HC-One Limited

Aldergrove Manor Nursing Home

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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

Our inspection took place on 3 and 6 February 2015 and was unannounced. We last inspected the service on 9 July 2014. At that inspection we did not identify any areas where the provider was not meeting the law.

Aldergrove Manor accommodates up to seventy people and caters for older people (Nightingale unit), older people with dementia (Haven unit) and people who have a physical disability (Phoenix unit) within three separate units. The service provides nursing care with nursing staff available 24 hours a day in Nightingale unit.

The service had a registered manager at the time of our inspection, although we were made aware that they had left the service. A registered manager is a person who has registered with the Care Quality Commission to manage

Summary of findings

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. Another manager had assumed responsibility for the day to day running of the service a week before our inspection, and has since our inspection become the registered manager.

We did find there were areas that impacted on the safety of the service. People did not always receive their medicines in a way that was safe or ensured the medicines would be effective in improving people's health.

Staff were not deployed in a way on Nightingale unit that ensured people's care was always consistent and safe. We found staff were deployed in a way that ensured people were safe on Phoenix and Haven units.

The manager and staff demonstrated awareness of what could constitute abuse and that matters of abuse should be reported in order to keep people safe. Staff were aware of how to report issues to the provider and to outside agencies so that any allegations of abuse would be responded to.

We saw occasions where people's rights and freedom were restricted. We found there were no safeguards in place to ensure that any deprivation of a person's liberty was agreed with the managing authorities, this so any deprivation was in a person's best interests and applied in a way that minimised any impact on their freedom.

There were occasions where the care and treatment of people's fragile skin did not always ensure they received effective care on Nightingale unit. People told us that their health and well-being was however supported by external healthcare professionals, when required, such as district nurses and doctors. We also found there were regular audits in place to identify specific risks to people's health, for example monitoring of people's weight loss and incidents such as falls that we saw informed how staff provide care.

People had a choice of food and drink and were complimentary about the food that was available to them. People that needed assistance with eating were appropriately supported by staff.

Staff told us they received appropriate and sufficient training but some were concerned they lacked a knowledge of people's individual needs so they were able to apply their knowledge and skills consistently.

People and relatives we spoke with were complimentary about the service and its staff, describing them as caring. There were some occasions however where we saw people's privacy and dignity were compromised.

People told us that they, or their families where this was their choice, were able to have involvement in how their care was provided. We saw that people had an individual plan, detailing the support they needed and how they wanted this to be provided.

The provider gathered people's views in a number of ways, for example through the use of surveys, meetings and face to face discussion. We saw that the provider had a complaints procedure that enabled people to raise concerns with these responded to appropriately.

We saw that some people had the opportunity to participate in meaningful recreation and occupation but there was scope to improve the stimulation available for more dependent people on Haven and Nightingale units.

Regular audits were carried out by the provider. We saw that some issues identified by these were been addressed, although there were other areas where these audits had not been effective in identifying and addressing shortfalls for example ensuring medication was managed safely. The provider and new manager had acknowledged and were aware of shortfalls in the service however and were looking to ensure there was improvement.

We found breaches in respect of the safe management of medicines, person centred care and consent to care. This meant that the law about how people should be cared for was not met. 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?
The service was not always safe.

People could usually expect to receive their medicines but the service did not consistently follow safe practice in respect of administration of medicines. The service did not always provide staff on Nightingale unit in a way that ensured the care and support people received was consistent. They were enough staff available on other units to support people's care delivery. People felt safe and staff were aware of how to identify and report any abuse or discrimination.

Requires improvement

Is the service effective?
The service was not always effective

There were occasions where people were restricted to keep them safe. On these occasions people's legal rights were compromised and safeguards to protect their rights were not in place. People had access external healthcare services as and when needed, but steps to promote the care and treatment of people's fragile skin were not consistently applied .People had a choice of, and were supported appropriately with their meals. Staff received training that ensured they had the skills and knowledge needed but some staff did not feel they knew people they cared for well enough to ensure the care they received was effective and reflected the provider's expectations.

Requires improvement

Is the service caring?
The service was not consistently caring

There were some occasions where people's privacy and dignity were compromised. However people told us that staff usually provided care in a way that was kind and respectful. Staff sought people's views and acknowledged these. There were many examples we saw of staff providing care in a way that put the person first.

