HC-One Limited

Priory Gardens

Inspection report

Lady Balk Lane
Pontefract
WF8 1JQ
Tel: 01977 602111
Website: www.example.com

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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?	Good

Overall summary

The inspection of Priory Gardens took place on 21 September 2015 and was unannounced. We also visited a second time on 23 September 2015 and this visit was announced. We previously inspected the service on 30 July 2014. The service was not in breach of the Health and Social Care Act 2008 regulations at that time.

Priory Gardens is a nursing home currently providing care for up to a maximum of 72 older people. The home has three distinct units providing care and support for people with nursing and residential needs including people who are living with dementia. On the days of our inspection 52 people were living at the home.

The service did not have a registered manager in place. 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 2008 and associated Regulations about how the service is run. The previous manager had left the organisation in July 2015 and the home was currently being managed by a 'turn around' manager.

Summary of findings

Everyone we spoke with, told us they felt safe and staff we spoke with were aware of their responsibilities in keeping people safe from harm.

We saw evidence that equipment was serviced and maintained, and there was a procedure in place in the event of a fire.

People told us there were not enough staff. The manager had reviewed the staffing levels at the home and some changes had been made.

People were protected against the risks associated with the use and management of medicines.

We saw evidence staff received regular training and supervision relevant to their role. New staff were supported when they commenced employment.

People told us staff gained their consent prior to undertaking care related tasks, but, where people lacked capacity, there was a lack of documented evidence regarding the decison making process.

People were offered a choice of where to eat their meal and asked what they would like to eat and drink. Two people's food records were incomplete which meant we could not evidence they had received adequate nutrition.

We saw evidence people received input from other healthcare professionals.

Building and refurbishment work was still ongoing at the home when we visited. Relatives told us the registered provider had written to them to advise them of this work. The décor of the dementia unit was designed to enable people who were living with dementia to navigate their way around.

We observed staff were kind and caring in their approach to people. Staff spoke about the people they cared for in a professional manner and were knowledgeable about people's needs, likes and dislikes.

People's care records provided the details staff required to enable them to meet people's individual support needs. However, the quality of information recorded about people's life history, hobbies and interests was inconsistent.

Complaints were recorded, including a record of the action taken to resolve the issues raised.

Senior managers also visited the home at least monthly. There was a system in place to continually monitor the quality and safety of the service people received. This included management reports, staff meetings and service user's feedback.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

People told us they felt safe. Staff had received safeguarding training and were aware of their responsibilities in keeping people safe.

We found the recruitment process for one staff member was not robust.

People told us there were not enough staff.

Medicines were managed safely.

Is the service effective?

Requires improvement

The service was not always effective.

Staff received ongoing training and support.

Where people lacked capacity, mental capacity assessments were not reflective of all aspects of their care needs.

People were offered a choice of meals and drinks but food records were not always accurate.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring.

We observed staff to act in a friendly and caring manner. People's privacy and dignity was respected.

Staff encouraged people to make choices and decisions about their daily lives.

Is the service responsive?

Requires improvement

The service was not always responsive.

There was a lack of evidence that people were supported to participate in meaningful, person centred activities.

People's care records provided detailed information about their care and support needs.

There was a complaints system in place.

Is the service well-led?

Good

The service was well led.

Feedback from people and staff was positive about the turnaround manager who was in post until a new registered manager could be appointed.

Summary of findings

The registered provider had a system in place to monitor the quality of service people received.	

Priory Gardens

Detailed findings

Background to this inspection

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

This inspection took place on 21 September 2015 and was unannounced. The inspection team consisted of three adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this occasion had experience in caring for older people. We were also accompanied by a Care Quality Commission (CQC) analyst team leader, who shadowed the inspection process as a part of their professional development. One inspector visited the service again on 23 September 2015.

