Methodist Homes

St Raphaels

Inspection report

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Ratings

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

Overall summary

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 and to pilot a new inspection process being introduced by the Care Quality Commission (CQC) which looks at the overall quality of the service.

We found that a new manager had been appointed in May 2014 and had recently applied to become registered manager. The previous registered manager had left some time previously and had recently submitted their application to deregister as manager for this service. A registered manager is a person who has registered with CQC to manage the service and shares the legal responsibility for meeting the requirements of the law, as does the provider.

The last inspection took place on 27 and 29 November 2013, this was a follow up inspection related to previous breaches, to check that the service was meeting the regulations for medicines and care and welfare of people and found the service met these regulations.

Summary of findings

St Raphaels is registered to provide accommodation and nursing care for up to 58 people who have nursing or residential care needs. There are two units which accommodate 38 people in total with residential care needs and a unit for 20 people with nursing needs.

There were 48 people using the service on the day of the inspection. We found people's safety was being compromised in some areas. There were inadequate procedures in place in case of fire. We have referred this to the London Fire and Emergency Planning Authority to assess if the provider was meeting required fire safety standards. We found the provider was not always meeting the regulations in relation to people's consent to care and mental capacity assessments, the management of medicines and in their arrangements for emergencies. You can see the action we have asked the provider to take at the end of the full version of this report.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The service was reviewing whether any applications needed to be made in response to the recent Supreme Court judgement in relation to DoLS that had changed what was regarded as a deprivation of liberty. They told us they were in contact with the local authority about what action to take.

Risks to people were identified and reviewed when required and there were enough staff to meet people's needs. There were adequate maintenance systems in place, and equipment at the service was checked regularly by staff or external contractors.

People told us they were safe, happy and well looked after. We observed good relationships between staff and people at the service and with their relatives. We noted staff took their time to interact with people in a meaningful way and treat people with dignity and respect. There was a range of activities available which people could chose to join in with.

Staff had adequate training to carry out their work and support people according to their care plans. People's health was monitored and they or their relatives were involved in planning their care. People had enough to eat and drink and those who required support with their diet were identified and plans put in place to meet their needs. People were consulted about the service and they knew how to complain if they were unhappy.

The new manager had made some improvements and identified the need for further changes at the service. Most of the staff we spoke with were positive about the changes and felt the service had improved. There were systems in place to monitor the quality of the service and learning or actions identified; although these were not always consistently put into practice. While we could see that progress had been made there were still some improvements required.

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 safe in some areas we looked at. There were problems with the administration and dispensing of medicines and people's allergies to medicines were not recorded by staff. There were inadequate arrangements in place to respond to possible fire emergencies. People's capacity to make decisions had not always been assessed or recorded in accordance with the Mental Capacity Act 2005.

People told us they felt safe. Staff were aware of safeguarding adults procedures. Assessments were carried out of risks to people and there were plans in place to manage these risks. Risk assessments were regularly reviewed to ensure they were up to date.

There were appropriate staffing levels to meet people's needs. Equipment was routinely serviced through maintenance contracts, and staff made regular checks of equipment that was used on a daily basis.

Is the service effective?

Requires Improvement

The service was not always effective. Staff were suitably trained to meet people's individual needs. Their training was refreshed at regular intervals.

People were protected from the risk of poor nutrition and hydration because risks were identified and appropriate actions taken to reduce the risk. Relevant health professionals were consulted where necessary to ensure people had the right support with their dietary needs.

People accessed appropriate health, social and medical support when it was needed. Professional advice was recorded on people's records and included in their care plan.

Is the service caring?

Good

The service was caring. People spoke warmly of the staff and told us they were caring and supportive and knew them well.

People told us they were involved in making decisions about their care and support needs. They told us that staff were kind, caring and respected their privacy and dignity. We observed this to be mostly the case.

People's preferences for their end of life wishes were recorded where known and their families involved.

Summary of findings

Is the service responsive?

Good 

The service was responsive. Care plans were drawn up in consultation with people or their relatives when appropriate. They outlined people's care and support needs and were regularly updated. Staff were knowledgeable about people's support needs, their interests and preferences in order to provide a personalised service.

