw that this information contributed to people's plans of care. We saw that people's likes and dislikes were recorded. For example, food preferences and how they liked to spend their time. Overall, we observed care was delivered to people in a way that responded to their needs and did not cause them to become anxious. However, we saw some variation across the four units in staff talking to people and asking them or involving them as far as possible in what they would like.

One relative told us, "I think my family member has enough to take part in here." One activities staff member told us, "Activities are planned for and take place in the different units. I am aware that some activities need to be more dementia care focused and hope to develop those." One staff member told us, "We've had a baking session that people enjoyed and took some people to a garden centre last week." We observed staff had positioned chairs for one group of people so that they could enjoy a film together. One person told us, "It's good." Overall, we saw most people had opportunities to participate in meaningful activities to them but also saw some people were not offered any activity or given any safe object to handle that may mean they become less anxious. We saw one unit had two televisions on showing different programmes and no one appeared to be watching either. People appeared confused by the competing noise in the communal lounge.

Relatives told us that they knew how to make a compliant. Most of the relatives that we spoke with told us that they had no concerns or complaints about the home. One relative told us, "If anything concerned me, I'd speak to the manager. They seem approachable." One relative told us, "I don't feel very satisfied with the overall service provided and am looking elsewhere for my family member." Overall, we saw that the issues raised had been investigated and resolved. For example, we saw that concerns had been raised about the laundry service by several relatives due to items of clothing missing. The acting manager told us, "We have implemented a new system and this has improved things considerably." Staff told us that if anyone at the home appeared concerned by anything they would attempt to find out what it was and resolve it.

Requires Improvement

Is the service well-led?

Our findings

There was a new acting manager in post. They told us, "I started in December 2014. I intend to apply to become the registered manager and have just started the process." I know that there is a lot to be improved up on here but have made a start."

There was a management structure in the home that enabled the acting manager to delegate responsibilities to a deputy manager and staff on the four units. Staff told us that the manager was approachable. One staff member said, "We are still getting to know the new manager but so far so good." One relative told us, "The manager goes around and talks to people." The acting manager told us that they completed daily 'walk about' on the different units so that they had a visible presence and to promote an open and inclusive environment where people and staff were able to voice their opinions to them. The majority of staff felt that things at the home had improved since the acting manager and new nursing staff had commenced their employment.

Staff told us that they felt they worked well as a team. One staff member told us, "On this unit, the team has really improved recently." Staff told us that staff meetings were now planned for and took place. The deputy manager told us, "Support and supervision of staff had slipped. Most staff have now had a one to one supervision session and others are planned for. There is still some way to go but things are improving."

One relative told us, "I have been asked for feedback and I have completed a form." The deputy manager showed us completed feedback surveys that covered a range of services within the home, such as the environment and food. We saw that all surveys were in a written format that most people that lived there would find difficult to understand due to their dementia. We discussed this with the acting manager and they told us, "Most people's relatives complete the surveys on their behalf. But, it is something we can consider for the future to develop a more accessible feedback survey for people here in addition to the written surveys for relatives." An accessible feedback survey would enable some people that lived there to give their views about the service.

We saw that there were quality assurance systems in place to monitor the quality of the service provided to people. We looked at completed feedback surveys and saw that there was a statistical analysis of results but no action plan to make any improvement needed. We discussed this with the deputy manager. They told us, "We'd look at the person's next feedback form to see if they were now satisfied." This meant that there was not always a timely response in assessing whether people felt improvement in the service provided had been made.

We saw that actions had been identified as needed for staff to support people in the management of diabetes. We found some action had been implemented but saw some information was not detailed. We discussed this with the deputy manager. They told us, "We did identify that people's care records should detail their optimum blood glucose level. It should be there and it is not. The actions have not been fully implemented but I will make sure the information is added."

We looked at January / February 2015 unit medication audits. We saw that the audit dated January 2015 for Osbourne unit was incomplete and contained blank pages. Overall, we found that the audits had not identified the issues that we found with the management of people's medicines which showed us that the audits were not effective.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that suitable arrangements were not in place to ensure that people received their prescribed medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent We found that the provider not was meeting the requirements set out in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.