Molescroft Nursing Home (Holdings) Limited

Beverley Grange

Inspection report

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Ratings

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

Overall summary

We carried out this unannounced 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 CQC which looks at the overall quality of the service.

Beverley Grange is a purpose built home situated on a housing development in a residential area on the outskirts of Beverley. It is set in its own grounds with plenty of space for people to sit and enjoy the fresh air. The service was opened in 1999 and provides long term and respite stays, looking after people who need residential care or nursing care. Respite stays are usually short periods at the home often used to allow people time to recover from illnesses or injuries.

At the time of the visit there were 67 people living in the home.

The last inspection of this service was in January 2014. At the time the service was meeting all of the assessed areas.

Summary of findings

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. DoLS are part of the Mental Capacity Act (MCA) 2005 legislation which is in place for people who are unable to make decisions for them. The legislation is designed to make sure any decisions are made in the person's best interest. The registered manager told us that no-one in the home had required any support with DoLS as everyone had been assessed as being able to make decisions without this support. However, we found one person had a restriction with no evidence if this was agreed.

We found there were not enough staff to support people. People told us they did not always have their personal care needs met.

Information regarding an allegation of harm had not been handled correctly by the home; this meant people were not fully protected.

Medicines were not handled correctly in the home; records were not kept up to date and monitoring checks were inadequate.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Staff received training to help equip them with the necessary skills to meet people's needs. We found assessment systems in place which recorded people's individual needs. When we spoke with staff they were aware of these needs.

People told us staff were caring and polite and overall we observed a positive culture in the home.

There were systems in place to support people with their dietary needs, for example support relating to special diets for people with diabetes. However, support with the eating of meals required improvement and not everyone had easy access to drinks.

Activities were available to people but only in one area of the home. People who did not access this area were not provided with activities and no individual one to one activities took place.

People told us they were able to complain but how this was handled by the home varied. Additionally there were systems in the home to audit and monitor service provision. However, the records we reviewed showed that the system currently in use was mainly a tick list; we found that these lists were not completed correctly and provided no evidence of how this was used to improve the service to people who lived there.

Although meetings took place there was little evidence that consultation comments were used by management to improve service provision.

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. There were not adequate numbers of staff to meet people's needs. Safeguarding information had not been handled correctly in order to protect people and keep people safe. Additionally medication management did not ensure people's medication needs were safely met.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. DoLS are part of the Mental Capacity Act (MCA 2005) legislation which is in place for people who are unable to make decisions for them. The legislation is designed to make sure any decisions are made in the person's best interest. One person had restrictions in their life and it was not recorded if their permission had been sought regarding this.

Recruitment processes were in place but these did not make sure that all references provided information regarding the person's skills for the role applied for. This meant staff could be employed who did not have the skills to effectively meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective. The support people received with their meals did not always ensure their needs were met.

Staff had received training appropriate to their roles to help them with meeting people's needs and people were supported to receive support from professionals to help make sure their health needs were met.

However, some health monitoring equipment was out of date which meant there was a risk of people not receiving the correct support.

Is the service caring?

Good

The service was caring. People told us staff were "Polite" and "Marvellous". Changes had been made to daily routines to meet people's individual assessed needs.

Personal care plans had been developed to make sure people's individual needs were known by staff. Additionally people's privacy was respected.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's individual needs were known in the home as assessment and care planning processes were in place.

Activities provided were based on group activity and little one to one activities were offered to people. This meant not everyone had their relaxation and leisure needs met.

Summary of findings

There was a system for the handling of complaints although people's experiences of this varied. People could not be assured their complaint was handled correctly.

Is the service well-led?

Requires Improvement

The service was not well-led. Checks were made on the running of the home but these were not well completed. These had not identified areas of improvement, for example, with medication. Consequently people could not be assured management would be aware of areas of improvement to ensure the correct support for people.

There was a registered manager in post in the home and staff felt they were able to approach. Staff were confident in raising concerns to improve care for people.

Systems were in place to consult people about the home although practice with this varied. People could not be assured their views would improve life in the home.

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Detailed findings

Background to this inspection

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.

The inspection team comprised of two inspectors, a professional 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.

Prior to this inspection we spoke with commissioners of services and reviewed information we held about the service. This included a review of any notifications the provider had sent to us about incidents in the home. The service also completed a provider information return (PIR) which gave us additional information about the home. The provider information return (PIR) is a form which asks the provider to give some key information about its service, how it is meeting the five questions, and what improvements they plan to make.