Requires improvement

Is the service responsive?
The service was responsive.

We found that while people were involved in planning their care, there were occasions where the care people received was not consistent or as agreed. A number of people did however feel their care matched their expectations. Most people were happy with how they spent their time, but there was scope to improve stimulation for more dependent people. People or their representatives were provided with guidance on how to complain and these complaints were responded to appropriately.

Requires improvement

Is the service well-led?
The service had not been well led.

Requires improvement

Summary of findings

The provider had identified weaknesses in management. The provider had recognised areas where the service needed to improve. A new manager for the service, although aware of the need for improvement in some areas had not been able to implement these changes by the time of our inspection. The provider had taken steps to promote improvement by suspending admissions to the one unit and seeking to work collaboratively with commissioners.

Aldergrove Manor Nursing Home

Detailed findings

Background to this inspection

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

Our inspection was undertaken by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. We were also accompanied by a pharmacist inspector and a specialist professional advisor who was a nurse.

We had contact with the local authority and local commissioners as part of our inspection to discuss information that had been shared with them about the service. We also looked at information we received from the service after our last inspection in July 2014, for example statutory notifications. These are events that the provider is required to tell us about in respect of certain types of incidents that may occur like serious injuries to people who live at the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 12 people who lived at the service and three relatives/visitors of people that used the service. We spoke with a senior manager and the manager. We also spoke with eleven staff which included nurses, care staff, a cook and a domestic.

We looked at 11 people's care records to see if their records were accurate and up to date. We looked at records relating to the management of the home, including quality audits, complaints records, staff training and development records. We looked at the recruitment records for three staff.

Requires improvement

Is the service safe?

Our findings

People had not always received their medicines safely. We found that where people needed to have their medicines administered directly into their stomach through a tube the provider had not ensured the necessary safeguards were in place to make sure that these medicines were prepared and administered in a safe way. We found that where people needed to have their medicines administered by disguising them in food or drink the provider had not ensured that all of the necessary safeguards were in place to make sure that these medicines were being given safely. We also found a person, who required a medicine to be administered before meals to ensure it was effective, had not received this medicine in this way.

We observed staff give people their medicines and saw poor administration practices took place on the nursing unit. For example, we saw that medicine administration records (MARs) were being signed before the medicines were given to people and before staff could be certain people had taken their medicines. We looked in detail at seven people's MARs and found that people's medical conditions were not always treated appropriately by the use of their medicines. For example we found that staff initials were missing from the MARs record so we could not be certain people were given their medicines, with no other recording to show that people had received some of their medicines as prescribed. Nurses we asked were unable to tell us why these gaps in records were present.

A relative told us about a person who had medicinal skin patches applied to their body for pain relief. They told us these were applied but was unsure if the area they were applied to varied as would be expected. Despite good records of where the patches were applied we found the patches were not always being applied in accordance with the manufacturer's guidance. We looked at the disposal records for people's medicines that were no longer required. These records could not evidence that these unwanted medicines were being disposed of in a safe way.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 12(2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].

People told us they were satisfied with how and when they were given their medicines. One person said, "I get my medicines on time, I get my painkillers on time and I can take tablets so that's fine with me". Another person told us, "They [medicines] are on time. I can ask a member of staff for painkillers if I need them". We found medicines were being stored securely, and at the correct temperatures, so they were safe to use. Medicines requiring cool storage were stored at the correct temperature and would be effective.

There were not always enough staff available with the right mix of competence and experience to keep people safe on Nightingale unit. People told us they sometimes had to wait for assistance from staff. One person said, "When I buzz [with call button] if short-staffed it takes them [the staff] a bit longer than 15 minutes but 15 minutes is about the average". Another person said they had to wait at times and did not get a shower as often as they liked with comment that, "Definitely not enough staff". A relative said, "The availability of staff, on a weekend is rubbish" but response times to requests for assistance, "Have got better, sometimes five minutes but sometimes have waited 30 minutes to 45 minutes to an hour". People told us that there was a change in staff on a regular basis one person telling us, "Every day I see a different face". We received some concerns from people before our inspection about the availability and competence of staff and the impact this had on people's safety. Staff we spoke with at the inspection also expressed concerns about people's safety due to staffing issues on Nightingale unit. They also told us a number of experienced staff had left with some staff not as familiar with people's needs, this including some agency staff. One of the staff working on Nightingale said they did not know people's needs well enough and this was a concern to them, for example they were unclear as to how people should be transferred safely. Other staff said those staff normally based in other units did not know how assist people on Nightingale with some aspects of their personal care. One staff member told us, "We are always short-staffed", and another said, "Not enough staff, people with high dependency and dementia not getting care they deserve and we have no breaks and have to work over".