Prior to the inspection we reviewed all the information we held about the service. We also spoke with the local authority contracting team. Before the inspection, we asked the provider to complete 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 used a number of different methods to help us understand the experiences of people who lived in the home. We spent time in the lounge and dining room areas observing the care and support people received. We also used the Short Observational Framework for Inspection

(SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with eight people who were living in the home and six relatives of people who lived at the home. We also spoke with the assistant operations director, the manager, a nurse, a unit manager, a senior carer, two care staff and a member of the catering team. We also spent some time looking at nine people's care records and a variety of documents which related to the management of the home.

Requires improvement

Is the service safe?

Our findings

Everyone we spoke with told us they felt safe or they felt safe leaving their family member in the home. One person said "I think it is safe. I've certainly had no problems. The staff are never sharp with you." Another person said, "Yes, I have no worries or concerns about what happens here, they are really good." A relative told us, "(Name of person) is safe here".

The registered provider had a safeguarding policy in place which detailed types of abuse, the action staff should take in the event of having a concern that someone may be at risk of harm or abuse and the training staff should receive in this topic. This showed the registered provider had taken reasonable steps to ensure people who lived at the home were protected from the risk of abuse.

We saw from the registered providers online training records that 98% of staff had competed safeguarding training. All the staff we spoke with told us they had completed safeguarding training. Staff were able to identify different types of abuse and understood their role in relation to reporting any incidents or situations which may put people at risk of harm. The manager told us they also completed safeguarding training and were confident in their knowledge of what constituted a safeguarding concern. They also told us that in the event they needed further guidance, they would contact the local authority safeguarding team.

When we reviewed one person's care plan we found evidence of a potential safeguarding issue. When we asked the manager if this matter had been reported to the local authority safeguarding team they told us it had not as no harm had occurred. We asked them if they would discuss this incident with the local safeguarding team. The manager did this and informed us they had been advised this did not require a safeguarding referral.

Each of the care plans we reviewed contained a number of risk assessments including skin integrity, nutrition, bed safety rails and falls. We noted most of the risk assessments were reviewed and updated at regular intervals. However, we noted in one person's care plan, some of the risk assessments had not been reviewed between January and April 2015.

The assistant operations director told us all accidents were recorded and a copy of the accident report was sent to the manager to be reviewed. The details of the accident were then entered on to the online quality monitoring system. They said they received an email alert when an accident was entered onto the system. We noted some people who were at risk of falls were nursed on low beds and falls sensors were also seen in some people's bedrooms. Outside the entrance to one of the unit's information was displayed for staff and visitors regarding falls prevention.

During the afternoon of the first day of our inspection a fire test was conducted. Staff responded promptly to the drill. Following the drill we asked one member of staff about the action they took. They said when the alarm sounds, one member of staff remains on each of the units to ensure people are safe. Other staff go to the fire panel to receive information and instructions from the senior person in charge of the building. This evidenced staff were aware of the action they should take in the event of the fire alarm being activated.

We saw fire evacuation slings were located at various points around the building. This equipment is required to assist people who have mobility problems in the event they have to be moved urgently. A fire file was kept on each unit which included a personal emergency evacuation plan (PEEP). This is a document which details the safety plan, e.g. route, equipment, staff support, for a named individual in the event the premises have to be evacuated. This showed us the home had systems in place in the event of an emergency situation.

We inspected records for the moving and handling equipment, gas safety and fire detection systems. We saw regular servicing and inspections had been completed by the relevant external contractor. The manager told us the maintenance person completed a number of health and safety checks on a weekly basis. This included water temperature, fire equipment and window restrictors. This demonstrated the registered provider had a system in place to ensure people's safety was maintained.

We looked at two staff files and saw staff members had completed an application form and a record was retained of notes made during the candidates' interview. Potential employees had been checked with the Disclosure and Barring Service (DBS) before they started work at the home. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. We noted in one of files we reviewed that only one references had been obtained. The

Is the service safe?

reference had been written by a friend and therefore there was a risk the reference may not provide an unbiased view of the candidate's suitability to work with vulnerable adults. We looked at the registered providers' recruitment policy. This instructed 'at least two satisfactory references must be obtained for all applicants before they commence their employment'. This was brought to the attention of the manager on the day of the inspection.