We spoke with 16 people who used the service. We also spoke with the registered manager, six care staff, eight visitors to the home, reviewed six people's personal files alongside of records and documents in relation to the management of the home. This included a review of six people's care files and three staff files. We spent time with people and observed daily life in the home.

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Is the service safe?

Our findings

People who lived in the home told us that there were times when there were not enough staff. Comments included, "They are always short of staff" and "Yesterday, they were short staffed, only two on, and I had to sit around in my dressing gown for two hours waiting to be assisted. Another person who lived in the home told us they should have had their shower the day of our visit but staff were too busy. One person who lived in the home told us that they also felt that a lack of staff meant people's opportunity's to go out in the local community were limited. One visitor told us they felt there were not enough staff as staff, "Rush in and out"

Two visitors told us that in their opinion there could be more staff. One visitor added that when they have asked for something for their relative, for example, a cup of tea they had on occasions been told "I am sorry we are a bit short" (staffed) by staff. A visitor told us of their concern for another person who they had previously been watching over a period of time and had let the staff know of their concerns. But unfortunately nothing was done and then they had a nasty fall. The visitor also felt that there was sometimes a lack of communication between the staff.

Staff told us they felt there were enough staff to meet people's needs. We were told that the service "Hasn't used agency staff in two years."

On the day of the visit two people told us they had not received a bath. They had been told there were insufficient staff to assist them with this. This did not make sure people's personal hygiene needs were met in the home. One person who lived in the home explained to us that at lunch time that day they had tried to get their medication, but the staff was busy and had told them they would get back to them. By 14.00 they still had not had their medication. Later that afternoon we checked to make sure that they had got their medication which was then the case. The person had not been given an explanation for the delay other than the initial comment that staff were busy. This had the potential for people's medication needs not to be met.

We saw that for people with more advanced stages of dementia, there appeared to be few staff available to just 'be with' those people, other than for providing care. One visitor told us in their opinion, "The call bells ring for ever, there is no one around." We also observed a person who lived in the home rang their bell for assistance. After four minutes of waiting for assistance we approached staff and asked them to attend to the person. We observed staff were busy throughout the day of the inspection.

There were staffing rotas in place which recorded how staffing levels were planned within the home.

Overall It was clear that there were concerns with the current staffing levels in order to meet people's needs. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the action we have asked the provider to take can be found at the back of this report.

People were not consistently safeguarded from abuse. Although there was a safeguarding policy and staff told us they had received training in safeguarding adults, we found two instances of potential abuse which had not been reported to the local safeguarding adult's team. In one instance the provider had not responded appropriately when information of concern had been raised with them. This meant that the risks to the person and others had not been fully investigated nor appropriate action taken to keep people safe. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the action we have asked the provider to take can be found at the back of this report. These concerns were reported to the local safeguarding team by CQC following this visit.

People were not protected from the risk of harm in relation to their medicines. This was because systems in the home were not safe when handling and disposing of medicines. Medicine was stored correctly within the home but errors in records compromised the overall safety. This placed people at risk of not receiving their medicine.

People's details were recorded on a Medicines Administration Record (MAR). Information included for example, the person's name, their prescribed medicine and when it was to be administered. Several of these did not include a photograph of the person. This would have assisted in identifying the person when administering medicine. It would also reduce the risk of errors occurring.

We found that stock balances of medicines were not always correct. For example, 12 people's MAR records were unclear or had different stock amounts to what we found stored in the home. It was clear that stock balances were not checked and correctly brought forward. This compromised

Is the service safe?

the security of medicines as balances were not clear and discrepancies could not be easily identified. Additionally there was no clear audit trail of the exact amount of medicines an individual had received. This did not follow the medication policy which recorded that all staff must physically count medicines and that a monthly check would be completed.

Several people's MAR chart had handwritten entries for prescribed medicine. These had not been countered signed and checked by a second person. The policy held in the home for the safe handling records that transcribed records must have two signatures. Practice did not follow the homes own policy on the safe handling of medicines. Counter checking and signing by a second person helps to make sure that they receive the correct medication.

One person who lived in the home was prescribed creams to be applied to their skin. There was no chart or directions to show where the cream was to be applied. This had the potential for the cream to be applied incorrectly. Another person who lived in the home was able to administer their own medication. There was an assessment to help make sure this was safe and the person remained competent to do this. However the date for review of the assessment had been a month prior to our visit. There was no assessment to identify if the person's needs had changed and if the person remained safe to administer their own medication. This meant there was the potential that people's health and medication needs were not safely met.

