Bupa Care Homes (CFHCare) Limited

Manor Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 24 November 2015 and was unannounced.

The last inspection of the service was on 19 May 2015 when we found breaches of Regulation relating to the management of the service, safe care and treatment, need for consent, person centred care and good governance. At this inspection we looked at whether these breaches had been met. Improvements had been made in all areas, although there were still some breaches of Regulation because there were not enough improvements in the way in which people's consent was obtained and how their social needs were met.

Manor Court Nursing Home is owned and managed by Bupa Care Homes (CFHCare) Limited (BUPA). The home is registered to provide accommodation, personal and nursing care to up to 120 people. The home is divided into four units, each unit catering for people with different needs. Larch unit is for older people who have dementia; Willow unit caters for older people, some who are receiving palliative care. Sycamore unit is for younger adults (people under 65 years) who have a physical disability. Beech unit was opened earlier in 2015 and is commissioned by the local Clinical Commissioning Group to provide care, support and rehabilitation to people who are recovering from an injury or illness and hoping to move back home. People living here are able to stay at the home for up to six weeks. At the time of our inspection 75 people were living at the home.

There was a manager in post. They had applied to be registered with the Care Quality Commission and were waiting for confirmation of their registration. 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.

Improvements had been made to the assessment of people's mental capacity and recording their consent. However, these were not enough. Some people's capacity had not been accurately assessed and information about this was not clear. Whilst some people had been asked to give recorded consent to their care and treatment, others had not and there was no, or limited information to show whether they consented to their care.

People did not always have the opportunity to take part in social activities which met their needs and reflected their preferences.

There were not always accurate, complete and contemporaneous records of the care planned and provided to each person.

Risks to people's safety and wellbeing had been assessed and were being managed. The concerns identified at the last inspection had been addressed.

People's medicines are managed so that they are received safely, with minimal risk of harm.

The provider had procedures to safeguarding people and the staff were aware of these and followed them.

There were enough staff to keep people safe and the recruitment procedures were designed to check staff suitability to work with vulnerable people.

Parts of the environment looked worn and were not thoroughly cleaned. However, the provider had a plan to address these, including the replacement of malodourous carpets. Other areas of the building were clean and well maintained.

The staff received the support and training they needed to care for people.

People's healthcare needs were assessed, recorded and monitored. They had access to a range of healthcare professionals

People's nutritional needs were met and their preferences and needs were recorded. However, people did not always feel the timings of meals met their needs.

People told us the staff were kind, caring and polite. We observed this, although some of the staff were focussed on the task they were performing and did not always explain what they were doing to people.

People's privacy and dignity were respected.

People's needs were assessed. Care and treatment were planned to meet these assessed needs.

There was an appropriate complaints procedure and people felt their complaints were investigated and acted upon.

There were not always accurate, complete and contemporaneous records of the care planned and provided to each person.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Risks to people's safety and wellbeing had been assessed and were being managed. The concerns identified at the last inspection had been addressed.

People's medicines are managed so that they are received safely, with minimal risk of harm.

The provider had procedures to safeguarding people and the staff were aware of these and followed them.

There were enough staff to keep people safe and the recruitment procedures were designed to check staff suitability to work with vulnerable people.

Parts of the environment looked worn and were not thoroughly cleaned. However, the provider had a plan to address these, including the replacement of malodourous carpets. Other areas of the building were clean and well maintained.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Improvements had been made to the assessment of people's mental capacity and recording their consent. However, these were not enough. Some people's capacity had not been accurately assessed and information about this was not clear. Whilst some people had been asked to give recorded consent to their care and treatment, others had not and there was no, or limited information to show whether they consented to their care.

The staff received the support and training they needed to care for people.

People's healthcare needs were assessed, recorded and monitored. They had access to a range of healthcare

professionals

People's nutritional needs were met and their preferences and needs were recorded. However, people did not always feel the timings of meals met their needs.

Is the service caring?

Good

The service was caring.