People told us they did not think there were enough staff on duty at the home. All the people we spoke with, except one, said there were not enough staff. One person said, "When we are in the dining room, they (staff) are trying to do several things at once. They never say 'you'll have to wait' or anything like that, it's just that I can see they are struggling." Another person said, "They say 'I'll be two minutes', but they never come back." .A relative said, "Staff numbers vary, but often there is not enough." Another relative told us their relative lived on the dementia unit and needed two staff to support them to use the toilet. They said, "They need three staff on duty all the time. When two staff are with (relative) there are no staff are on the floor."

Staff also told us they felt more staff were needed to meet people's needs Staff also told us the manager had recently reviewed staffing levels at the home. One staff said, "I think the manager is trying to get us more staff." One staff member said staffing had been reviewed on the unit they worked on. We asked them if this had made a difference. They said, "It has made a positive difference."

Throughout the inspection we observed staff to be busy. We did not observe staff having time to sit down and spend time with people other than as part of a care related task. At lunchtime we observed people did not always receive their meal in a timely manner. On the dementia unit people began to be seated at the dining table from 12.45, however, the first meal was not served to someone until 13.15. On the nursing unit a number of people were still waiting to be served their lunch at 13.10. This was also reflected on the residential unit where people were waiting for twenty five minutes to be served.

A member of staff told us that earlier in the day on the dementia unit they had been busy in the office and the other staff member was supporting someone in their bedroom. They said during this period when staff were not present a person had tried to take a hot cup of tea from a visitor. When the visitor prevented the person taking the cup, due to the concern about scalding, the person became upset. The staff member explained there had not been a staff member to intervene to diffuse the situation. On another unit we heard a person ask a member of staff to take them for a cigarette. The staff member responded, "I'm so sorry I just haven't got time to take you at the moment."

The manager told us they had implemented a review of the staffing levels when they had commenced working at the home in August 2015. They said they had increased the number of night staff from five to six immediately and they had then consulted with staff to gain their thoughts about the staffing requirements for the home. They showed us a document which recorded the staffing review. This detailed a need to increase the number of staff on the morning shift for the nursing unit and residential unit. Staff felt an increase of staff in the late afternoon and evening would be more beneficial for the dementia unit. The manager told us the home was covering these hours with agency staff until further staff could be recruited to fill the shortfall.

When we looked at the staffing review document, dated 7 September 2015 we noted on the dementia unit two people were reported to require two staff for transfers and hygiene needs. It also recorded three people used a walking aid and required 'constant guidance to use the aid otherwise are at increased risk of falls'. This demonstrated that despite the review of the staffing levels, the changes may not ensure there are enough staff available to ensure people's welfare and safety.

One person we spoke with told us they required regular pain relief. They said, "When I ask for it they will give it to me." During our visit we looked at the systems that were in place for the receipt, storage and administration of medicines. We saw a monitored dosage system (MDS) was used for the majority of medicines while others were supplied in boxes or bottles. We checked one person's medicines and found the stock tallied with the number of recorded administrations. We also checked three medicines which were stored in the controlled drugs cupboard. The stock tallied and each entry was completed and checked by two staff. A staff member told us the controlled drugs stock was checked twice a day to ensure that all the stock was accounted for.

Requires improvement

Is the service safe?

Staff told us they received regular training in medicines management and also received an assessment of their competency. This meant people only received their medicines from people who had the appropriate knowledge and skills.

The manager told us regular medicine audits were completed and staff also completed a random audit of five medicines per day to ensure the stock balances were correct. We looked at the medicine audit dated 14 August 2015 and saw that where issues had been highlighted an action plan was recorded. This showed people were protected against the risks associated with medicines because the registered provider had appropriate arrangements in place to manage medicines.

Requires improvement

Is the service effective?

Our findings

We asked one staff member how information regarding people who lived at the home was passed to different members of the team. They said there was a handover between staff at the changeover of each shift and there was also a communication book and a diary for each unit where staff could write relevant information which staff needed to be aware of.

