Haven Lodge Opco Limited

Haven Lodge 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?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

We inspected this home on 3 and 4 December 2015. This was an unannounced inspection. The home was registered to provide residential care and accommodation for up to 108 older people over four floors. At the time of our inspection 66 people were living at the home. The home was split into three units on three of the four floors, Cherry, the third floor, of the building providing accommodation for people with nursing needs, the second floor, Sycamore, providing care for people with nursing care who are living with dementia and Willow on the ground floor of the building accommodated people living with dementia.

A new manager was in place at the service. The new manager confirmed that they had begun the process to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Summary of findings

People we spoke with told us that they felt safe living at the home and relatives we spoke with confirmed this. We found that staff knew how to recognise when people might be at risk of harm and were aware of the registered provider's procedures for reporting any concerns.

At the time of our inspection we were told that there were adequate staffing levels to meet people's individual needs but people, relatives and staff told us this was not the case and the manager stated they needed to improve levels. It was identified that at times more staff were needed to ensure staff responded to people's needs in a timely manner. Call bells were not answered promptly at times and relatives told us that they thought more staff were needed to support their loved ones to ensure their needs were met.

People's rights were not fully protected because the correct procedures were not being followed where people lacked capacity to make decisions for themselves. The home was not consistently undertaking mental capacity assessments in accordance to the principles of the Mental Capacity Act (2005). Applications to deprive people of their liberty under the Mental Capacity Act (2005) had not been submitted to the Local Authority for people who lacked mental capacity. However, staff did seek people's consent before providing support or care.

People were supported by staff that had received training and had been supported to obtain qualifications. This ensured that the care provided was safe and followed best practice guidelines. References were requested to ensure new staff were suitable to work with people who needed support. However, in all the staff files we reviewed, DBS (Disclosure and Barring Service) evidence was missing. The manager provided this information following the inspection. Staff had not received regular supervisions or yearly appraisals

People were supported to receive their medicines in a timely manner and medicines were stored securely and at the correct temperature however there were inconsistencies in recording on one floor.

There was caring and compassionate practice and staff demonstrated a positive regard for the people they were supporting.

People's needs had been assessed but care plans were not always person centred and they had not been developed to inform staff how to support people in the way they preferred. Measures had been put into place to ensure risks were managed appropriately.

People's nutritional and dietary needs had been assessed and people were supported to eat and drink sufficient amounts to maintain good health. People were supported to have access to a wide range of health care professionals.

People were asked to join in a range of activities but they were not always person centred and suitable to meet people's individual choices. There was little evidence to support people had been able to maintain interests that they had before moving to the home. People who were confined to their rooms were at risk from social isolation.

There was a complaints process that people and relatives knew about. There were inconsistencies experienced by relatives as to the effectiveness of the complaints process. Systems were not in place to help the provider learn and develop the service from feedback and outcomes of complaints.

The service was in the process of a lot of changes due to the change in manager and the systems in place to monitor and improve the quality of the service were not yet embedded. The manager and provider had identified many improvements that were needed and had plans in place to improve the quality of the service.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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 always safe.

The views of people living at the home, their relatives and staff were mixed regarding the suitability of staffing levels.

Action required in relation to fire safety had not been completed and this potentially placed people at risk.

Risk assessments were completed to help protect people's health and well-being.

Suitable arrangements were in place to ensure the premises and equipment used by people was safe.

Medication was appropriately stored and administered.

Is the service effective?

Requires improvement 

The service was not always effective.

Suitable arrangements were not in place to ensure that staff were provided with on-going formal supervision and appraisal.

The home was not fully adhering to the principles of the Mental Capacity Act (2005) for people who lacked mental capacity to make their own decisions.

Deprivation of Liberty Safeguards (DoLS) had not been made for people who lacked capacity.

Staff sought the consent of people before providing routine care and support.

People told us they liked the food and got plenty to eat and drink.

People had access to external health care professionals. The staff arranged appointments readily when people needed them.

Is the service caring?

Good 

The service was caring.

People and their relatives were positive about the care and support provided at the service by staff.