We spoke with the manager who told us how they were trying to limit the impact on people due to staff vacancies. They told us that they were looking at how they could recruit and retain nursing staff to enable them to cut down on the use of agency nurses. They did say that they tried to use the same agency nurses wherever possible; this confirmed by one of the agency nurses we spoke with.

Requires improvement

Is the service safe?

People who lived on Phoenix unit told us that there was enough staff to respond to their needs. One person told us, “They [the staff] are fairly quick – you got to understand that you might have to wait a bit if they are with someone else. If they are going to be a while they tell you”. A relative told us, “I personally don’t think there is enough staff” and was concerned staff on Haven unit were moved to Nightingale unit and replaced with agency staff. They felt this impacted on the consistency of care although staff told us this practice had reduced since the new manager had taken over.

People we spoke with felt safe. One person told us, “I have never felt unsafe” and another said, “Never feel unsafe, but I know what to do [if they did]”. Some people also told us that their possessions were safe one saying, “Yes, my possessions are safe. I can lock my door and go out; I have a key to a lockable cupboard”. Staff were able to explain how to report or escalate concerns appropriately and understood when to ‘whistle blow’ on poor practice as evidenced by a number having contacted us prior to our inspection. The manager showed a good understanding of what constituted abuse, and we had been informed of allegations of abuse in a timely manner. We were aware that the provider had taken steps to work with the local authority when they had concerns about people’s safety. This showed the provider and staff had an understanding of how to recognise and report potential abuse.

We looked at the recruitment checks for staff that were recently employed. We found that appropriate checks had been carried out prior to the employment of these staff. These included Disclosure and Barring Service checks (DBS). DBS checks enable employers to check the criminal records of employees and potential employees so they can ensure they are suitable to work at the service. Staff we spoke with confirmed they did not commence work until their DBS checks were completed. We found the service had carried out checks on agency staff they used and we found these in place. Agency staff we spoke with also confirmed these checks had been completed, with nurses employed confirming there was checks on their professional registration numbers.

We found that the provider carried out risk assessments to identify risks to people, for example from moving and handling, falls, choking, pressure sores and malnutrition. We found that where equipment was identified as needed to reduce the risk to people this was available, for example fall mats were in use when people were identified at risk of rolling out of bed. There were also risks assessments in place to highlight dangers presented by the environment, and we saw steps were taken to minimise these.

Requires improvement

Is the service effective?

Our findings

We observed various practices which restricted people's movements and may require consideration as Deprivation of Liberty Safeguards (DoLS). DoLS are safeguards agreed with the local authority that are used to protect people when their liberty may be restricted to promote their safety. People on Nightingale unit said they were asked about their choices but one person said, although most staff respected these there had been one occasion, "The other day when told I can't go back to my room". There was one person on Nightingale unit who was constantly supervised by staff, due to the risk of falls, this to keep them safe. We saw on Haven unit that three people's walking frames were located out of their reach. Staff said they were not accessible to these people as they may be at risk of falls if they moved about. Staff said if people tried to stand they would get them their walking frames. We saw after lunch some people congregated by the door out of the unit, which was locked. Staff told us that the people knew this was the way out of the unit, and one person said they needed to leave. We saw staff distracted people and encouraged them back to the lounge without any distress. This showed that people were potentially restricted which potentially infringed their rights. We checked to see if there were any agreed DoLS in place to ensure any restrictions to these people's liberty was minimised. Some staff we spoke with thought a DoLS was in place for two people, although the manager told us there was no current DoLS in place. They said that they were looking to review the need to make applications for DoLS where appropriate.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].

One person on Phoenix unit told us that, "I have my freedom". Other people on Phoenix unit said they could make decisions about their life and staff gave them choices. A person on Nightingale told us, "I can decide, when get up, go to bed for example". A visitor on Nightingale unit told us the staff listened to their relative.