We looked at medicines which were described as Controlled Drugs (CD). These are medicines that are prescribed to people and are controlled under the Misuse of Drugs legislation. We found two of these medicines were recorded on the MAR chart but were not recorded in the CD book. This does not follow required practice for these types of drugs.

Medicine no longer required was returned to pharmacy. Records were kept of these. However, no signature was obtained to confirm their return to the pharmacy. This meant there was no audit trail for the correct disposal of medicine in the home. The policy for medicines recorded that the signature should be obtained; staff were not following the guidelines within the home.

This was a breach of Regulation 13 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the action we have asked the provider to take can be found at the back of this report.

Systems were in place to support people with the handling of their money. This included using computerised records and obtaining receipts. These helped make sure records were accurate and an audit trail for checking was in place.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. DoLS are part of the Mental Capacity Act (MCA) 2005 legislation which is in place for people who are unable to make decisions for themselves. The legislation is designed to make sure any decisions are made in the person's best interest.

We were told that training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was viewed by managers as very important. Staff told us and the training matrix recorded that over 90% of the staff had received this training. However, in discussion not all of the staff were clear on what MCA and DoLS were or the impact for people. There were some inconsistencies between the high staff uptake in this training and staff understanding of its application. The lack of staff understanding had the potential to impact on how people were supported with this.

Care plans included a consent form for permission from the individual , for example, for an immunisation. This provided easily accessible information on some fundamental consent issues for those with capacity to decide. However, this was not completed in everyone's folder. This meant there was an inconsistent approach to how peoples consent was gained with the potential that this may not occur for everyone.

We found that one person was using a chair which restricted their movements. Appropriate assessments were not in place to make sure the use of this chair was agreed to by the person and in their best interest. This meant the person may have been restricted against their wishes.

For other people risk assessments were appropriately and clearly recorded in care plans. For example, nutrition with weights record, infection control, health and safety, fire safety, falls, and tissue viability. We saw evidence of staff anticipating risk and preventing falls. For example, one person who was walking in socks on a laminate floor was guided to sit down and their slippers put on. We saw in care

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Is the service safe?

plans that falls assessments reflected the partnership with the local Falls Prevention team and that a multi-disciplinary approach was taken in managing falls. This meant people received professional support to help prevent them falling.

Staff told us, "Sometimes people can be challenging, so we just step away, give them some time and try again. Sometimes, we try using different members of staff. It just depends on the individual. We know them all and what and who they like." Another staff member said, "We get to know the patterns they live by, like one person who wants to get up and have breakfast later than anyone else. That's fine and if it's getting near to lunchtime then we've made her a kitchen area where she can make herself breakfast if she wants so she feels like she's got some independence."

There was a business continuity plan in place to assist staff should an emergency occur in the home. However, this did not include all details, for example the location of the water or gas shut off tap. This would assist staff to manage an emergency of this type.

People were supported by staff who had been recruited through the homes recruitment process. However, two people had provided references which were from personal friends. As these were not professional references the referee would be unable to comment on the person's suitability for the role from a manager or employer perspective. This restricted the information available to the provider when assessing if the person was suitable for the role.

The recruitment process included interviews and checks, for example a Disclosure and Barring Service check (DBS). A DBS check records if the person has a criminal conviction which would have prevented them from working with vulnerable people. This helped to make sure that staff were suitable and people were protected. In feedback the provider told us about the system in place to review DBS checks. This included that upon receipt these would be viewed by an administrator, manager and a director of the organisation. This review would help to identify whether the person had a criminal conviction which may prevent them from working with vulnerable people.

When nurses were employed their professional identification number was checked. This verified they were registered to work as a nurse and could 'practice' within the home. This helped to keep people safe.

There was a staff disciplinary procedure in place. This helped to make sure staff worked to the correct standards and people received appropriate support.

Requires Improvement

Is the service effective?

Our findings

Staff told us about the training they had completed in the last year. This included Moving and Handling and end of life care. The staff training matrix recorded that over 90% of staff had received training in Moving and Handling, First Aid, Health and Safety and Equality and Diversity training. In addition to this some staff had completed individual courses. One example was that a staff member had completed a course on catheter care. This meant people were supported by a staff team who had received the necessary training. Staff files included evidence of the training they had completed. For example, one recorded training in relation to dementia care, health and safety and person centred planning. We saw evidence that the service was signed up to the 10-point Dignity Challenge. Dignity awareness and training was an on-going and continuous training topic from induction onwards.