People told us the staff were kind, caring and polite. We observed this, although some of the staff were focussed on the task they were performing and did not always explain what they were doing to people.

People's privacy and dignity were respected.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

People did not always have the opportunity to take part in social activities which met their needs and reflected their preferences.

People's needs were assessed. Care and treatment were planned to meet these assessed needs.

There was an appropriate complaints procedure and people felt their complaints were investigated and acted upon.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

The provider had made improvements since the last inspection, however further improvements were needed in some areas.

There were not always accurate, complete and contemporaneous records of the care planned and provided to each person.

The provider had an action plan for continuous improvements and there was evidence that changes had taken place at the service. The provider worked with external agencies to monitor the quality of the service.

A new manager had been appointed and people felt that they

were approachable. People felt they had opportunities to give their views on the running of the service.

Manor Court 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.This inspection took place on 24 November 2015 and was unannounced.

The inspection team consisted of three inspectors, a pharmacy inspector, a nurse specialist advisor 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 on this inspection had personal experience of caring for someone who used health and social care services.

Before the inspection we looked at all the information we had about the location including notifications of significant events and safeguarding alerts.

During the inspection we spoke with 19 people who used the service, nine of their visitors and staff on duty, who included the manager, deputy manager, nurses, health care assistants, the activity coordinators, catering and domestic staff. We also met three health care professionals who were visiting the service on the day of the inspection. The provider's regional manager met with us at the end of the day for us to feedback our findings.

We looked at the records relating to the care and treatment of people living at the home, including 11 care plans and the records of care provided including monitoring charts. We looked at how medicines were stored, administered and recorded, staff recruitment records for five members of staff, and the record of training and support given to all staff. We also looked at the provider's own records of accidents and incidents, safeguarding alerts and quality monitoring.

Good

Is the service safe?

Our findings

People told us they felt safe at the home and well cared for. One member of staff told us, ''the top priority is the safety of our residents.''

At the inspection of 19 May 2015 we found that some of the practices at the service put people at risk. In particular we observed people being supported to eat and drink in a way which meant they were at risk of choking.

At this inspection we found improvements had been made to the way people were supported to eat and drink. The staff had improved records about people's individual needs with regards to food and drink texture and consistency. The staff, including kitchen staff, had received guidance and training to help them understand about the importance of this. People who had specific needs with regards to the consistency of food had been referred to speech and language therapists, who had created individual guidelines. These guidelines were incorporated into care plans and the staff we spoke with were aware of people's needs. We observed that people were provided with food and drink which met their individual requirements. The staff supported people at a pace which suited their needs.

At the inspection of 19 May 2015 we found that people were at risk because their medicines were not always managed in a safe way. At this inspection we found improvements had been made to the way in which people's medicines were managed. We saw protocols for the use of PRN (as required) medicines were in place. The staff had also recorded pain assessments to help identify how each person indicated they were in pain. Concerns we had identified about the storage temperature for insulin had been resolved. Medicine administration records were accurate and up to date

The service followed current professional guidance about the management and review of medicines. Each unit had a copy of 'NICE Guidance: Managing medicines in care homes' within their medicines policy which demonstrated an awareness of relevant guidelines. However, the medicines' policy stored in Willow Unit was not the provider's most current one.

People's medicines were reviewed on a regular basis by three different sources. We saw evidence that the local Clinical Commissioning Group, community pharmacy supplier and GP surgery reviewed people's medicines at least every three months between them, which demonstrated an effective mechanism for managing the risks of medicines.

People received their medicines as prescribed. We saw 15 medicines administration records (MARs) with no gaps or discrepancies. Stocks were accurately accounted for on the MARs, although there was an inconsistency in approach to recording of running balances. This had been completed for some people in Willow unit, but not Sycamore. In addition, this had been completed for some medicines but not all the medicines for the same person. However, the physical stock levels matched those signed for on the MAR. We spoke to three people in Sycamore unit about their medicines and they told us they were happy with their

medicines arrangements, received them on time and felt supported with their individual preferences and needs.