Our observations demonstrated that staff was friendly, kind and caring towards the people they supported.

Staff demonstrated a good understanding and awareness of how to treat people with respect and dignity.

Is the service responsive?

Requires improvement 

Some aspects of the service were not responsive.

Summary of findings

Care planning did not include activities that would be meaningful to people based on their personal history and preferences.

Some people were in their rooms for large periods of the day or stayed in their room all the time and were at risk of isolation.

Complaints were not accurately logged and there were no time-scales to inform when complaints would be investigated and concluded.

Is the service well-led?

Requires improvement 

The service was not consistently well led.

Quality control processes were not rooted within the service and were unclear and failed to identify issues that needed to be addressed.

The manager had notified the CQC as required by legislation, of any accidents or incidents, which occurred at the home. However formal notification where a person has been deprived of their liberty had not been reported.

People were supported by staff who felt supported by the management team.

People using the service and their relatives were given the opportunity to have a say on how the service was run.

Haven Lodge 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 3 and 4 December 2015 and was unannounced. It was carried out by three adult social care inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the home before the inspection visit.

We reviewed the information we held about the service including safeguarding alerts and other notifications. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law.

We spoke with 15 people who used the service, four relatives, 12 members of staff, three visiting professionals, the manager and the regional manager. We reviewed 12 people's care plans and care records. We looked at the service's staff support records for nine members of staff. We also looked at the service's arrangements for the management of medicines, complaints and compliments information and quality monitoring and audit information.

We also received information from one health professional and two community professionals prior to the inspection.

Requires improvement

Is the service safe?

Our findings

The service was not always safe.

We asked people living at the home whether they felt safe. One person told us, "Safe? In here, yes, I feel safe." Another person told us, "It's very nice here, I feel safe and secure."

On the first days of our inspection, we found that there was not a safe procedure for recording visitors in and out of the building. We spoke with the manager about this. The manager told us that they thought it was "Down to visitors to remember to sign in". Health and Safety policy and fire regulations stated that visitors' needed to be signed in which meant the staff had not been following the agreed policy.

The building had an emergency call system to allow people living at the home to call for assistance from their bedrooms. We found that the bell rang for prolonged periods during the inspection without a timely response from staff. We were told by the manager that they did not do any monitoring of call bells or staff response times. This meant that people could be left for unmonitored periods while waiting for assistance. One person living at the home said, "At times, I think I've spent over 20 minutes waiting." On one occasion we heard the call bell ringing for in excess of five minutes which was then switched off by a member of staff without going into the room. Staff said that the system would continue to ring if another person called for assistance before the first call was reset. This meant that it would be difficult for the manger to monitor how long people had been waiting for assistance and people were put at risk of not being attended to in a timely manner. One relative said, "When [relative] presses the buzzer in their room, they [staff] take ages to come." We discussed this with the provider who said that they would consider a better system of monitoring.

The views of people living at the home and their relatives were mixed regarding the suitability of staffing levels. At the time of the inspection over the three floors, there were 15 care staff on duty, plus the manager, two nurses, three kitchen staff, three domestic staff, a head housekeeper, two laundry assistants and a maintenance person. A person living at the home told us, "I think there is enough staff, I don't need much help. A shortage doesn't affect me. I don't often see agency staff." A member of staff told us, "Staffing is sometimes short, especially when someone is sick" and "I have been here for four years, staffing levels are abysmal, so many staff are leaving". Another staff member stated, "Sometimes when people go off sick we are short staffed. I have been called in from home in order to change a catheter because no one else was qualified to do it, this is a nursing home, people need nursing care but we do not have the skills. But I do think the people who live here are safe".