We saw the menus offered a variety of meals. This included two choices both at lunchtime and the evening meal. However, over half of the people we spoke with told us the food was "Very much the same and we can work out what we are getting on which day of the week." Comments also included, "The food is quite good but it gets boring", "The food is luke warm when it arrives, I ask for a small portion but there is no detailed thinking to this," and "It is generally ok but it gets monotonous." One person told us how when they went out each week and returned just after lunch. They told us staff "Saved" them their lunch. One person living in the home told us the mealtimes were taking longer and they were not happy with this.

The chef told us about the specialist diets available for people and how this helped meet people's nutritional needs. The chef also told us how people were asked daily and in meetings about their food preferences. Also that people could choose to have snacks.

We observed lunchtime was a relaxed experience for people. We also observed a meal being given to someone whilst in bed in their room. The staff member explained and encouraged the person to be independent whilst cutting up their food for them. The staff member left and told the person they would be back in five minutes. They did not return after 10 minutes and the person's meal got cold. We also noted the person's jug of water was not in reach. It was on the side away from the bed. This meant the person had not received good support to meet their nutrition and hydration needs.

We also noted that jugs of water were not in easy reach for several people in the home. Records also did not record the person being given a drink; despite it being a warm day. We asked the provider to address this.

We saw evidence in care plans of working partnerships with, for example, GPs, district nurses, dieticians, Community Mental Health team, tissue viability nurses, opticians and podiatrists. All of which was based on assessed individual needs. This helped to make sure people got the right support in the meeting of their needs.

We were told that long term conditions, for example, diabetes, asthma, cardiovascular disease, chronic obstructive pulmonary disease (COPD) etc. were managed by the nurses. This was in partnership with the GPs and any relevant specialist nurses.

One relative told us, "I've no doubt Mum's safe here. The staff are great. I live just down the road and come and go as I want. Whenever anything's wrong, like she's not well at the moment, they tell me straightaway and that they've had the doctor out to her."

One professional told us they felt people's needs were met in the home. They confirmed staff worked well with them and followed their instructions. We were told "They work well with us as a team and there is a good relationship here."

Some people required medical aids or testing equipment to help them with the monitoring of their health needs. When we looked at these we found several items were out of date. For example, glucose testing strips would be used to assist people with the monitoring of their diabetes. As these were out of date there was the risk they would not show correct results and people's health would be compromised.

Good

Is the service caring?

Our findings

One person told us they felt staff were always polite, although sometimes staff raised their voices. Another person said, "I can ask them anything. I have my hair done here and I can go around the place as I want. There's always someone around to help." One person told us, "I think the staff here are marvellous. In fact, it's excellent. I came here with my husband and we had a room together and a sitting room. This room here was our sitting room. They were so kind to me."

Relatives told us that staff were "Very good" at dealing with them. They described staff as "Friendly, flexible, always cheerful and treat people in a caring way." A visitor told us people were well cared for and had no complaints. Another person said "They're lovely. They seem to really know what they're doing and they always tell me what's what with Mum". Comments included, "The carers have become our friends", and "The staff do care." One relative said, "They're very approachable and always around." Another said, "I just ask them. They're easy to talk to. Any of them."

One person living in the home told us, "Little rules are fetched in and some staff know and others do not, which then causes friction, it's the little things." The provider fedback that all information was shared and there was no friction amongst the staff team.

The managers including the registered manager told us they felt "This is like a community. We are all family and get to know everyone really well."

We saw and heard evidence of a warm, flexible approach to individual care needs. This reflected a priority in safety whilst promoting independence. For example, we heard that one person liked to sit near the front door and a settee had been placed there for them. We were told "X is comfortable there and watches everything going on and they are perfectly safe. It's their home and they should feel at home." We were also told about another person who liked their own space and to stay in their room. Staff respected this whilst also making sure the person was safe. A third person liked to sit in the front hall to give them a different view. A small sofa had been placed in the entrance area where they liked to sit. We were told "It's their settee, Only they use it. It's a secure area and they never move. We can see them all the time but they are perfectly happy." This reflected a caring attitude by staff; respecting people's individual wishes.