Medicines were stored, given to people and disposed of safely. They were appropriately stored in locked cabinets. Controlled Drugs and items requiring refrigeration were also stored appropriately. We observed a medicines round at the Sycamore unit, in which a nurse ensured people were administered medicines safely. This included appropriate hygiene procedures prior to administration and appropriate recording of medicines usage on the MAR. Medicines were disposed of safely in the pharmaceutical waste bin or sharps container, with records of collection by the contractor seen.

Guidance was given to staff about homely medicines. There was a homely medicines policy in each of the units. In addition, the nurse in Willow unit showed us a separate cabinet for homely medicines with stock level records. They demonstrated accurate knowledge with regards to the needs and preferences of individual people.

The staff had assessed and managed risks to people's safety and wellbeing. For example, the use of bedrails to prevent people falling from bed had been assessed. These assessments reflected individual needs. The use of this equipment was regularly monitored by senior staff. All staff had been given training on the safe use of bedrails and other equipment. They undertook hourly checks of people in bed and to ensure they remained safe.

The risk for people moving around the house, and transferring from chairs to bed had been assessed. These assessments were reviewed monthly, or more often if needed. The assessments included guidance for staff on how to support people safely and to encourage independence. The provider employed two physiotherapists who ensured risk assessments and care plans about moving safely and the use of equipment were up to date and accurate. They monitored people's different mobility needs and made sure they had the equipment and support they needed to stay safe.

The staff recorded all accidents and incidents. The manager reviewed the information about these after each incident and made sure the staff had responded appropriately, and people had been made safe. They also ensured risk assessments and care plans were updated where needed. The manager analysed information about accidents and incidents to identify any trends so that preventative action could be taken to minimise the risk of reoccurrence.

The provider had a procedure regarding safeguarding and whistle blowing. Information about this was displayed around the home. The staff were aware of the procedure and told us they had received regular training in safeguarding adults. They were able to describe what they would do if they suspected someone was at risk of abuse. The provider had worked with the local safeguarding authority to investigate allegations of abuse since the last inspection. They had notified the appropriate agencies, including the Care Quality Commission, when safeguarding alerts were made. They had also identified potential abuse for some people who had received care at another service before they moved to Manor Court, and during hospital stays. They had acted appropriately and made sure the concerns were reported to the safeguarding authority and investigated. There were records of safeguarding alerts and the provider's response to this. The senior staff had a good knowledge of specific concerns at the time of the inspection and were able to describe the action they had taken and the wellbeing of the people involved.

Some people told us they did not think there were enough staff employed to meet people's needs. However others told us they thought the staffing levels had improved and there were more permanent staff recruited. The manager confirmed that they were recruiting staff but there were some vacancies for nurses and these

were sometimes covered by temporary staff. The permanent staff told us this sometimes affected the consistency of care. The staff told us that when care assistants were on leave or had short notice absence they were not always replaced and this had an impact on the care. They told us they sometimes had to work in different areas of the home to cover staff absences. The manager told us that the staff were normally based in one unit in the home, but sometimes did cover vacancies in other units. She told us that this was not detrimental to the units they had left because they were taken from a unit with less people living in, however she acknowledged that this sometimes had an impact on consistency of care.

During our inspection we observed that people were kept safe with the staffing levels provided. Call bells were answered promptly and the staff regularly checked on people in their rooms and communal areas. The records of care provided indicated that regular checks on wellbeing were made. People told us they were able to have the care they needed, including regular baths and showers. They told us call bells were answered promptly and they did not have to wait for care and support. However, in some areas of the home people spent long periods of time without participating in specific activities or engaging in conversation with staff.

There were appropriate procedures for the recruitment and selection of staff. These included making checks on their suitability to work with vulnerable people, such as criminal record checks and references from previous employers. The staff had a formal interview and this was recorded. The registration details for qualified nurses and the eligibility for staff to work in the UK were checked. The staff records we viewed contained evidence of these checks.

