Alder Meadow Limited

The Knoll

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 28 and 29 June 2016.

The Knoll provides residential and respite care for up to 34 people. At the time of our inspection 23 people were living there. There was no registered manager. 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. A new manager has recently been employed and the intention was for them to become the registered manager for the service. There were no breaches of legal requirements at the last inspection in September 2014.

All areas in the home were not clean and infection control procedures were not always followed. This required improvement. Quality assurance procedures identified when action was necessary but action was not taken to improve the service with regard to cleanliness. People had commented they may have to wait longer for assistance at the weekend when there was no manager available.

Peoples lived in an environment which could be more 'dementia friendly'. We made a recommendation to improve this. People were provided with personalised care and were supported to make their own choices and decisions where possible. Relatives had signed consent when they were not legally able to. This in not in line with the Mental Capacity Act 2005 (MCA). People's care was not always regularly reviewed to record progress and make changes.

People were usually treated with kindness and they told us staff were good when they supported them with their care. Staff knew how people liked to be supported. People told us they felt safe in the home. Staff knew how to keep people safe and were trained to report any concerns. People were supported by staff that were well trained and had access to training to develop their knowledge. End of life care was planned and people and their relatives were supported by the staff and healthcare professionals.

People told us the food was good and there was a choice of meals. They had home cooked cakes and pastries to choose from. People nutritionally at risk were monitored and appropriate meals and drinks were provided.

People had activities to choose from which included quiz games, exercise classes, pet therapy, arts and crafts and music therapy. Care staff had helped to provide activities for people when there was no activity coordinator but there had been less individual engagement with people. An activity co-ordinator had recently been employed and improvements to activities had begun.

The new manager and the area operations manager, representing the provider, monitored the quality of the service with regular checks. People and their relative's views and concerns were taken seriously. They contributed in meetings and were provided with a record of the meetings. Staff felt well supported by the

manager and the area operations manager who were available to speak to people, their relatives and staff. Staff meetings were held and they were able to contribute to the running of the home.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

Requires Improvement

This service was not as safe as it should be.

The home was not clean and people were at risk when staff did not follow infection control procedures.

People's care and support needs were assessed to monitor the staffing levels required but there was less staff at the weekends which meant people may have to wait longer for assistance.

People were safeguarded as staff were trained to recognise abuse and to report any abuse to the local authority safeguarding team.

People were protected by thorough recruitment practices.

People's medicines were managed safely to ensure people were receiving medicines correctly and staff were competent.

Is the service effective?

Requires Improvement

The service was not as effective as it should be.

People made most decisions and choices about their care when possible. Relatives signed consent when they were not legally able to. This in not in line with the MCA 2005.

The environment did not effectively meet people's needs living with dementia and there was insufficient bathing facilities.

Staff training was up to date. Individual supervision meetings were completed regularly to monitor staff progress and plan training. .

People had access to social and healthcare professionals and their health and welfare was monitored by them.

People's dietary requirements and food preferences were met for their well-being.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with compassion, dignity and respect.

Staff treated people as individuals and encouraged them to be independent.

People were cared for near the end of their life with the support of healthcare professionals to ensure their needs were well met when required..

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Some care plans required updating and some monthly reviews were incomplete and did not always include people or their relatives.

People took part in activities and there were improvements since the activity coordinator had recently returned .

Comments or concerns were investigated and responded to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The quality checks completed included people and their relatives view of the service but improvement were not completed soon enough.

The manager was accessible to staff and people and planned improvements for the service were.

Regular resident and staff meetings enabled everyone to have their say about how the home was run.

The Knoll

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 and 28 and 29 June 2016 and was unannounced. The inspection team consisted of one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert had experience in older people and people living with dementia.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We had 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 this information to assess how the service was performing and to ensure we addressed any potential areas of concern.

We spoke with six people, four relatives, the new manager, a representative of the provider, two care staff, a chef, two healthcare professionals visiting the service, an ancillary staff member, the maintenance person and the activity coordinator. We looked at information in four people's care records, three staff recruitment records, staff training information, the duty roster and quality assurance records. We checked some procedures which included medicines and safeguarding adults. We had information from a healthcare professional following the inspection. We received recent quality monitoring information from the Commissioners, Gloucestershire County Council.

Requires Improvement

Is the service safe?

Our findings

People were not protected against the risks associated with infection control when the service was not cleaned to an acceptable standard. Areas of the service were not clean. The lounge areas and dining room were dusty and dirty and there was no cleaning programme for a deep clean. The cleaning schedule for the communal areas had not been completed. Some of the furnishings in the two lounge areas did not look clean and were 'tired' and required replacing. One person had very dirty windows in their bedroom and sat facing them most of the day. There were mixed views from people about the cleanliness of the home. One person told us about the cleanliness of their bedroom, "Usually it is [clean] but not always I did have a word with them about the dust in my room" and "The home is usually clean but not always." Another person told us, "My room is very clean, cleaned every day and very comfortable they keep my room" and "The home is spic and span it's always clean and tidy and I do a little bit of cleaning myself and I get on very well with the maintenance man X." One relative told us about cleanliness, "Yes I do [clean] her room and I think the home is clean." A healthcare professional had found equipment in use was dirty and two ground floor sanitisers used by staff were empty. The staff toilet was not clean and smelled unpleasant.