The provider had arrangements in place to gather feedback from people and their relatives, and this was acted upon.

Is the service well-led?

Requires Improvement 

The service had not been consistently well-led. There had been a number of changes of manager in the last two years and a period when there was no registered manager in post. The current manager had been in post since May 2014 and had made some improvements to the service, including more emphasis on person centred care and improvements in record keeping. Most staff were positive about the changes and felt they were well managed.

There were systems in place to monitor the quality of the service. These had identified some of the breaches in regulations we found, but consistent action to address these was not in place or not always being followed through.

St Raphaels

Detailed findings

Background to this inspection

The inspection team comprised of an inspector, a specialist nursing advisor, a pharmacy inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience for this inspection was a carer of someone using this type of service.

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 spoke with the local authority commissioner of services and the local safeguarding team to obtain their views.

During the visit we spoke with 21 people using the service, eight relatives, two nurses, two senior carers, five care staff, a volunteer co-ordinator, two domestic staff members, a cook, the manager and the deputy manager for the service. We also spoke with the GP who was visiting the service during the inspection.

Not everyone at the service was able to communicate their views to us so we used the Short Observational Framework for Inspection (SOFI) to observe people's experiences in the day. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We looked at areas of the building; we also looked at a sample of 14 records of people who used the service, five staff records and records related to the management of the service.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Requires Improvement

Is the service safe?

Our findings

We found some medicine administration records (MAR) were not completed fully or accurately. For example, eight out of 11 people on one unit, and nine out of 20 people on another unit did not have their allergies recorded on their medicines charts. This meant that people may be at risk of potential adverse reaction to some medicines if taken.

All medicines were stored securely and at the correct temperatures to remain fit for use. People's medicines were reviewed regularly by the GP. Although people's medicines had been ordered on time, we found that medicines had not been checked early enough for discrepancies to be noted and remedied. There were issues with the supply of medicines on the day of our inspection. We found that some as required (PRN) medicines had not been supplied by the pharmacy. People had not missed any of these medicines as staff had administered medicines left over from the previous month. However we found people had received their medicines late and therefore not always as prescribed, while staff sorted out medicines supplies and paperwork. Some prescribed creams were not in stock that day and therefore had not been applied. Arrangements were being made to resolve this. Staff had not always documented clearly on people's medicines records when medicines were stopped by the GP.

The quantities of some medicines in stock had not been recorded on people's medicines records which meant staff could not carry out a stock count to check for correct administration. Therefore any errors in the administration of medicines would not be readily identified. Accurate medical records were not always being maintained.

We discussed our findings with the home manager who told us that the service had recently changed over from an electronic to a new paper-based medicines ordering and recording system and it was taking staff some time to get used to the new system. We saw that the service carried out regular medicines audits and these issues had already been identified as requiring improvement. Due to the issues we found we were not assured that the provider had a robust and safe system in place for the management of medicines.

This was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We found there were inadequate procedures in place to deal with emergencies. Staff were trained in first aid and fire safety and when questioned knew how to respond to a medical emergency. We saw that staff had access to contact numbers they could use in the event of an emergency. There was a business contingency plan to provide guidance on emergency contacts and places to evacuate to in the event of an emergency, such as fire or flood.

Eight staff we spoke with gave several different answers about what they would do in the event of a fire and where they might assemble. Most staff members thought there had not been a fire drill for some time. Staff were therefore unaware of how to respond appropriately in the event of fire. This could place people they care for, relatives or staff themselves at risk in such an emergency. We looked 16 personal emergency evacuation plans. These instruct staff or emergency services how to support people's safe evacuation from the premises in an emergency. We saw 12 had not been reviewed since 2012. This meant that staff may not have up to date information on how to safely support and evacuate people from the building in these circumstances.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We spoke with the manager about our findings. They said they had first taken action to try and resolve problems associated with not having a central fire display panel in one place. We have referred St Raphaels to the London Fire Emergency Planning Authority to assess whether the provider's fire safety arrangements were meeting required standards.