We saw the registered provider operated an online training system but staff told us some courses were delivered face to face, for example, moving and handling and first aid. All the staff we spoke with told us they had received training in a variety of topics. This included infection prevention and control, dementia and food hygiene. A nurse told us extra training was also available to support staff in their role which included catheter care and how to use the MUST tool. This is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. A senior carer told us the registered provider also offered staff training in supporting people who were living with dementia. They said this comprised five parts and they had completed parts one to four so far. A carer told us they had completed the first level and 'it had been very interesting'.

The manager told us how they could assign training to staff and monitor their progress to ensure the required training was completed. This demonstrated the registered provider had a system in place to ensure staff received training to provide them with the skills and knowledge for their roles.

We asked how new staff were supported in their role. One member of staff told us they had been employed at the home for over a year but had not received any induction training when they had commenced employment. When we raised this with the manager, they showed us evidence this staff member had received and completed induction training.

A senior carer told us new staff shadowed a more experienced staff member as new staff needed to get to know peoples likes and dislikes. They told us they had recently taken on the role of senior carer and they had also had a number of shadowing shifts to support them in their new role. This demonstrated staff were supported in their role.

Staff told us they had received supervision with their manager. When we spoke with the unit manager they told us they completed the supervision for the staff on their unit. The manager told us staff supervisions were slightly behind schedule at present. They said this was due to the change in manager and changing priorities, for example the refurbishment project which was currently in progress.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

One person told us, "Staff always ask permission before they do anything with or to me." Another person said, "They always ask for my consent."

We saw from the registered providers online training records that 49 of the 54 staff listed had completed training in MCA and DoLS. The remaining 5 staff had commenced but not yet completed the training. Staff we spoke with were able to tell us about the MCA. The nurse said, "We never assume people don't have capacity." Another staff member said DoLS were needed for "People who wanted to go home but couldn't." A senior carer told us some people who lived on the dementia unit were able to make some decisions but where more complex decisions were needed, other people were then involved in the decision making process. This showed that staff were aware of their responsibilities under this legislation.

The manager told us no-one at the home had a DoLS in place. They said they had spoken to the local authority about people who lived at the home and it had been concluded that no one required an urgent DoLS authorisation. They said the local authority had advised them to begin submitting DoLS assessments for other people over the coming weeks. They told us they had submitted four applications so far. This evidenced that although some people had been deprived of their liberty,

the home had requested DoLS authorisations from the local authority in order for this to be lawful and to ensure people's rights were protected.

The care plans we reviewed had mental capacity assessments in place for people who were unable to consent to their photograph being taken for identification purposes. We also saw people had care plans in place which indicated the level of capacity they had. For example,

Requires improvement

Is the service effective?

on one person's care plan it was recorded, 'capacity may fluctuate, may need capacity assessments to enable (person) to make informed choices'. However, we reviewed the care plan for one person who clearly lacked capacity and required staff support with personal care but we did not see any recorded evidence of a formal assessment of their capacity or best interest decisions regarding these aspects of their care.

We asked people their opinion about the meals they received at Priory Gardens. One person said, "The food is very good." Another person said, "The food is homemade, nothing fancy, but it suits me." One person told us, "They come with a printed sheet, but if you don't like either of the options no alternative is offered." A relative said they had no concerns about the food provision in the home.

There was a kitchenette area on each unit which enabled staff to access drinks and biscuits for people. The menu was on display in each unit which detailed a choice of two options for the lunchtime meal.

At lunchtime people were offered a choice of where to sit. One person said they did not want to eat in the dining room. We heard staff offer to take their meal to the person's room for them. Staff asked people which meal they wanted to eat and asked if people wanted gravy adding to their meal. However, the meal was plated up by staff which meant people did not have the opportunity to decide on the quantity of potatoes and vegetables which were put on their plate. We heard staff asking people if they had had enough to eat or if they wanted any more.