One person said "I think they need more help" and another stated it "does concern me when there's only one lady at lunch" to assist. A relative also told us, "There is not enough staff. [relative] is on their own for too long." Another relative told us, "They're [staff] great in themselves; they're just rushed off their feet" and "I worry if the staff have the time to feed people. I have asked if they could have volunteers feed people at lunchtimes. The nursing situation is better now". We saw that staff took time to talk to people as they assisted them to eat but did not always engage with people when completing other care tasks. We observed staff being moved from one floor to another to cover staff illness, whilst the impact on people was limited, it did mean that staff were left to cover the workload. We were told that the allocation of care staff was determined by the completion of a dependency tool by the provider, from their office away from the service. The dependency tool should ensure that sufficient staff were deployed to meet the needs of the residents. The manager told us that improving staffing levels was a priority but they were finding it difficult to recruit suitable staff from the local area, therefore is using a high number of agency staff, who do not know the people within the service and therefore continuity of care.

This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People were protected from bullying, harassment and avoidable harm because staff were trained in relevant topics and told us they applied this training in the delivery of care. When asked, staff demonstrated that they had a good understanding of the needs of the people living at the home. Staff were trained in adult safeguarding and demonstrated an understanding of safeguarding procedures and knew what to do if they had any concerns that any form of abuse had occurred, for example reporting to the unit manager or manager or local authority.

We saw five care plans which included some evidence of regular review by the unit managers. The files contained up

Requires improvement

Is the service safe?

to date information and had been checked daily. Risk assessments were counter-signed by visiting professionals. This demonstrated that the provider was making good use of external resources to reduce risk.

Accidents and incidents were recorded as part of daily records. These records were reviewed by senior staff, but there was no process in place to identify patterns or learn from previous incidents. This meant that accidents and incidents were more likely to re-occur because causes and preventative measures were not formally considered.

We asked how people were supported when they became anxious. The manager told us the focus of the service was on early intervention and de-escalation techniques. Staff agreed that this was the case.

The provider had a fire alarm system in place and extinguishers at appropriate points throughout the building. The fire alarm was tested weekly. Although there was a general evacuation plan, people living at the home did not have any individualised emergency evacuation plans (PEEPS) for staff to use in the event of an emergency in place. This meant that they may be at additional risk in the event of a fire. We discussed this with the manager who told us that they would produce a plan for each person living at the home. When asked, staff said that they knew what their roles were in the event of an emergency but said they would like more practice.

Staff files contained a minimum of two references which had been secured before the person started work. We reviewed nine staff files relating to their pre-employment checks. There was no new completed DBS reference numbers available in any of the files we looked at. A completed DBS is important as it ensures the person is checked to their suitability to work with vulnerable adults. However, the provider confirmed to us in writing that they had rectified this issue by supplying us with the DBS reference numbers and people were being supported by suitably checked staff.

We checked the provider's approach to the storage and administration of medication. Medication was stored in the clinical room on each floor. The room was lockable and specifically allocated for the storage of medication. We looked at selection of the medication administration records (MAR) for people over the three floors of the service. They included a picture of each person and administration instructions. The MAR sheets that we saw were complete. This gave a clear audit trail and enabled the staff to know what medicines were on the premises.

Medicine that required refrigeration was stored correctly and daily fridge temperatures were recorded and signed for on two out of the three floors. We spoke with the manager and area manager who stated that this would be actioned straight away and further training be given to the staff responsible for recording. We were advised that some of the people currently living in the home were prescribed drugs that required additional storage. These drugs were stored safely in a separate lockable cabinet. There were separate storage facilities for homely remedies, topical medicines (creams) and medication which was to be returned to the pharmacy. Returns were clearly labelled, and were accurately recorded. Medicine audits were completed by the unit managers and followed a detailed audit template. Therefore any issues or errors could be identified and the manager could take action to reduce the likelihood of repeat errors.

We were told that one of the people currently living at the home required covert medicine. Giving medicine covertly means medicine is disguised in food or drink so the person is not aware that they are receiving it. The nurse was able to explain and demonstrate what procedures had been followed. This procedure was in-line with the Mental Capacity Act (MCA). Some people were prescribed medicines only when they needed it (often referred to as PRN medicine). Staff were able to describe for us how they identified when people needed the medicine, usually for pain relief or when they were distressed. People had a PRN administration plan which meant that PRN medication was administered is a safe and timely manner.

Requires improvement

Is the service effective?