People told us they felt safe. One person told us, "Yes the staff are wonderful, they are reassuring and gentle and always speak kindly to you. I do feel safe." Our observations confirmed that people seemed relaxed when speaking with staff and enjoyed their company. Staff knew how to recognise signs of potential abuse and the relevant reporting procedures. They were also aware of the home's whistleblowing policy and who they could contact to raise whistleblowing concerns. We saw from staff records that they attended regular refresher training on safeguarding adults so that their knowledge was up to date. There were up to date safeguarding procedures with relevant contact details for staff to refer to if they needed to raise an alert or seek advice.

Requires Improvement

Is the service safe?

Records held by CQC that we looked at prior to the inspection showed the current manager had made appropriate safeguarding referrals and followed local safeguarding protocols when necessary. They had followed clear staff disciplinary procedures when they had identified unsafe practice. This showed that there were systems in place to try to protect the safety and well-being of people using the service.

The care records we looked at showed that possible hazards to people were identified and guidance provided on how staff should support them to manage the risk of harm. Moving and handling risk assessments were in place and completed with instructions on how to support the person concerned. We saw these were reviewed regularly to reflect any changes in the individual's care needs.

For people with skin pressure risks we saw appropriate monthly risk assessments were completed. Two people had hospital acquired pressure ulcers. Body maps were completed to assess and monitor their skin integrity; staff informed us that body maps were completed each time they observed a change in people's skin conditions. We saw turning charts were used to ensure people with fragile skin did not lie too long on one part of their body to minimise the risk of pressure. We saw these charts were completed and up to date.

People at risk of falls had detailed falls risk assessments. If they had fallen, a new risk assessment was completed and action taken where necessary, such as a referral to an occupational therapist. There was also a period of increased monitoring of people's mobility and where required an extended risk assessment was in place to ensure that the risk of falls was minimised.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The registered manager confirmed that no one using the service was subject to DoLS under the Mental Capacity Act 2005. They were aware of the recent Supreme Court ruling and were in the process of contacting the local authority for further guidance to ensure that the service considered what was required and in the best interests of all the people using the service. The manager was familiar with how to make an application and knew when to request a standard or urgent authorisation from the local authority.

Staff understood what processes should be followed if someone did not appear to have capacity to make a specific decision. Training records confirmed that staff had received training on the Mental Capacity Act 2005. However in three care records we looked at where it stated people lacked capacity to make a decision about consent to their care, there were no recorded mental capacity assessments to evidence how that decision had been reached. This meant that people could be deprived of their rights to make decisions unnecessarily and their rights may not therefore be being recognised. We discussed this with the manager and saw they had already identified the immediate need for the completion of mental capacity assessments in their own action plan in July 2014, but these had not been completed.

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

The manager told us that staffing levels were determined by the number of people using the service and their needs; although there was no formal dependency tool in place to assist with this process. Most people we spoke with and their relatives said there were enough staff to meet their or their loved one's needs safely. At the inspection we observed there were sufficient numbers of staff available. The manager told us they had recently increased the number of staff on duty in the morning following a complaint from a relative about how long their family member had needed to wait before staff were available to assist them with personal care in the morning. They were in the process of monitoring if this increase had resolved the problem. Two relatives told us they thought the staffing levels had improved recently although one person said they thought there needed to be more staff available in the morning and evening.

People were protected by a safe recruitment system. We looked at five staff records and saw the home operated a robust recruitment procedure with the necessary identity, criminal and character checks completed. An up-to-date record to confirm that nurses continued their registration with the Nursing and Midwifery Council was kept by the administrator.

The service had a volunteer coordinator and approximately 30 volunteers who helped at the service, usually with activities. The coordinator told us that appropriate checks were carried out on volunteers which we saw were in line

Requires Improvement

Is the service safe?

with the provider's recruitment policy. This ensured that processes were in place to minimise the risk of anyone becoming a volunteer at the service who was unsuitable for work in social care.