The service monitored people's health and care needs, but steps to promote the health of people's fragile skin were not consistent. Commissioners told us before our inspection that some people had developed pressure ulcers (broken areas of skin), and some of these were judged to be avoidable. We saw a number of people were assessed as needing frequent repositioning to relieve pressure on their skin, but we saw some occasions where this did not happen. We looked at care records for two people with pressure ulcers and one person assessed as having fragile skin on Nightingale unit. One person developed a pressure ulcer four days before our inspection. There was no documentation of redness or non-blanching areas prior to this, which would usually be indicators of potential skin breakdown. This would be unusual if there was regular skin inspection carried out. Records made when people were repositioned did not always state the condition of the person's skin at that time. At the point the pressure ulcer developed we found that information about the pressure ulcer was well recorded, with a referral made to an external specialist nurse. We found some conflicting information in people's records, for example how often a person's skin should be checked. Different records stated this could be each time the person was moved although they identified different frequencies for repositioning which meant the care people should receive was unclear. Care plans stated the equipment needed to reduce the risk to people's skin and how this should be checked by staff. One person's care plan stated their air mattress should be checked daily, although records showed checks at times were not carried out for up to 12 days. Another checklist stated what the setting for the air mattress should be based on the weight of the person. We found the setting of the person's air mattress was incorrect and would have compromised effective protection for their skin. We saw one person assessed at risk of broken skin was not repositioned for periods in excess of two hours when their records said they needed two hourly repositioning.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 9(1) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].

People on Phoenix unit told us they were repositioned to ease pressure on their fragile skin on a regular basis. One person said "Yes, for my pressure sores, they know how to do that, because of the time I spend in the wheel chair ". Another person on this unit told us, "They [staff] check [their skin] regularly and they [staff] body map every week". Records on this unit and showed people's fragile skin was monitored, with specialist advice sought and appropriate equipment used. People told us they saw external healthcare professionals as and when needed. One said

Requires improvement

Is the service effective?

they "I've got the flu and I am going to the doctors, the nurse comes in too". Another person told us they, "Had new glasses and see doctor as required, chiropody every quarter". A relative told us that the home had made arrangements for a person to see external health care specialists. We spoke with staff and they understood when they needed to escalate any concerns about a person's health.

People were satisfied with the food that was available. One person said, "The food is very good, the chef comes around and has a chat with you and does it for you, proper menu as well". The person showed us a copy of the menu in their room. A second person said, "They feed you brilliant" and a third, "The food is very nice". One person told us they had, "Drinks as required" while another person said, "It depends who [staff] is on, some really good at helping replace drinks". A relative told us some agency staff brought a person's meals and drinks in and walked off when the person needed assistance on occasion, although this they said when raised with the manager there had been improvement in staff responses. We saw people were given a choice of meals at lunch time. On Nightingale unit when the person was unsure what meal they wanted the staff showed them different meals so they could make a better informed choice. People when able were encouraged to eat independently, this with the help of specialised equipment when needed. Staff encouraged people by offering food at a manageable pace and verbally supporting them.

Permanent staff received sufficient training in subjects that gave them the knowledge to provide people with safe and effective care, for example how to move people safely, health and safety and supporting people with dementia, but some felt they need more support with gaining knowledge of people's individual needs. We spoke with recently employed staff about their induction. A newer member of staff said they had shadowed staff but there was a lot to learn and said they had not had time to read care plans or spend time getting to know people. Another member of staff said they had training as needed but there were difficulties applying this when they felt they did not know people they cared for well enough, and did not feel supported to gain this knowledge. They said that they had spent three days shadowing other staff but did not feel this fully prepared them. Agency nurses told us they received basic mandatory training (for example training about health and safety) from their agency, but this did not include everything they dealt with on a daily basis, for example tissue viability or pressure ulcer prevention training. One agency nurse said if they felt they were working beyond their limits they would ask for the necessary training. The manager had increased the number of nurses on duty during the day in recognition that they may need support when they had responsibility for the day to day management of Nightingale unit. Another nurse also told us that the new manager, as a nurse was able to better support them as they had clinical knowledge of the nursing task. People we spoke with on Phoenix unit had no concerns about the agency staff and a staff member on this unit told us that agency staff, "They are never left alone, they are always paired up. They are never unsupervised or unguided. We introduce them to every resident".

Requires improvement

Is the service caring?