Our findings

The service was not always effective

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Training records showed that the majority of staff had received training in the application of the MCA and DoLS but one member of staff, who had undergone training, could not remember anything about it. We observed staff putting the principles of the MCA into practice. For example, we saw one person living with dementia refusing to move from the dining table. A member of staff spent time talking to them and explaining their choices in way they could understand. They agreed to move to a more comfortable chair. Another member of staff said, "We help them to choose their own clothing and take time to explain what's being done. Some people can still make their own choices and we encourage that."

The service was not implementing DoLS. All the floors of the service were locked with key pads. People did not have the number to the key pads and it was not accessible to them. A number of people on this floor were subject to continuous supervision and were not free to leave. The service had not applied to the appropriate authorities for a DoLS authorisation as required.

Some mental capacity assessments had been carried out for a variety of activities. However, these were generic in wording and not specific to individual decisions by individual people. Neither did they address that a person's condition may mean that their capacity to make decisions could fluctuate and there may be times when a person is better able to make a decision

The manager confirmed that DoLS applications had not been submitted for any of the people living at the home. This meant the service was working outside the legal framework of the Mental Capacity Act, by not following the principles of the Mental Capacity Act (2005).

This was a breach of regulation 11(3) and regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In line with the provider's policy supervision sessions had not been undertaken and planned with staff and staff confirmed that they did not receive regular supervision from their managers. Supervision is a formal meeting where staff can discuss their performance, training needs and any concerns they may have with a more senior member of staff. We also noted that yearly staff appraisals for staff had been not undertaken or planned. Appraisals are meetings with the manager to reflect on a person's work and learning needs in order to improve their performance. Staff were not happy with this process and felt unable to discuss issues important to them in an open and constructive setting. Nursing staff stated that they received no clinical supervision and felt that this would be beneficial to them as a group. We spoke to the manager and regional manager about this and they showed us a spreadsheet of future supervision dates for staff that were starting with each unit manager. The manager stated that appraisals would happen this year.

People were supported by staff with the appropriate skills and training to meet their needs. We observed that on commencing employment all staff underwent an induction period. Staff records we reviewed showed this process was structured around allowing staff to familiarise themselves with the service's policies, protocols and working practices. Staff told us that they 'shadowed' more experienced staff until such time as they were confident and competent to work alone. Staff were able to access training in subjects relevant to the care needs of people they were supporting. The provider set yearly mandatory training which included first aid, infection control, food hygiene, moving and handling, fire safety awareness, safeguarding adults.

Requires improvement

Is the service effective?

People were supported to have sufficient amounts to eat and drink and maintain a balanced diet. People told us they enjoyed the food and were given a choice of meals and drinks. One person said, "Yes, the food is very good, two choices and the chef is pretty good with cakes and crumbles." Refreshments and snacks were observed being offered throughout the day. A person said, "They're not just doing that because you're here."

On Willow floor we found that staff were allocated to a dining area to cover over lunch and each staff was responsible for completing the food and fluid chart for the area of the home they had responsibility for. However, the list of resident's names was kept in main dining room. We checked the list and saw there were no dates on each one. We were shown by the unit manager the list for afternoon tea with ticks by it. However we checked this list at lunchtime, it was not the list for that day. We asked the unit manager to look at the list and explain how they could tell everyone had eaten at lunch and breakfast, they were unable to. They agreed there were no dates. This concern was raised with the manager and regional manager. On the second day of inspection, a clear list with dates already provided had been put in place and the manager was going to monitor this daily.

People's dietary needs had been assessed and where appropriate referrals to a dietician or GP had been made. Where people had been identified as at risk of not eating or drinking sufficient amounts to maintain good health action had been taken to address this. Weekly menus were planned and rotated every four weeks. People could choose where they liked to eat; some chose their bedrooms, others in the dining areas. We observed the lunchtime period. The tables in the dining areas were dressed with place settings, tablecloths and condiments. Staff supported people appropriately and people were able to enjoy their meal at their own pace. There were systems in place to communicate people's dietary needs and requirements to the catering staff. The cook spoken with said they were committed to providing people with good quality food in line with their preferences. They said, "If it's in the kitchen you can have it and I will do my best to make sure it's just what the person wants."