We saw people were offered drinks throughout the day. On one of the units we saw a staff member bring round drinks of juice at 11am but people were not offered the option of a hot drink until 11.40am. On another unit hot drinks were not served in the lounge until 11.45am. We heard two people complain that the tea was not hot enough. A staff member responded, "Well we can't have it too hot or you might burn yourself." This indicated that staff may be prioritising risk aversion before considering people's preferences and individual abilities.

We reviewed three days' food intake records for two people and found the records lacked details of the meals and snacks people were offered and ate or declined. For example one person's record had no information about snacks for mid-morning or mid-afternoon. The second person's record detailed they had refused breakfast, lunch and supper. Nothing was recorded for tea. When we checked the weight records for these two people we saw they had both had a degree of weight loss and it was therefore important that accurate food records were maintained to evidence their nutritional intake.

People told us they were enabled to access other healthcare professionals when required. One person said, "If I need a doctor they will get one for me." Another person said, "Oh yes, when I was poorly the staff sent for a doctor."

We saw documented evidence in people's care plans that they received input from other healthcare professionals. For example, G.P, district nurse and speech and language therapists. This showed people using the service received additional support when required for meeting their care and treatment needs.

One relative we spoke with told us their relative had required urgent attention at the hospital. They said they had to take their relative as they were told there were no staff available to take them. The manger told us they were aware some people had previously been sent to appointments without a staff escort. They showed us a memo which had been issued to staff which instructed staff to ensure, whenever possible, that people should be supported by staff when they need to go to the hospital.

The registered provider notified the Care Quality Commission that major refurbishment work was to commence at the home over the summer period. This was scheduled to last approximately four months. When we visited the home it was clear this work was still ongoing but the impact on people's lives appeared to be low. Rooms where work was being completed were secured to prevent unauthorised access and had a notice on them advising that work was in progress. Relatives told us the registered provider had written to them to inform them of the work which was to be done. The senior carer told us the dementia unit, which was situated on the ground floor, was to have patio doors built as part of the refurbishment work, to enable people to access the secure garden. They told us this would be 'very good' for the people who were living on the unit.

On the dementia unit we saw bedroom doors painted in various colours and toilet and bathroom doors were all painted yellow. People's bedroom had their names on them and memory boxes were located outside their

Requires improvement

Is the service effective?

bedroom doors. Pictoral signage was used on the lounge and dining room doors. This enabled people who may no longer be able to fully comprehend the written word to be able to navigate around the home.

Good

Is the service caring?

Our findings

People told us staff were kind and caring. One person said, "When I came back from hospital they were all stood at the door to say welcome back." Another person said, "They are very, very caring and there is none of this 'you are a nuisance' they seem to really care about me." A relative said, "It's nice and clean and the staff are wonderful." Another relative told us about their family member had celebrated a recent birthday, they said, "Recent birthday celebrations were excellent, they (staff) put on an excellent spread."

A member of staff said, "People are treated very well. Staff care for people. Staff try to make people's lives as good as possible". Another staff member told us they delivered person centred care and treated everyone as individuals. When we spoke with a nurse, they said, "We talk to people as individuals."

People who lived at the home were appropriately dressed, people's nails were clean and men were clean shaven. This indicated staff had taken the time to support people with their personal care in a way which would promote their dignity although we noted a number of ladies were not wearing stockings, tights or socks. Clocks in the communal areas and in people's bedrooms were set at the correct time. Having clocks set at the correct time enables people with dementia to rationalise daily routines, for example, meal times.

Throughout the inspection we observed staff to have a caring and compassionate approach with people. Staff spoke to people in a knowledgeable way which indicated they knew them well. Three of the staff we spoke with told us they tended to work on regular units. One said, "Before, we changed units all the time, now we tend to work on a set unit." This meant people were supported and cared for by staff who knew them well.

We heard staff apologise to people if they could not immediately do what the person wanted them to do. While we noted staff's verbal and non-verbal communication was appropriate, we did observe there was extensive use of terms of endearment such as love and darling. However, people who lived at the home did not appear concerned by this.