Our findings

People's privacy and dignity was not always maintained, for example we saw one occasion where a nurse was carrying out a procedure which compromised a person's privacy and dignity. This was carried out in the communal lounge and there was no consideration to taking the person somewhere private or using privacy screens. There was also one occasion on Haven unit where we saw a person being supported towards a toilet opposite the lounge area. When walking back towards the lounge a staff member realised the toilet door was open and attempted to close it as we walked past, although the privacy of the person using this toilet had been compromised for a short while. We saw that a number of people on Nightingale unit who chose to stay in their bedrooms had their bedroom doors left open. We spoke with some people who confirmed this was their choice, although one person told us, "Sometimes I do ask them [staff] to pull the door to and they leave it open". Some people were not able to tell us their views. We asked staff if people's preferences about having their bedroom door open was always sought and some said people's relatives would be asked if the person could not say. They told us they would close bedroom doors when personal care was given, which we saw did happen with notices to alert other staff that to respect the person's privacy. One member of staff did tell us that some people's bedroom doors were left open, "So staff can check on them" however. We saw that people's bedroom doors on other units were shut, except where people told us they wanted them open.

We spoke with one person on Haven unit who had specific wishes regarding the clothing they wore due to their culture. We saw that the person's headdress did not match their head covering which would be expected. We raised this with staff who then offered the person a choice of two other head coverings, although this indicated that there was a potential lack of awareness about the importance of how this person was supported to dress. We spoke with the manager about those areas where people's privacy and dignity was compromised and they told us that they would take action to address these matters through educating staff.

People on Phoenix unit told us that staff were caring and they were happy with how support was provided. A person on this unit said, "This unit is like a large family, it's a good thing everyone gets on". A second person said "Staff are lovely always polite". We observed people and staff laughing and joking together on Phoenix unit and saw people appeared to have a good rapport with staff. People were open about the things they like and didn't like, such as one of the activities offered on the day. Several people were referred to by staff by "Nicknames" instead of their first names, people telling us they preferred staff to use these.

People on Nightingale unit told us, "They [staff] go out of their way to please me; they are all nice to me". Another person told us the staff were caring apart from one or two incidents that they had spoken to the manager about and were been addressed. Another person told us they liked the staff and they were happy how they treated them. We saw staff interacted with people in a kind and caring way on Nightingale, for example when staff spoke with people they did so in a warm and friendly way, listening to what they were saying and offering them choices.

People we spoke with on Haven unit said staff were respectful. One person told us, "They [the staff] are all very nice, if you want help they will help you but they don't bear down on you. They [staff] have been very good, they have been kind ". A relative told us, "Staff do their best, they are very caring and genuinely seem to love the people". We heard staff call people by their preferred names and we saw staff spoke to people respectfully. We saw staff used terms of reference that showed respect for people of different cultures. We saw staff spoke with people in a calm manner throughout our inspection. We saw that the service supported people to maintain relationships, for example married couples were able to share a bedroom where they wished to, with the second bedroom available to them as a sitting room. There were some people on Haven unit whose first language was not English and we saw that staff were available who were multilingual and able to converse with people in their chosen language.

We saw people on Phoenix unit were supported to be independent. One person told us, "I made my bed this morning and I change my sheets and blankets" and another said, "I can do a lot of things for myself, I get help if I need it, I can always ask". We saw that people were encouraged by staff to be independent where able, for example some people took an active part in cleaning up after lunch and doing their own laundry. We saw some people in Haven unit were encouraged to be independent

Requires improvement

Is the service caring?

where able, although staff did not allow everyone to move around independently due to the risk of falls. We saw people on Nightingale unit were encouraged to be independent where they were able, for example people were encouraged to eat their own meals. Staff we spoke with were aware of the need to promote people's independence and were able to share appropriate examples of how they did so with us, for example they told us how one person's was risk assessed to identify how this would allow them to maintain their independence in making a cup of tea, but with minimal risk.

We spoke with relatives who told us that there was open visiting and we saw that they were able to take an active part in the care of people they visited so as to maintain relationships.

Requires improvement

Is the service responsive?