The floor supporting people with dementia, Willow, had been designed with contrasting colours and equipment to assist people with orientation. For example, the colour and choice of flooring materials contrasted with the colour of walls and furniture. Toilet and bathrooms doors used pictures and words of a size easily recognised. People were able to see a large clear orientation board which told people the day and date. These measures helped people who may be trying to make sense of the world around them and as a result add quality to their lives. The lounge in the dementia unit benefitted from patio doors which gave access to a well-furnished outdoor space. However, there was a strong smell of urine on entering Willow floor, we spoke with the head housekeeper and manager about this and they acknowledged this was the case and new carpet cleaners were on order as the ones they had were not working effectively. The manager did tell us that it would be easier not to have carpet but people living on Willow floor liked carpet and it was their home and their choice.

People were supported to maintain good health. Records showed that people were registered with a GP and received care and support from other professionals such as the district nurse and chiropodist. One person said, "They [staff] suggested seeing the GP without being asked." Another said, "I saw the chiropodist yesterday, they come every six weeks".

Good

Is the service caring?

Our findings

The service was caring.

People made positive comments about the quality of the care provided at the service. One person told us, “Staff on the whole are really good. They are kind and I treat them as friends.” Another person told us, “The staff are very nice, I cannot grumble about anything. They are all very good.” Another resident said they think carers are “Wonderful, they show great kindness” and “Never get irritated”. Relatives told us that the care and support provided to their member of family was good. One relative told us, “Think it is fantastic [Haven Lodge] and I cannot fault it for my relative. They [staff] really do look after our relative.” Another relative said “I find it absolutely brilliant here; she has been here nearly three years and stays nearly 90% of the time in her bed. She is well looked after here. The room is good; she can sit in a special chair and look out of the window. I think we were lucky to find this place”. One person stated to us that they had suggested to the unit manager on Willow floor that the tables be set up in the dining hall like a café and this was listened to. The person said this gave them more dignity. This demonstrated that the staff team listened and respond to people’s and relatives views.

We observed that staff interactions with people were positive and the atmosphere within the service was seen to be welcoming and calm. We saw that staff communicated well with people living at the service. For example, staff were seen to kneel down beside the person to talk to them or to sit next to them and staff provided clear explanations to people about the care and support to be provided. We saw a member of staff held a hand of resident who looked lost, smiled and lead them back to the tea room gently. They also held hands and touched faces when talking with residents.

Staff understood people’s care needs and the things that were important to them in their lives, for example, members of their family, key events, hobbies and personal interests. One relative told us, “The care here is very good and the staff know the needs of [person’s name] well.” On Willow floor the unit manager showed us a pilot’s uniform which was on display that belonged to a resident. They knew his history and showed us his room which had photos up of his past. The unit manager felt that they and staff would know people’s preferences and past life’s.

People were also encouraged to make day-to-day choices and their independence was promoted and encouraged where appropriate and according to their abilities. For example, several people at lunchtime were supported to maintain their independence to eat their meal. People had specialist aids available, such as, plate guards and dedicated cutlery. Staff asked people for their preferences throughout the day and ensured that these were met. One member of staff was noted to spend considerable time with one person so as to try and establish their drink preferences. The member of staff demonstrated time and a genuine interest in the person they were talking to by making eye contact and by placing their hand on the person’s arm to provide comfort and reassurance. The member of staff was observed to not rush the person and to give them plenty of time to respond to their questions. This offered the person ‘time to talk’ and to have a chat. The outcome was that the person received a drink of their choosing.

Our observations showed that staff respected people’s privacy and dignity. We saw that staff knocked on people’s doors before entering and staff were observed to use the term of address favoured by the individual. In addition, we saw that people were supported to maintain their personal appearance so as to ensure their self-esteem and sense of self-worth. People were supported to wear clothes they liked that suited their individual needs and staff were seen to respect this. One person confirmed to us that they had chosen what clothes they wished to wear that day.

People were supported to maintain relationships with others. People’s relatives and those acting on their behalf could visit at any time. One relative told us that they were able to visit their relative whenever they wanted and they were always made to feel welcome by staff.