The environment was adequately maintained. People were able to access all floors safely with the support of staff or by using the lift. Staff were aware of how to report a maintenance issue and said that normally these were addressed promptly. In an emergency we saw that staff had access to the provider's contracts team for work to be carried out.

Most people told us that repairs were usually promptly attended to, although one person told us they had reported that their bathroom tiles needed re-grouting and were still waiting. We saw from the maintenance book that this issue had been reported on 21 July 2014. The manager told us the maintenance person at the service had been on long term sick leave; arrangements had been made to cover this work with maintenance staff from another service run by the provider, but this was causing some delay.

Equipment at the service, such as hoists and wheelchairs, was regularly checked and serviced when required. While individual slings were in use for most hoists the manager informed us they were in the process of obtaining these for the standing hoist. Daily checks were made of pressure mattresses and bed rails to ensure that these functioned correctly and safely. Staff and people at the service confirmed there was an adequate supply of equipment. Fire-fighting equipment, alarms, electrical installation and electrical equipment had been regularly tested and maintained to ensure they were safe to use. We were told that action was in progress to try to rectify fluctuating temperatures in the water supply to one section of the service. Water temperatures were checked monthly and when personal care was provided and the manager said they would reconsider the frequency of these in view of the problems currently being experienced.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us they thought the staff knew what to do and offered care and support effectively. Arrangements were in place to provide staff with appropriate knowledge and skills to carry out their work effectively. Newly appointed staff were supported to learn about their roles. We spoke with one new member of staff and they told us they completed an induction programme, which included training that the provider considered mandatory and shadowing more experienced staff prior to working alone. They said, "I found the training useful but the shadowing really helped to make sense of everything."

Staff training records showed staff had attended training courses on topics relevant to their role. Records confirmed training was mostly up to date and in the occasional area where a member of staff had missed the training they were booked for a subsequent one. We saw staff had additional training to learn how to meet people's needs. The record for a senior carer include training on safe medicines practice, diabetes training, end of life (pain management), the prevention and management of urinary tract infection and managing challenging behaviour. Staff we spoke with confirmed they received regular refresher training across a range of areas. On the day of our inspection we observed staff to use appropriate moving and handling techniques.

We observed on the day that there were a number of agency staff working at the service. The manager told us they used the same agency and tried to have regular staff from the agency where possible. Agency staff on duty informed us that they had received an induction to the service. We spoke with one agency staff member who was knowledgeable about the person they were supporting and was familiar with their care plan.

Staff told us they received regular supervision. One person said, "Supervision is monthly on the nursing floor and two monthly on the residential floors. You can talk about any issues and about training." The five staff files we looked at showed evidence of recent supervision having taken place. Two of the five records had annual appraisals recently completed. The manager told us that since they had started at the service they were in the process of working through the annual appraisals for relevant staff.

People's views varied about the food they ate. Approximately half of the people told us that the food was good and there was plenty of it. The other half described it as '"average" or "OK". We saw that people were provided with a choice of food and their preferences catered for. For example, we were told by the chef that one person's preference was to have a lamb chop on a Monday and we observed this was provided.

People were supported to have enough to eat and drink. We observed a choice of hot and cold drinks being offered to people throughout our visit. People in their rooms had access to water jugs. There were also snacks available during the day.

The food was well presented and was available in different consistencies when needed. We observed people were supported to eat at their own pace and in a sensitive way, although we observed that interaction between staff and people in the dining room was limited to the task at times. People were also supported to be as independent as possible through the use of adapted cutlery.

We were told a new menu had recently been introduced to add variety. However, some people expressed difficulty in following the format for the new menu. We told the manager about this who said that they were trialling a new version of the menu and would be reviewing this.

Kitchen staff told us they could meet any cultural preferences when needed. One person told us "They know I'm from (another country) and they always try to please me." People told us they chose where to have their meals. Staff said they encouraged some people into the dining room for some sociability. We saw some people eating in another room with their relatives, whilst others chose to eat in their bedrooms.