Our findings

People were involved in developing their care plans but this did not always result in their care being consistent on Nightingale unit. One person on Nightingale unit told us the care was as they expected and they said they had some involvement in their care plan. Another person on this unit did not know about their care plan but said they were happy with the care and staff always asked what they wanted. A relative we spoke with was satisfied with the care but said there were occasions where there was some scope for improvement, for example they told us of an occasion where they had spoken with a member of staff about the incorrect care provided and they had said they had not read the person's care plan. The relative did say that, "Things are getting better" and they thought the personal care staff provided was to a satisfactory standard. Another relative we spoke with (about Nightingale unit) did say they had some concerns about staff not following a person's care plan, and were concerned this may impact on their well-being as it did not reflect their agreed care plan. Some of the staff we spoke with on Nightingale unit, unlike the other units, were concerned that they did not have time to read people's care plans and that they were not aware of people's preferences and needs. One member of staff said, "No time to read care plans, without reading can't deliver care to current standards" which reflected comments from some other staff on this unit. This showed some staff on Nightingale unit may not always confident they knew people's preferences as to how they wanted the care and treatment provided.

People on Phoenix unit said their care was reviewed if needed. One person on Phoenix unit told us, "They know me and what I need" another person saying, "Quite happy here get everything I need". Another person said, "We're reviewed every so often. They ask about welfare, what you do, what you would like to do" and a third said "Yes, All the staff know my care plan – They ask what I like and don't like". Another person said they, "Have not had a review in a long time – I don't need one – they know me and we talk all the time". We saw pre-admission assessments had been completed before people came to live in Haven unit and these were updated as people's needs changed. Staff on this unit told us they were involved with updating people's records on a regular basis, and when their needs changed, which reflected what we saw recorded. We also found on Haven unit that people's preferences were recorded, for example when they wanted a shower, and when they wanted to get up or go to bed. We saw care records on Nightingale that showed people's needs were assessed and care plans were updated based on changes to people's needs. We saw that these records reflected how people wanted their care provided and their individual preferences.

We looked to see how people were involved in making decisions about the home. One person told us they were aware of meetings but had no interest in attending. Another person told us "We are always filling forms in. We go to the residents' meeting". Two relatives told us they attended meetings one saying, "They have had a residents and family meeting a couple of weeks ago".

We spoke with people about how they spent their time. People's ability to pursue their interests or take part in social activities was mixed. One person on Phoenix unit told us, "I do arts and crafts, and exercise. We have parties. We pay 20p for 2 games of bingo. My family comes and visits. The home takes us to West Park, Black Country Museum" and another said, "Me and the staff play darts". We saw that there were group activities available which some people said they liked, and people were occupied with their chosen day to day routines. In Haven unit we saw stimulation was mostly through television and radio, with some books and a few games which the unit manager told us the activities coordinator had left with them for staff to utilise over the weekends. One person told us they liked to go to the shops, but a staff member said, "We have taken them a walk to the shops but it's too cold at the moment". We saw that there was a group exercise session in the afternoon. One of the staff said, "The activity co-ordinator has not been up as frequently as they used to be. They used to come up daily but now it is maybe twice a week. There could be a lot more stimulation". Some people we spoke with on Nightingale were able to occupy themselves one telling us, "I've got (X) football and movies, I'm quite stimulated". Another person said they were happy with how they occupied their time but said, "Staff may talk to me for five to 10 minutes" but did not always get time. For more dependent people on Nightingale we did not see many people received individual stimulation. We spoke with the activities co-ordinator who worked across all the units, who said there was little time to visit several people who stayed in their rooms on Nightingale as there were occasions they were asked to monitor the lounges when other staff were busy. They also told us that many people on Nightingale

Requires improvement

Is the service responsive?

needed one to one support with stimulation at times, and this did impact on their time when they wanted to provide stimulation for a number of people. This showed that there was some scope to improve people's stimulation on Nightingale and Haven units.

People we spoke with told us that they were able to complain to staff. One person told us, they knew who the new manager was and knew how to complain but, "Nothing to complain about". Other people we spoke with knew who to raise complaints with. We spoke with relatives who were also aware of how to raise complaints one having done so. They told us that there had been some improvement as a result. Both told us they would approach the manager if they had concerns. We saw information as to how to make a complaint was available and accessible within the service. There were two recorded formal complaints received in the last 12 months and these had received a response following investigation. There had been a delay in response to the one complaint, although the more recent complaint was responded to in accordance with the provider's procedures. This showed people knew how to complain and were confident in raising their concerns.

Requires improvement

Is the service well-led?

Our findings

The registered manager had left the service shortly before our inspection and a new manager had taken over responsibility of the day to day running of the service a week prior to our visit. The new manager has been registered by us since our inspection.