We saw care plans were thorough and with evidence of relatives' involvement. A relative said, "We do have better involvement with the care plan reviews these days." We were told that care plans were work in progress. Evidence showed they were becoming valuable, meaningful documents that shaped individualised care

Whilst care plans contained appropriate and personalised information, there was inconsistency in the way they were set out. Some care plan reviews were written on old paperwork, whilst other reviews were completed on new paperwork. This did not make care plans easy to use, although this was due to a review of the care plans and changes were being undertaken. Care plan reviews were regularly undertaken and clearly dated and signed accordingly. A daily diary on both floors was used to highlight which plans were due for review. It also showed any appointments or visitors expected.

We saw people's records were stored securely in a main storage area. This helped to protect people's privacy. When we looked at the staff training matrix we saw that over 90% of the staff had received training in relation to dignity. We also saw and heard evidence of kind, gentle and patient interactions between staff and people in managing moving and handling. We saw evidence of privacy and dignity being respected. For example, staff knocked on doors before entering rooms and they talked respectfully with people. They explained if they needed to undertake a care task for someone and ensured discretion during personal care or moving and handling and when asking if people were comfortable. We heard much informal 'chit chat' with people in addition to the care that was being provided.

Requires Improvement

Is the service responsive?

Our findings

In discussion, staff told us about the needs of people who lived in the home. We were told people were involved in making decisions about risks which might affect their care. For example, one person wanted to have a bath instead of a shower. They told us, "I would love to have a bath, but just at the moment, it's not safe because I've just had X and have one or two other problems to be sorted out first. I'm looking forward to having that bath though!" Another person told us some days were better than others. They said this depended who was on duty. They commented, "Oh no there's no choice who puts me to bed. There are two people who I do not like, but you have to put up with who comes, they are always short staffed." They told us that they did not feel able to mention this. They further commented, "They are always too busy for me to have a word with and explain how I feel."

A relative told us, "My mum's really independent and wants to do everything herself. But, agreed it was best to be helped up into her bathroom and then she can do the rest herself. It's the getting up and in there that's risky for her. But they're very patient with her and encouraged her to do what she can but with their help."

Relatives visited through the day. We spoke with eight visitors and people told us they felt the home kept them involved and up to date. They told us the home consulted them and they were aware of people's care plans.

Following admission and assessment, people had named nurses and keyworkers allocated. This was once staff had gained an understanding of the person including their likes and preferences. This meant staff were 'matched' with people. People with a particular interest in, for example, music or gardening, would be matched to staff members known to have similar interests and experiences. This helped develop relationships.

Care plans contained a robust admission assessment which gave staff an immediate overview of the person's needs. Care plans clearly reflected personalised care. They included an 'About Me' document, life histories and end of life care wishes.

People's spiritual preferences were clearly recorded in care plans and formed part of the on-going care plan. This was shaped in accordance with changes in preferences and choices. For example, a resident who was a Jehovah's Witness declined the invitation staff made to arrange meeting with visiting Jehovah's Witnesses. The care plan recorded this might change in the future.

The care plan of one person who did not have verbal communication reflected a clear plan of assessing pain management. This was through observation of non-verbal gestures and some physical behaviour. This meant that staff were aware of when the person was in pain and they would be supported with this.

Care plans also contained an overview of current needs, likes and dislikes as a snap shot summary on one sheet of paper. The review form was regularly used and updated and placed in an accessible file at the nurses' stations. The information was being transferred onto computer so that they could be updated more easily in future.

We heard the recognition from staff that people's choices change and the importance of sharing information with all staff. One member of staff told us, "I'd like to introduce a flash card system for the tea trolley so that we know instantly who has how much milk, how many sugars, if they want tea or coffee. They might always have tea, but then one day it changes to coffee. We all need to know."

The activities programme was comprehensive and well received by relatives and people who lived in the home. However, during the day we observed a lot of people who lived in the home sat in the foyer area and who went to sleep. One person told us "I don't like going down to the foyer they just go to sleep all day."

We saw and heard staff explain things to people and entertainment was being led by a staff member in the foyer. Indoor skittles was held in the morning and there was a singer in the afternoon. We saw involvement and enjoyment amongst people with the afternoon's entertainment. Some people had musical instruments that they could tap in time to the music. There was a communal atmosphere and the people smiled and some even had a dance.

Coloured pom poms were given out and people were encouraged to wave them in the air. This provided chair based exercises.

People we spoke with all knew the singer who sang on a Tuesday afternoon. We were told on several occasions, "Oh, the singer is good; they work in the kitchen you know?"