A nutritional assessment tool was completed to monitor people's nutritional status and included people's preferences. We saw that these were regularly updated to reflect any changes in people's dietary needs. Catering staff had copies of these preferences as a well as a list of people's allergies and any dietary medical needs, including those people who required fortified food. So they were aware of people's dietary needs.

People were screened at frequent intervals for the risk of malnutrition and those at risk were referred to relevant health professionals such as speech and language therapists and dieticians. Of the 14 plans reviewed, one care plan had yet to be updated following recent advice from the dietician. We pointed this out to the nursing staff,

Is the service effective?

who updated it subsequently. Each person's record included an up to date support plan with details of how to support the individual with their nutritional needs. Food and fluid charts were regularly completed for those at high risk. People's weights were also checked on a regular basis. This ensured that people's nutritional needs were identified, monitored and planned for.

We saw that for those people whose nutritional intake required close monitoring, food and fluid charts were maintained and updated throughout the course of the day to ensure they were as accurate as possible. Where people needed to be fed through a tube into their stomach (percutaneous endoscopic gastrostomy) because they could not take food orally, accurate records were maintained and external health professionals made regular visits to monitor the nutrition regimes and to assess their nutritional intakes.

People were appropriately supported to access health and other services when they needed to such as GPs, physiotherapists, chiropodists, opticians and dentists.

People told us that they were able to see health professionals when needed and that the service supported them with this. People's records showed that the service had made timely referrals for health and social care support when they identified concerns in people's wellbeing. We found that on two occasions where referrals were made, these had not been chased up to ensure a prompt response. The deputy manager then followed these up on the day of the inspection.

Information from health professionals was acted upon. For example, we noted that a community psychiatric nurse had visited an individual in the home with behaviours that challenged others. We saw that a behaviour chart had been maintained by staff. This provided information surrounding the incidents that had triggered certain behaviour and actions to take to minimise it. We spoke with the GP for the service who was visiting during the inspection. They said that staff listened and acted upon their advice and they had no concerns about the care provided.

Good

Is the service caring?

Our findings

People and their relatives spoke positively of the staff and felt they knew their needs well. A relative said, "They treat my mum like family; they are so good to her." Another relative told us in their view "'this is the best home in the area." A person who used the service said, "I am content here, there is nothing I need that can't be got for me, the staff are gentle and kind and people here are friendly." One person told us the staff are "caring, friendly and polite at all times." Another said, "I cannot fault them, they bend over backwards for us." A third person remarked, "They go out of the way to help, if I need it." One relative commented, "I cannot fault the staff at all. They are very professional. They understand my relative." We observed throughout the day that staff interacted warmly with people and their relatives and that the atmosphere was relaxed and friendly.

People we saw throughout the day looked physically well cared for. They chose where they wished to be throughout the day. One person told us they preferred to sit in their room in the day but came to the lounge in the evenings. Staff told us visitors were welcome at any time during the day and this was confirmed by relatives who visited that day. One relative said "I came in at all different times at first, to reassure myself."

Staff knew the people they cared for well and understood their likes, dislikes and the best way to engage with them. Staff understood and respected people's individuality and it was clear when we spoke with them they knew people well.

People told us that staff were prompt to answer their call bells in the day or at night. One person said "Someone always comes when I ring. Nothing is too much trouble." A relative told us they thought staffing levels had improved. They commented "There are more staff now and less buzzers going off all the time."

We saw that people or their relatives were involved in development and review of their care plan and had signed to confirm their agreement with the plan. Care plans were kept in a separate wall cabinet in each person's bedroom. This meant they were accessible to them and their families when they wanted to look at them.

We saw staff sought consent before offering care to people. Staff we spoke with explained how they sought permission and explained what they did before carrying out personal care. For those people who were unable to communicate they showed an awareness of nonverbal signals they may give to indicate their views.

There were consent forms for specific decisions related to people's care such as obtaining a photograph or consent to share their records with health professionals. These were usually signed by the individual themselves or if appropriate a family member had signed to show their agreement with a best interest decision. Although we found that there was no signed consent for a pressure mat in one care plan for someone who had capacity to make decisions and who was at high risk of falls. We pointed this out to the manager who agreed to address this issue.