Some parts of the environment had a malodour of urine throughout the morning. The staff told us this was due to carpets which were due to be replaced. On arrival at the home we found three bathrooms and toilets which were dirty, including urine on the floor. Two hours later one of these bathrooms had not been cleaned. This room was being used by people who lived at the home and they could have been at risk from poor infection control management. The staff cleaned this area when we alerted them to this. Other areas of the building were kept clean. There was a schedule for cleaning, including deep cleaning. There was also information about good infection control practices displayed around the home.

Parts of the environment looked worn and damaged. These included a damaged carpet, which was secured to prevent people tripping during our visit. Some of the walls and furniture were marked or damaged. The manager told us there was a refurbishment plan which included addressing these areas. She showed us evidence of the plan which included addressing risks to people's safety, such as levelling uneven pathways, as a priority. Other areas of the building had already been refurbished and looked clean, bright and well maintained.

Requires Improvement

Is the service effective?

Our findings

At our inspection on 19 May 2015 we found that some people had their liberties restricted in an unlawful way. For example, through the administration of sedative and covert (without the person's knowledge) medicines.

At this inspection there were no medicines being administered covertly. The care plans we viewed had a section where there were questions to assess the mental capacity of people to suitably administer (or give consent for the administration of) their medicines. There was also evidence of this in the medication administration folder. The manager described the procedures the home would take if they were to provide covert administration of medicines in the future. The manager and deputy manager demonstrated suitable knowledge of these procedures in line with the Mental Capacity Act 2005.

The law requires the Care Quality Commission (CQC) to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. The manager was aware of their responsibilities under this legislation. Applications to restrict people's liberties had been made to the appropriate authorities and the manager told us they were waiting for the authorisation for these. For example, some people were restricted from leaving the home without support because they were considered at risk. There were applications in respect of this.

At the inspection of 19 May 2015 we found that people's capacity to make decisions about their care and treatment had not always been assessed. Their consent to care had not always been obtained.

At this inspection we found that improvements had been made. The provider had started to assess people's capacity. In some care plans we found detailed assessments which indicated people's individual capacity with regards to different aspects of their care. For example, making decisions about day to day care and making more complex decisions.

However, the assessments in some people's care plans were incomplete. In others the assessments were not clear and included contradictory information. When we spoke with the staff about their understanding of capacity and consent, their knowledge varied. Some staff were able to explain about this, however others did not understand that people had the right to make choices if they were assessed to have capacity to do this. They did not understand the legal requirements of the Mental Capacity Act 2005 or their responsibilities under this. Some staff did not understand the principles of DoLS and did not understand that DoLS authorisations were related to specific decisions not about all aspects of an individual person's care.

We also found that recorded consent to care and treatment varied. In some cases the staff had obtained people's signatures and recorded consent to aspects of their care. For example, being administered a flu vaccination, having their photograph taken and consent to their care plan. In these cases we saw people had acknowledged they had read and understood the information. However, we also saw that some people

had not been offered the opportunity to consent to their care and treatment. In some cases there was no capacity assessment so we could not see whether the person had the capacity to consent. In other examples, the staff had recorded people had capacity, but there was no record of their consent.

Whilst improvements in this area had been made the provider was still failing to meet their regulatory responsibility to obtain people's consent to their care and treatment.

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

Records of staff meetings and the manager's own audits of the service acknowledged that this was an area needing improvement. The manager told us that they had planned further training and guidance for all staff and an audit of care plans to make sure this information was appropriately recorded.

In some care plans we saw evidence that the provider had consulted with people's representatives to make decisions in their best interest. This was recorded and there was evidence of agreement from the representatives.

We saw four care plans which included a document authorised by the person's GP, their representative and staff that they should not be resuscitated if their heart stopped. The documents we viewed had been completed accurately and gave information about why this decision had been made.

The staff told us they felt supported and had the training and supervision they needed. They explained that they had been given an induction into the home when they started work there. This had included a range of training. They said that they had regular opportunities for training updates from the provider. Some of the training was provided by the manager and senior staff team at the home. The staff told us they enjoyed this and found it relevant to their work. The provider was supporting nursing staff to update their clinical training so they would evidence this when they renewed their registration. The manager had an electronic record of all staff training which included alerts when training updates were required.