Requires Improvement

Is the service responsive?

However, during the day we did not observe any staff members spending one to one time with people in the home. Staff appeared busy. Activities took place in the foyer only. One person told us "There's very little to do, I do read, and do various things for myself."

There were various lounges but during the day of the inspection they were not fully used. Additionally there was a conservatory which was the home for all the boxes of activities. However, this room got very hot. This meant people were not accessing the communal space away from their rooms. This meant their opportunities for social interactions was limited.

We were told people could come and go as they pleased in the home and that they were encouraged to go outside in the garden (which is discreetly secure). For people nursed in bed, we were told, "We can transfer them into a bucket chair and take them into the garden for a while for some fresh air if they would like to." Staff said, "People have their own potting and planting greenhouse and we've applied for the Beverley in Bloom competition. So the ones who can and like to do gardening can use it. We've a few who are often out there."

We looked at the two complaints received by the home this year. One of these had been acknowledged as received. However, there was a lack of detail about any investigations completed. This included the outcome or if the complainant was satisfied with the outcome. The registered manager told us these records were stored elsewhere and we were not provided with these. Without clear complaint systems in place people cannot be sure their concerns will be responded to appropriately.

There was a complaints policy for the home which included the details of who to contact and the expected response times. Four people who lived in the home and a relative complained about a person who called out constantly. They said, "Most of the time they are just walked past and ignored." Staff did not action this. We discussed this with the provider at the time of the visit.

We saw evidence of the informal introduction of a 'You Say We Do' system of communication between people, relatives and staff. This was introduced recently and with positive results. Suggestions could be made in writing (or verbally) and given to staff to discuss and then make whatever response required. For example, one person complained their mail was given to them late. Following discussion, an action plan was agreed. Subsequently, all post from the Royal Mail is now stamped as soon as it's delivered with a date of receipt. It is then taken to the person's room. This person was pleased with the result.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post in the home. Although some of the people who lived in the home and a visitor told us they did not know who the registered manager was.

One member of staff felt there was a good culture in the home and another felt the registered manager was approachable. We found there was a welcoming approach and visible registered managerial presence where managers worked and interacted with people very openly. This suggested an inclusive service.

There was a whistleblowing policy held in the home. This guided staff on raising concerns. Two staff told us how they knew how to raise whistleblowing concerns. We also saw the staff training matrix recorded over 90% of staff had received training in whistleblowing. Staff told us they were confident in raising issues about improving the service for people.

There was a quality assurance system held within the home but this was not always effective. This included monthly audits which were undertaken in various areas in the home. The audits covered medication, catering, mattresses, training, accidents and complaints. However, the audit of the medicines in July had not identified the concerns recorded earlier in this report. The system was mainly tick boxes which recorded little actual detail. For example, who had completed the check and when. The limited information meant it was not clear how the system was used drive or monitor improvement. There were no action plans or follow up details recorded to check on the development of the service. The registered manager accepted our findings in feedback and was to address this.

People living in the home were consulted through the use of questionnaires. These had been completed in January 2014 and 18 replies had been received. Comments received varied from “Food good”, “Quite happy”, “Staff are approachable” and “Food is tasteless”. However, there was no information to show what actions had been taken in response to the comments received. It was not clear if people’s comments had been responded to. One relative told us they had been sent a questionnaire, had completed and returned this. They had not noticed any changes from their feedback.

We recommend that the service considers how it records any required actions identified from consulting people who lived in the home.

One person told us they used to have a newsletter and that they helped with that, but that had stopped. They told us, “I asked for the latest copy of the newsletter, the latest one was May 14.” We observed a book in the reception for people to make comments in. This was for management to get feedback and act upon. There was a notice on the front door letting visitors now about this book. However, we also found that complaints had not always been responded to appropriately. Managers were asking for feedback but were not always responding to comments received.

We saw that meetings between different staff and managers took place within the home. For example, the provider met with senior managers and there were also small staff meetings. One member of staff told us they were consulted as they attended small group meetings with the registered manager. One person who lived in the home told us that over the years they used to have meetings, people and relatives meetings. But also said “Meetings do not make any difference.”

This did not make sure that people felt included in and consulted about their home.

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 **How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe use and 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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **How the regulation was not being met: People who use services and others were not protected against the risks of abuse. 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 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **How the regulation was not being met: People who use services and others were not protected against the risks associated with inadequate numbers of suitably qualified and skilled staff. Regulation 22**