While each of the care plans we looked at contained a document where people's life story could be recorded, the information recorded was limited. For example, much of the document was blank for one person who was living with dementia. Having detailed information about a person's life enables staff to have insight into people's interests, likes, dislikes and preferences. Life history can also aid staff's understanding of individual personalities and behaviours.

One person said they felt the staff encouraged independence but provided help when it was needed. Another person we spoke with told us, "They (staff) are very good with dignity and things like that." We asked a staff member how they maintained people's privacy and dignity. They said, "We close doors and ensure we don't discuss confidential information in public, where we can be heard." This demonstrated staff respected people's privacy and dignity. The manager told us the home did not have a dedicated dignity champion but they said they wanted to ensure there was a member of staff on each unit who would undertake this role. Dignity champions are staff designated to ensuring all staff are committed to taking action, however small, to ensure people are treated with compassion, dignity and respect.

Requires improvement

Is the service responsive?

Our findings

One person said the only activity they could remember was, "When they (staff) sent a student in and they played some silly game with bean bags. They said they would like to go outside more. Another person said "I spend most of my time in my own room. I think there are some activities, but I don't know what." We asked staff about the provision of activities for people. One staff member said the new activities organiser was 'brilliant' and was 'very good with people'.

The activities coordinator was on holiday when we inspected Priory Gardens. We heard a member of staff discussing the activities schedule with people. They said, "There will be no activities while they (activities person) is off. There is no back-fill." When we asked the staff member about this, they told us, "Someone (staff member) did come in the other day so people could play bingo because they had been promised that and would be disappointed otherwise." We asked the manager about the absence of activities when the activities organiser was on holiday. They said they had been able to cover some but not all of their shifts with care staff. We did not observe any activities either organised or occupational during the morning of our visit. In the afternoon a theatre company came to the home and put on a show for people.

We noted one person's social assessment recorded they 'liked to dance' but this was not documented in their daily activity care plan. Another person's plan recorded they enjoyed reading magazines, watching TV and memories from the past. The document did not detail the types of television programmes they liked to watch and when we reviewed their daily logs for a three week period there were only two references made to any form of activity or occupation. This being 'attended the church service' and a 'motivation class'. Enabling people who live in care homes to take part in meaningful and enjoyable activities is a key part of 'living well'.

The unit manager said when a person was admitted to the home an initial 'seven day' care plan was implemented. They said a more detailed care plan was then developed as they had got to know the person's abilities, needs, likes and dislikes. We saw evidence of a seven day care plan in two of the care plans we reviewed.

Each of the care plan files we looked at contained a number of care plans which were relevant to the individual. Each care plan was person centred and detailed their support needs. For example, one person's care plan for sleeping recorded 'likes to go to bed after tea… has two pillows'. We also noted care plans were reviewed and updated regularly. One of the care plans we reviewed had been updated to reflect the input from the speech and language therapist. This showed care planning took account of people's changing care needs. The manager told us care plans were reviewed regularly and a matrix was kept on each unit to enable staff to know which files required reviewing.

People we spoke with were not aware they could become involved in their care plan. When we looked at people's care files we saw minimal evidence of either their or their relative's involvement. This meant we were unable to evidence that people had been consulted about their care and support or that they had been actively involved in making decisions about these matters.

We asked people what they would do if they had a concern or complaint about the home. The majority of people said 'there would not be any need to do that. One person said, "No I wouldn't know how to complain but if I was worried about anything I would just tell the nurse." A relative said, "We have made a complaint in the past, verbally, to the manager." They said they had felt listened to when they complained and the current manager had apologised to them about the matter.

The manager understood the policy and procedure in the event anyone wished to raise a complaint. They told us any complaints were recorded on the registered provider's online quality monitoring system. They said there had been one formal complaint since July 2015. We saw evidence the matter had been investigated and a letter had been sent to the complainant which included an apology. This evidenced the registered provider had an effective complaint system in place.

Good

Is the service well-led?

Our findings

The registered manager had left the organisation in July 2015 and there was a 'turn around' manager in post.