The staff told us they had regular meetings with their manager as a group and individually. Some of the things the staff told us were, ''A good thing is we always work as a team. If there are issues we raise it with the manager'' and "we are really supported in the unit with the unit managers".
We saw evidence of this. The staff told us they were able to discuss their work, procedures and training and share information and concerns. There was a handover of information each time the staff changed and they told us they were given information about changes in the needs of the people who they were caring for. There were communication records in each unit for the staff to record and share changes and information about people and the unit.

People told us the staff supported them to stay healthy and they could see their doctor whenever they needed. One visitor told us the staff were very prompt at calling for additional support when someone became unwell. There were records to show the staff monitored people's health and wellbeing and that they called for the doctor or emergency services when people's needs changed.

The home employed nursing staff throughout the day and night to identify and meet general nursing needs. There was evidence they consulted with other specialists to support people with specific needs. For example, they had worked with an external tissue viability nurse to make sure people received the right support with wound care. We met three visiting healthcare professionals who told us they worked closely

with the staff at the home to meet people's healthcare needs. There was evidence of regular consultations with a variety of professionals. The staff had systems to record when people needed to see a certain professional. We saw they had made timely referrals and followed these up when people needed healthcare support.

The Clinical Commissioning Group representatives visited the home regularly and reviewed care plans, including identifying how the staff had responded to changes in people's health needs and worked with other professionals.

People were supported to have a varied and nutritious diet. Most people told us they were happy with the food they were given. Comments included, "It's tasty and it's hot", "the food is alright", "for a hospital it's very nice food", "the food is very good – not just good but very good" and ''the food is good.'' Some people told us the food was sometimes cold.

Some people were concerned about the timing of meals. For example, they received their breakfast mid-morning, then their lunch an hour later and their evening meal by 5pm. They said that because the meals were so close together they were sometimes not hungry. People said that there was a long time between the evening meal and breakfast. Although snacks were available in the evening and when people woke in the morning, not everyone was aware of these and some people wanted larger meals, particularly when they first woke. Some people told us they waited until 10.30am or 11am to have breakfast, which was several hours after they had woken.

People's nutritional needs and dietary preferences had been recorded in their care plans. Their nutritional needs were reassessed at least once a month. Where people had been identified at risk there was a plan to manage this risk, including referral for specialist support, fortified foods and regular weighing to monitor changes. Some people's food and fluid intake was monitored and recorded. This information was shared with visiting dietitians. We met a visiting dietitian who told us they were satisfied with the way in which the staff followed their guidance and monitored people's nutritional needs. The staff were aware of people's individual needs and preferences and we observed people being given choices at mealtimes. The food was fresh and well-presented. People were able to have food which met cultural or health related special diets. The information about people's individual needs and preferences had not always been provided to the kitchen staff, who relied on handwritten notes rather than specific and clear plans.

People's weight was generally well maintained and where people had lost weight this was being monitored. The reasons for this had been recorded. The manager had a record of all changes in weight and made sure action was taken to offer people the support they needed.

Good

Is the service caring?

Our findings

At the inspection of 19 May 2015 we found that people living on Willow unit did not always receive care which was personalised and respected their dignity. The staff were sometimes too busy to listen to people's requests and respond to these.

At this inspection we found improvements had been made and the staff were generally caring and attentive. We observed some interactions where the staff were focussing on the task they were performing rather than the individual they were supporting. In these examples, the staff did not notice that people were trying to attract their attention or were not entirely comfortable. When the staff did notice people's discomfort or distress they attended to this promptly and in a caring way. They were also kind and polite in their interactions. The staff appeared aware of individual needs and provided care that met these.