Requires improvement

Is the service responsive?

Our findings

The service was not always responsive.

We saw that care files were not person centred and did not always reflect the preference of people; they used several of the same phrases and sentences, with many generalisations such as 'discuss with multidisciplinary team' and 'ensure privacy'. However, one file we looked at had a personal information sheet which recorded how many children people had, previous occupation and interests and basic medical information. We looked in detail at three care plans for people with complex needs. We observed completed food, fluid, nutrition and turn charts in all the care plans. Risk assessments and personal care records had been completed. In one care record there was no record of personal care activity since August 2015, this meant that it looked as though this person had not received any personal care for some months. This was confirmed by a relative who told us "Little things are careless; I'm really worried because they don't wash his hair and it's greasy." The relative explained that an occupational therapist came and showed staff how to position cushions as their relative was wheelchair bound but it was "a bit hit and miss" as to whether this happened. They suggested "A photograph of how the cushions should be positioned would be a good idea". They were also concerned that "He does not get any stimulation, they occasionally throw a balloon at him but he does not react." Annual and monthly reviews of care plans were very limited as they did not document that people or their relatives had been involved in them. One person said "I have no idea what you are talking about when you say care plan". A relative said "I have never been involved in a review of a care plan; the staff do tell me what's going on if I ask though".

Personal preferences such as what times people liked to go to bed, if they preferred a bath or shower, or male or female care staff were not recorded on care documents and people were not consulted about these decisions on an on going basis. We asked a member of staff if people could choose whether they wanted a shower or a bath, and they told us that "No we don't ask them, we just get them up and give them a shower". When we spoke to a person using the service about choice and control over their care they said they have showers and referring to speaking to staff about it said "I don't ask. I think it's what they want to do".

We saw that in two people's care plans it was recorded that they stay in bed and cannot partake in any group activities and are bathed and toileted in their beds. The records we looked at did not record what activities was provided for those people who remained in their rooms or those who were only brought to the lounge later in the day and were not included in any activities. We saw some people, who were unable to vocalise their wishes, spend the majority of the day alone in their rooms which may have put them at risk of isolation.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We observed one of the lounges and saw ten people that had used the lounge throughout the day. We saw activities taking place in the lounge in the morning and afternoon staff assisted the less able people and the atmosphere was lively and engaging. Some people told us they had access to suitable activities. For example, one person said, "There is always something going on in the lounge." The service had employed three activities co-ordinators, though one retired on the first day of our inspection, and people spoke highly of the activities and interactions. However, one person that we spoke with said they stayed away out of choice as they found the lounge "Too noisy and there's no one to have a conversation with". However we did observe a member of staff engage this resident and there was laughter between them.

We looked at the complaints that were logged for the last year. Not all complaints received by the service had been logged as the CQC had received complaints from relatives that were not logged by the previous manager. The manager and regional manager agreed that omissions had been made by the previous manager. Timescales had not been recorded for when complaints had been responded to. One person thought that the service listened to them and would respond promptly if they made a complaint. A relative informed us that the response to any issues raised depended upon the staff on duty at the time. This meant the service was inconsistent in responding to complaints and we could not be confident that complaints were recorded correctly and acted upon. A relative informed us that they thought the service, prior to the new manager arriving two months ago, did not easily welcome them to feedback upon their experiences about the care their relative had received. Their concern was that they did not take their views on board fully and change or develop their

Requires improvement

Is the service responsive?

practice to improve. None of the complaints records we saw showed what lessons had been learned and what changes had been made either before or after arrival of the current manager.

Daily handovers took place so that staff could update the next staff on shift about people's needs and if any changes in their care had been identified. Staff we spoke with told us the handover was a good source of information for keeping up to date with changes and information they required.

Requires improvement

Is the service well-led?

Our findings

The service was not always well-led.

People told us they felt the service was properly managed, they knew who the new manager was and they told us the staff team were open and approachable and that if there were issues they would be "Very comfortable in approaching the management team". They were confident their issues would be resolved. A relative told us, "I would talk with [the manager] he is very approachable and keeps us well informed, unlike the last one".