The manager had held a residents and relatives meeting to hear people's views of the service. We saw the minutes of the July meeting in which people's views about the timing of the main meal were sought among other issues. The provider also conducted an annual survey through an independent company to encourage open feedback from people using the service and their relatives. We saw from the survey that people's views were sought in a number of areas including the staff, food, access to healthcare and quality of life to identify any concerns and consider possible improvements to the service.

We observed that staff showed patience and understanding with the people who used the service. Staff spoke with people in a respectful and dignified manner and gave them time to make decisions without rushing them. Staff told us how they would protect someone's dignity while they gave them personal care by making sure doors were closed and that they usually knocked before they entered people's rooms. However we observed on one occasion a member of staff did not knock when they entered two people's rooms in the nursing wing. We discussed this with the manager who advised that they would address this with the staff member.

People were supported with end of life care. The service had links with a local hospice and their palliative care team. The chaplaincy team at the service were available at people's request where appropriate for support with pastoral care. Where people's end of life needs had been discussed with them or their family appropriate records were in place to ensure their wishes were met. For example, where appropriate, most Do Not Attempt Cardiopulmonary Resuscitation forms (DNAR) had been completed with the

Good

Is the service caring?

agreement of the person concerned and or family members, as well as the health professional. Two blank forms had been placed on care records to be completed which could lead to error in an emergency situation as it may be assumed it had been completed when people's wishes had yet to be ascertained. We spoke with the manager about this who agreed that only completed forms should be placed on people's records.

Good

Is the service responsive?

Our findings

People were given care and support that met their needs. For example, one person said "I get up when I like and go to bed when I like and have as many cups of tea as I like!" Another person commented, "I get all the help I need from staff, they are very supportive."

The care plans we looked at included a pre-assessment of people's needs before they moved into the home. A detailed support plan was in place which covered areas such as nutrition, personal care, communication, mobility and social, emotional and spiritual needs. The level of physical support people needed and what they were able to manage on their own was detailed in their care plan. One person who had recently arrived at the service told us, "They spent a lot of time on my likes and dislikes in that first week." Staff therefore had a detailed guide of how to provide personalised care to meet people's needs.

We saw care plans included 'My life story'. This captured important personal details about people and assisted staff to effectively support and care for them. The information recorded included: earliest memories, favourite clothes, proudest moment.

We found care plans had been updated when there were changes and reviewed regularly to ensure that there was an up to date record for staff of how to meet people's needs. Visits from any health professionals were recorded in the care records. We saw that relatives were kept informed about any changes to their family members.

We found that people's wishes in respect of their personal care were recorded in their care plan. People's preferred names were recorded and used by staff. People told us they chose whether to have a bath or shower and they could have this when they wanted to. Records we looked at showed "personal care given" without clear detail about what had been provided. Other staff would therefore be unaware if people's needs or preferences in respect of personal care were being met. For example, one person's care plan stated they should have a bath twice a week; however, we found only one record for a bath in the daily notes for a two week period. We pointed this out to the manager who said they had identified a training need with accurate record keeping and had booked staff on record keeping training the following month.

People's spiritual needs could be met either through the chaplaincy team or visits from other religious representatives that took place at the service. One person attended their church in the community. Staff supported another person to continue contact with their local Parish.

People's recreational needs were addressed. They told us that there were plenty of activities on offer and we saw that information about daily activities was made available to people. There was a designated activities organiser and they were supported by the volunteer coordinator and volunteers. People told us there were regular visiting musicians, entertainers, pampering sessions, exercise classes and that the service had held its summer fete the weekend before our inspection. Local school children also visited the home to talk with people in the service. One person originally from another country told us that someone visited to speak their native language with them. Adult volunteers also spent time with people who were unable to leave their rooms to provide some socialisation.

In the afternoon on both days of the inspection we saw people were being entertained by a singer /musician in the communal living room and we observed people enjoyed the sessions. Other people that had chosen not to participate were reading books in a quieter lounge.