People told us they found the care staff and nurses caring and kind. Some of the things they said were, "the people here are really lovely the staff are fantastic", "the staff are pretty good although some are more caring than others and sometimes they need to be prompted to do things", "the special ones, they know what to do", "very good, everybody is nice'', ''it is friendly, like family, caring", ''it is good here, the nurses are very good", ''the staff are very helpful; like the first time they see you they make you feel welcome….the best thing about this Home is the caring side; they are very good at that'', "I would recommend this nursing home", "it's really good her, the staff are good'', "care is very good", "the staff here know how he is and how to care for him'' and "I really love this place it is peaceful.''

The staff had good relationships with the people they supported. One member of staff told us, "I like to care for people the way I care for my own family." Another member of staff said, ''I feel good about helping people.''

People told us their privacy was respected. We observed the staff meeting people's needs in a discreet way. They knocked on bedroom doors before entering and made sure care was provided behind closed doors. People told us their religion and culture was respected. They were able to eat meals which reflected their cultural preferences and had opportunities to worship at the home. The staff told us they arranged events to help people celebrate their culture and religion, including a recent Diwali party and events planned for Christmas.

Requires Improvement

Is the service responsive?

Our findings

At the inspection of 19 May 2015 we found people's recreational and social needs were not always met in the same way throughout the home. In some units people wanted more opportunities for social activities and wanted their individual choices and preferences to be taken into account.

At this inspection we found some improvements had been made, however, these were not enough to meet people's social and leisure needs. During our inspection we observed some people had little to do and limited opportunities for interactions for long periods of time. For example, in one unit we saw that a group of people were left in the main lounge for almost two hours with the television on but no other activity. They were not given a choice of television station. The staff who entered the room sometimes checked on people's comfort and once offered them a drink, but there were no sustained interactions. In another unit we found that people were listening to music and there were small groups of conversation but for the majority of people in the lounge they were not engaging with people and had not been given anything to do. The staff spoke with some people but did not spend time with others who were unable to communicate verbally apart from when they were supporting them with something, for example to eat their lunch.

Some people told us there was not enough to do. Comments included, "when I'm at my own home I go to my club and I do quiz words, they don't have anything like that here; no dominoes. I like dominoes" , ''there is not much to do but I read'' and ''it's a bit slow, it is not so bad but not much to do.''

One visitor told us, "they do not do anything to stimulate them at all, the TV is on all day long showing unsuitable programmes – why do not show nature programmes that people might enjoy watching?.....They put [my relative] to bed when they want and sometimes when I get here at 11:30am and she is still in bed."

One person told us that bedtime at the home was 8pm because that is when they turned the television in the lounge off. They said, ''you have to watch the television in your bedroom if you want it after that time.''

This was a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There were activity coordinators who organised some group events. These included trips out of the home, for meals and to see the Christmas lights in London and some visiting entertainers during December. This was an improvement from the last inspection. The provider had employed rehabilitation officers in two of the units to offer additional support helping people to learn new skills. In two of the units people were supported to exercise by a physiotherapist and there were accessible kitchens for people to prepare meals. On the day of the inspection one of the activities coordinators told us they had been supporting some people with individual activities and escorting them to the hairdressers. There was no evidence of any other activities, planned or provided, by the activities coordinators or other staff.

We observed that in two of the units people were engaged in social activities or following their chosen

leisure pursuits during our inspection. The staff engaged with people and made sure they were receiving care which reflected their individual needs.

The manager told us that they had recognised a need to improve activity provision at the home. They said that they were looking at ways to support people outside of organised special events. The employment of the rehabilitation officers was designed to offer additional support which focussed on individual needs. The manager told us that she was meeting with staff and had started providing training around person centred care, to help the staff to understand about meeting the holistic and individual needs of each person. The staff had started to consult with families to develop more information about people's interests, hobbies and life before they moved to the home.

People's care needs had been assessed before they moved to the home. Pre-admission assessments included an overview of different aspects of care including senses and communication, skin integrity, eating and drinking, elimination, personal hygiene needs, mobility and risk of falls, sleep patterns, mental health needs, cultural and spiritual needs and information on the person's lifestyle. The care plans reflected the assessed needs. Some needs were reassessed monthly to identify whether people required different support.