People told us that the views were sought about home the home was run. One person told us, "We do the surveys with [staff]. We have had resident's meetings with the manager, either with the home manager or [Unit Manager]. We have had new things for the home. The lounge has been painted. I've got my own telly. So things have come from them". Another person said, "It's changed for the good to be honest" and, "They have changed this (the lounge) and now we have a pool table and new television". A third person said, "It is a better home now than it was before, the previous lot let the home go". People and relatives we spoke with were aware that there was a new manager and said that they had met, this indicating that they were visible around the home and making themselves known to people. One person said the new manager, "Seems quite nice" and they had met them four times. A relative told us, "With guidance, the unit managers are knowledgeable".

We saw the relatives had raised some concerns about staff in past meetings and another relative raised further concerns in January 2015 that included a lack of confidence in agency staff. We saw the provider had carried out a visit to the home in January 2015 which stated that they had been asked by staff about staffing levels and reinforced with the staff that they were not short staffed. We asked the manager how they calculated staffing and they said that there was a staffing grid that was used, although this did not consider for example the layout of the environment or how the number of people stopping in their rooms impacted on the deployment of staff. The turnover of staff, nurse vacancies and the use of agency staff to cover these was also impacting on the consistency of the service based on comments from people, relatives and staff, who had made the provider aware of these issues.

The staff we spoke with had differing views about the support they received. Some had a negative view of one to one support from a previous manager although some other staff said they had been well supported. Based on what staff told us, as confirmed by the manager, some staff had not received regular and consistent one to one support. They manager told us they were looking to plan regular one to one support for all staff. One member of staff told us, "The managers keep changing. We don't know if we are coming or going with the managers." A Nurse told us that they had not felt well supported by the previous manager as they did not have the knowledge to provide them with clinical support and, "Competencies for nurses had not been done". They were positive that the new manager was also a nurse with an understanding of clinical issues. Some staff were reticent about whether they were able to share their views, but expressed that they felt the approach of the new manager was an improvement. One staff member said that they, "Seem to be in the right frame of mind and wish to make sure residents get the best".

Staff we spoke with on Phoenix and Haven units were able to tells us how effective staff communication was supported through use of handovers. Staff on Nightingale unit said that communication needed to be improved, and they said that some important information was not always shared with them by some of the nurses. One told us there was, "No communication between staff", for example one person had an infection and they were not informed about this, which was important if they were to follow safe practices.

There were quality assurance systems in place to monitor care and plan on-going improvements in respect of the care people received. For example there was thorough provider audits that we saw had been completed, the last one in September 2014. These looked at a number of areas including, data reports on people's health that would flag up concerns based on for example weight loss, and falls which provided an easy to follow record of action taken to address risks to the people's health and well-being, and ensure these were followed up. Some other audits were not as effective however and this was acknowledged by the manager, for example medicines audits had not identified issues that we found and there were some repeated concerns relatives raised, for example there were still no drivers available for the home's minibus, this for daytrips.

The manager, although having been in post for less than two weeks at the time of our inspection did have a good understanding of where the service needed to improve. The provider had acknowledged that there were issues and had requested that commissioners became more involved in working with them to resolve issues that had arisen

Requires improvement

Is the service well-led?

following a number of safeguarding alerts that were raised. They had also agreed to a voluntary suspension on admissions to the nursing unit to support the service with resolving areas of concern. Feedback we received from commissioners since our inspection indicated that there had been a sustained improvement in the service and the provider was working collaboratively with the local authority and Clinical Commissioning Group.

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 Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 12(2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014]. The provider was not always ensuring that people's medicines were managed in a proper and safe way. There were occasions where safeguards were not in place to ensure people the received their medicine in a safe way, or in a way that ensured their medicine was effective. Systems did not ensure that the provider could ascertain if people had consistently received their medicines as prescribed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014]. Where people were unable to give informed consent that provider was not acting in accordance with the provisions of the Mental Capacity Act 2005. When care was provided in a way to promote people's safety and this potentially deprived people's freedom the provider had not made applications to the local authority for Deprivation of Liberty Safeguards. These would be needed to ensure any deprivation was proportionate to the risk and applied in the least restrictive way.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 9(1) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014]. People's care and treatment was not always provided in a way that ensured their needs in respect of their fragile skin were met.