The management team consisted of the manager and the regional manager. The manager told us that a morning meeting was held Monday to Friday with the unit heads, head housekeeper and chef. We saw that they discussed. One relative told us, "They have meetings where we can go and air any concerns that we may have." Staff meetings had also been held, though records showed that these had not been held on a regular basis, but the manager told us that since he had been in post, he had held a staff meeting and planned to make these a priority. Staff said that they were able to share their thoughts or concerns with the manager on a daily basis on his visits to the different floors. Discussed that day's business or updates of on-going issues. They also visited each of the units, the laundry room and kitchen on a daily basis throughout the week, so that people, relatives and staff could have an opportunity to speak with him. The manager told us that he was looking to introduce these meetings at the weekends as well.

All staff we spoke with told us they felt supported by the management team and by each other. They told us they felt able to speak to the management team if they had any concerns or suggestions of any kind. One staff member told us, "[the manager] is really supportive and is always contactable if you need him for anything." One member of staff described the best thing about the home as being "Everyone supports one another; there is a lot of support here".

People using the service and their relatives were encouraged to share their thoughts of the service they received. Regular meetings had been arranged. Both relative meetings and meetings for the people using the service had been held. Minutes of the last meetings held showed us that issues, such as how to make a complaint and what activities should be done next, had been discussed. One relative told us, "They have meetings where we can go and air any concerns that we may have." Staff meetings had also been held, though records showed that these had not been held on a regular basis, but the manager told us that since he had been in post, he had held a staff meeting and planned to make these a priority. Staff said that they were able to share their thoughts or concerns with the manager on a daily basis on his visits to the different floors.

The manager told us the aim of the service was to provide people with a personalised and caring experience. Staff we spoke with were aware of the provider's aims and objectives. One care worker told us, "It is to provide personalised care, to keep them [people using the service] happy, to provide a home from home and to make them feel loved and cared for."

The registered provider had some audits in place to assess, monitor and improve the quality of the service. However, these audits had not identified the issues we found in relation to assessing people's capacity to consent and assessment and consent to bedrails. We saw no records for auditing care plans which meant there was no system in place for identifying that people's care needs were not all in one place and that they weren't person centred and did not guide staff on how to meet people's preferences when delivering care . Some records showed that care plan checks were being done by staff, but did not show that any learning or improvement was being taken from them or that there was an overview of this from the manager or regional manager.

Some management tasks, such as care record reviews, had not been thoroughly undertaken. Care records were not consistently reviewed with people or their relatives which meant there was a risk of unsafe and inappropriate care and treatment being delivered as people's support had not been reviewed. This also highlighted gaps in the governance of the service.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Leadership was visible within the home with the manager interacting with people using the service and staff throughout the day. The manager was supported by a nurse manager clinical lead who we also observed supporting staff. Our observations and discussions with staff showed they were clear about their roles and

Requires improvement

Is the service well-led?

responsibilities and what was expected of them during their shift "We know what is expected of us depending on what floor we are on." However, agency staff thought they could benefit from information regarding their responsibilities and roles. We spoke with the manager about this and they said that they would make this information accessible on all the units for both agency care and nursing staff.

We saw evidence of partnership working taking place. The provider had fully embraced the "Dementia Care Matters" ethos and was trying to work to their principles which included working together with the local community and health and social care professionals to improve the lives of people within the home. Visiting professionals that we spoke with said that they had found the service accommodating and their communication was good. The manager actively encouraged local Gp's to visit and planned to reinstate a bi weekly surgery within the home. They told us local GPs visited the home when required to attend to a person's need. We saw records and care notes that there had been visits from local GP, opticians, chiropodist and social workers.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Some people who were unable to vocalise their wishes put them at risk of isolation.

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People's rights were not protected due to lack of capacity assessments and best interest decisions as required by the Mental Capacity Act 2005

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Providers must act at all times in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards: Code of Practice and 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 18 HSCA (RA) Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the needs of people

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation and nursing or personal care in the further education sector

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Systems were not in place to assess, monitor and improve the quality and safety of the services provided.