When we asked one person about the manager they said, "They came and introduced their self to me and from what I have seen they are alright." A relative said the new manager was 'someone who looked as though they could make things happen'. One relative we spoke with expressed concern regarding the turnover of managers at the home. They said there had been 'four or five in the last 3 years'. However, they added they felt communication was good at the home, for example they had received a letter about the refurbishment programme.

Staff spoke highly of the manager. One staff member said they had seen a 'difference since the new manager had been at the home'. Another staff member said the new manager was 'very nice and helpful'. One staff member told us about a method of working which they felt had not been effective and they had discussed how this could be improved with the new manager. They said this change had been implemented.

During the inspection we found the manager to be knowledgeable about people who lived at the home and the staff, despite the short period of time they had been working at Priory Gardens. However, when we rang the home to speak with them three weeks after the inspection, we were told they had been moved to another home operated by the registered provider and another 'turn around' manger was now in post.

The registered provider had a quality assurance and governance system in place to drive continuous improvement.

The assistant operations director told us that a senior manager visited the home at least monthly and a report was always generated from these visits. They said any areas identified which required action were always followed up at the next senior manager visit. We saw a health and safety audit report dated 15 September 2015 and a human resources report for 28 August 2015. These reports were all online and the manager showed us how they evidenced on the report when identified actions had been completed.

We saw an action plan dated July 2015 which recorded areas which the registered provider had identified as needing attention. This included issues relating to staff training, updating the online quality monitoring system and ensuring audits were up to date. We saw this document had been updated by the manager during September and indicated they were taking action to rectify the deficiencies identified.

The assistant operations director and manager told us about a monitoring report which had to be completed by the home manager each month. They told us this recorded key information relating to the performance of the home. For example, falls, pressure ulcers, weight loss and complaints. They showed us how this generated a report and the manger showed us how they could then open the report to gain a breakdown of the people identified within the report, for example the names of people who had lost weight.

The manager told us internal audits were completed by themselves, members of the staff team and senior managers. We reviewed how care plans were audited and the manager told us they aimed to audit 12 people's records each month. One of the unit managers showed us four care plan audits which had been competed for their unit in August 2015. We saw where issues had been identified and there was a section for staff to sign and date when the actions had been addressed. We also looked at a random sample of care plan audits which had been completed in September.

One staff member told us they had attended a staff meeting in the past. They said recently there had also been nurse and senior care staff meetings. The unit manager we spoke with also told us a 'flash meeting' was held daily. They said this included the person in charge of each unit and the manager. They explained this was an opportunity to quickly update everyone with any relevant information regarding people who lived at the home, staff issues and other matters relating to the day to day management of the home. The manager told us they had held a number of informal meetings when they had commenced working at the home, to introduce themselves. We saw minutes of meetings which had been held at the home although not all the minutes had yet been typed up.

We saw minutes of a relatives meeting which had been held in September 2015. This included the names of people who had attended and the matters discussed. We asked the manager how people who were unable to attend had been notified of the content of the meeting. They told us a

Good

Is the service well-led?

copy of the meeting minutes had been posted out to them. The manager said previous meetings had been scheduled by the previous manager for June 2015 but these had not taken place due to the refurbishment work. The manager also said that upon completion of the refurbishment work some people would need to move bedrooms. They said they planned to have one to one meetings with people and/or their relatives once the work was completed to decide upon the rooms which were available for them and which one they wished to move into.

In the reception area there was a device which enabled people to give electronic feedback about the home. The manager told us any comments entered on this system were sent automatically to the head office and then the information was forwarded to the individual home manager. They explained any negative feedback was fed into the complaints process. The manager showed us the most recent feedback which was a positive comment made by a visiting external healthcare professional.

We asked if there were any other methods for people to provide feedback about the home. They told us an annual survey was conducted in October each year. We looked at the survey results for October 2014. We saw the majority of areas scored over 90% satisfaction but the key areas which people were not happy included food not always being of good quality and limited choices, staff not always been available or not having time to talk to people and not being able to take part in activities and hobbies. We saw an action plan had been implemented to identify the actions required to address these matters.