Information about how to make a complaint or provide compliments and comments was displayed in the main communal area. We saw that it gave guidance on time frames for responses and who to go to if you were unhappy with the response.

Most people told us they had no cause to complain but knew what to do if they were unhappy. One person said "I would ask to see the manager straight away." A relative told us, "When I have any issues, I go to the manager and they are sorted out."

People's complaints about the service were listened to and acted upon. The complaints log showed that where complaints had been received they had been acted upon and the response logged. For example where complaints had been received about people waiting too long for personal care in the morning, the manager had responded by increasing staffing levels and the situation was being monitored. Another complaint related to the laundry, and the manager advised that there had been issues with the prompt return of clothes to people but this was being

Good

Is the service responsive?

worked on and we saw it had been addressed in a subsequent staff meeting. One person at the service told us they had made complaints, about the laundry system, and "it has been somewhat better since."

Requires Improvement

Is the service well-led?

Our findings

We were aware the service has had a number of different managers over the last two years and for a period in 2013 there had been no registered manager. The current manager told us that they had needed to introduce a considerable amount of change at the service so that it was more person centred rather than task focussed.

Staff we spoke with had mixed views about the management of the service. Most staff members we spoke with told us they thought the current manager had made considerable improvements at the service and they understood the changes they were trying to achieve. One staff member told us "He knows what he is doing. We had staff meetings every two weeks so we could talk about and improve everything, really everything we were doing." Another person told us they thought things had changed a lot "and for the better." One staff member said that they found the different managers they had in the last two years as unsettling, "Everyone has their different ways and it can be confusing."

The manager had been in post since May 2014. They showed us an action plan they had produced to address areas that they identified as requiring improvement. These included several aspects of the service including care records, people's comfort, and communication with relatives, catering and housekeeping. We saw that work was under way to complete the action plans. But some actions identified as requiring immediate completion had not all been completed such as mental capacity assessments.

The manager told us they had plans to ask for representatives from people who used the service and relatives to form a health and safety group and the chaplain was organising a dignity group that would include people who used the service and their relatives. This was to encourage people's involvement in the aspects of the home.

Staff meetings had initially been held fortnightly to ensure staff were aware of changes needed. We saw in minutes of staff meetings and clinical meetings that work had been focussed on training, staff appraisals, record keeping including accident and injury recording and promoting a more person centred care. For example, regular "bath nights" had been replaced by a record of people's preferences for when they had a bath or shower in their care plan. There were records of head of department meetings that had been held weekly when the manager first arrived. These had recently been replaced by 'daily meetings' to prioritise some actions needed.

Staff surveys were carried out annually and we viewed the summary results from one completed in May 2014 prior to the manager's arrival. We saw that at this point, 45% of staff felt they had an opportunity to contribute their views before changes about the service provision were made. Staff we spoke with felt they, and other staff members, could express their views at staff meetings, and that they would be listened to. They felt that there was support from the provider as there were regular visits from head office staff.

There were systems in place to monitor the quality of the service provided although the issues identified had not always been acted upon such as the need for a central fire panel. We were told that the manager or deputy manager made regular health and safety checks, although these were not recorded. However the need for a new kitchen floor and coffee tables had been identified and these had recently been replaced. The manager told us that an independent environmental audit had been completed in June and they were waiting for this report to identify any further action. The provider also carried out their own quarterly checks to monitor how the service was running.

Other audits were completed such as infection control, care plans and medicines. There was also a monthly audit arranged by the provider to monitor people who were at risk of developing pressure ulcers, falls and malnutrition. This was to ensure that any risks to people were identified and appropriate action put in place to mitigate risk. Accidents and injuries were recorded and were now being analysed since the manager had arrived. We saw that actions were identified as a result; including new risk assessments for people which we saw had been completed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People were not always protected from the risks associated with the unsafe management of medicines because the provider did not proper arrangements for the management of medicines.** Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People were at risk of inappropriate care and treatment as adequate arrangements were not always in place to deal with emergencies.** Regulation 9(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **The provider did not always have suitable arrangements in place to obtain or act in accordance with people's consent.** Regulation 18