There was clear information about wounds and how these were treated and monitored. The nurses had a good knowledge of people's wounds and other health care. They were able to tell us the action they were taking to meet individual health needs.

In some care plans there was a good level of detail about people's communication needs, including how staff should communicate with them and how they expressed different emotions. There was also information about people's lives before they moved to the service and things which were important to them. However, other care plans did not contain the same level of detail and information was not always clearly recorded.

The provider had a suitable procedure for dealing with complaints. People told us they knew how to make a complaint. Some people had raised concerns and they told us the manager had investigated these and fed back to them. We looked at the records of complaints and concerns. These included evidence that they were investigated, that the provider had responded to the complainant and taken action to put things right.

Requires Improvement

Is the service well-led?

Our findings

At the inspection of 19 May 2015 we found the permanent manager was due to leave the home shortly after our inspection and there had been no registered manager in post since August 2014.

At this inspection we found a new manager had been employed. They had applied to be registered with the Care Quality Commission, had been interviewed as part of this process, and was waiting to receive their certificate of registration.

People told us they liked the manager and found they were approachable. They said that they had introduced positive changes at the service. There was a clear management structure, which included a range of differently skilled, qualified and experienced senior staff. The manager told us that she was supported by the provider and the service was regularly visited by the provider's senior managers. Some of the things people and their visitors told us about the manager were, "the manager is very nice" and ''we have met her at meetings and we are able to express our views about the service.'' The staff told us that they felt well supported by the manager. They said that they were happy with the way the home was managed. One member of staff told us, ''the manager is very good.''

At the inspection of 19 May 2015 we found the provider had systems to monitor the quality of the service and these were comprehensive. Some of these had identified areas of concern. However, the risks to people's well-being and safety had not been appropriately managed.

At this inspection we found improvements had been made. The manager had introduced new systems for checking practice at the home and ensuring risks were identified and managed. These included senior staff spending time on each of the units and unit managers reporting on risks and outcomes for people who use the service.

We identified some areas where improvements had not been sufficient to meet the breaches of Regulation we identified at the last inspection. These included unclear information about people's consent to their care and treatment and this meant they were at risk of receiving care which was inappropriate and did not reflect their needs and wishes.

Some of the records at the home were not well maintained. For example, information about people's mental capacity was not always clearly recorded. Records of care provided to people varied in detail and quality and some records were incomplete. Information in the care plans to state what action staff needed to take to meet people's needs was not always clear.
In one care plan we found information which had been recorded and stuck in the plan on a post it note. In another care plan we found a hospital discharge letter for one person filed in the wrong person's plan.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The manager was aware of these and had an action plan to address these issues. The provider had created an action plan following the last inspection and improvements had been made in all areas. There was a plan to address the outstanding issues. There was evidence that the manager had discussed these areas of concern and plans for improvement with people using the service, their visitors and staff. The provider's action plan had been monitored by the local authority and local clinical commissioning group who had visited the service and carried out their own audits.

The provider had a system of audits which included the unit managers monitoring the use of bedrails, unplanned admissions to hospital, changes in people's weight, accidents and incidents and pressure sores on a daily basis and sharing this information with managers who analysed the information and identified areas of the service which needed improving. The manager shared this information and additional data about Deprivation of Liberty Safeguard applications, safeguarding alerts and referrals, infections, mortality and GP reviews with the provider. The monthly reports included evidence of action the manager had taken where there was concerning information.

People told us they had opportunities to feedback their opinions about the service, through meetings and through written surveys. People said they were able to tell the senior staff if they wanted something changes and they felt listened to.

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 9 HSCA RA Regulations 2014 Person-centred care The registered person did not always provide care which met service users' needs and reflected their preferences. Regulation 9

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person had not always obtained service users' consent to their care and treatment. Regulation 11

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not always maintain a complete, contemporaneous and accurate record of the care planned and provided to service users. Regulation 17(2)(c)