A cleaner told us there was one cleaner and one laundry person available each day. The rotas indicated the cleaners worked every morning until 14.00 hours. The cleaner was not using personal protective equipment for example gloves. They showed us where cleaning products not in use were locked which ensured people were safe. The laundry room required additional tiling to ensure all surfaces were able to be wiped clean and promote infection control. There was no infection control procedure in the laundry to guide staff and ensure the correct flow of soiled laundry to prevent cross infection. Clean laundry was stored on open shelves and there was a risk of contamination when staff handled soiled laundry nearby. Staffs personal belongings were stored in the laundry which could compromise the control of infection. There was a general infection control procedure for staff to follow and staff had completed infection control training. However, the Department of Health Code of Practice for adult social care on the prevention and control of infection and related guidance was not followed.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were sufficient staff to meet people's basic care needs but deployment of staff at weekends may need to be reviewed. There was no manager available at the weekend and care staff answered the telephone, door bell and questions raised by visitors. People told us there was sufficient staff to meet their needs but maybe not at the weekend. One relative said there was less staff one Sunday. One person said, "I think they're [staff] doing a good job but I think there's not enough staff at the weekends." Another person told us there were enough staff and said, "Yes I think so there's always someone about." One relative told us, "Yes I do think there is enough staff here what I can see and I'm here most of the time." People we spoke with knew they had a call bell to ring for staff assistance but one relative did not think the person living with dementia would know when to use the call bell. There were plans to appoint a deputy manager.

Peoples dependency was calculated prior to admission and at least every four months to monitor the

staffing levels. The February 2016 dependency tool calculation informed us there was enough staff to meet people's needs. The manager told us additional staff were deployed when people's dependency increased and they required assistance to appointments or hospital admission. The manager was supernumerary and there were four care staff in the morning and three in the afternoons for 23 people accommodated on three floors. There were two night staff.

Individual risk assessments were in place to support people to be as independent as possible. In the records we looked at we found risk assessments in place for people falling, their nutrition, how to move them and for risk of skin breakdown. Guides to the level of risk were recorded to ensure the correct action was taken. A healthcare professional found one person was at risk when the service was not using the correct chair and pressure relieving equipment. This was discussed with the manager and the person had been assessed and the correct equipment provided. The manager told us they would check every person was assessed to have the correct equipment and this was in progress.

People told us they felt safe in the home. Staff understood their safeguarding responsibilities and had completed foundation safeguarding training. Enhanced safeguarding training had been completed by15 of the 26 staff. Staff explained what they would do to safeguard people by reporting any incidents to the registered manager or the local authority safeguarding team. People told us they felt safe. One person told us, "Yes I feel safe I shut the door and that's it I can lock my door but I don't." Another person told us how they felt safe and said, "Yes I'm fine it's all locked up down stairs and I have a call bell but I've never used it up to now." One person said, "Yes I feel safe" and "nobody has upset me." A relative told us their mother was safe, warm and getting good food at the home. There was information in the entrance hall for relatives and friends regarding safeguarding people. Safeguarding records had been completed and CQC and the local authority safeguarding team were informed.

There were safe medication administration systems in place and people received their medicines when required. Medicines were stored safely at the correct temperature. Senior staff completed medicine administration and were trained by a local pharmacist and had an annual competency check. The medicines given 'as required' had a clear protocol for staff to follow and a clinical outcome recorded to monitor the effect of the medicine. A visiting dentist had prescribed a special toothpaste and mouthwash for one person which had been administered. When topical creams were applied they were recorded on specific charts, additional information of how much and where the cream should be applied would improve the record and ensure the cream was effective. A visiting GP told us they completed an annual review of people's medicines. Minor medicine errors were investigated and staff were reminded to always sign the administration record.

Safe recruitment procedures ensured that people were supported by staff with the appropriate experience and were of good character. Two references were held for each staff member which included their most recent employer. All relevant checks were completed and staff completed induction training.

People involved in accidents and incidents were supported to stay safe and action was taken to prevent further injury or harm. A monthly review of accidents was completed to ensure all possible preventative measures were working. One person in April 2016 was referred to a GP after several falls and was diagnosed as having with a urinary tract infection.

Regular monthly health and safety checks of the environment were completed by the maintenance person which included fire safety. A risk assessment of the environment completed in January 2016 had identified all actions were completed in February 2016. We looked at completed records of safety checks, for example, fire bells, call bells, hoists, electrical portable equipment and Legionella disease which was completed by an

outside agency.

There were arrangements in place to keep people safe in an emergency and staff understood these and knew where to access the information. There was a detailed contingency plan which covered emergencies for example, power failure, loss of information technology and adverse weather conditions.

Requires Improvement

Is the service effective?

Our findings

People's rights were not always protected when the staff did not act in accordance with the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People were supported to make their own choices and decisions where possible. Where people lacked the capacity to make some decisions the MCA was not always followed. A relative had signed a consent for one person and they did not have a Lasting Power of Attorney for health or finances. We were unable to see all mental capacity assessments as they had been archived.

One person had a mental capacity assessment and a 'best interest' decision was recorded. For example there was a 'best interest' decision and record for personal care and supervision outside the home. The person's family had been involved in the decision process. Although the person could make some everyday choices they were unable to understand the need to have personal care and always be supervised outside the home. The staff we spoke with had some understanding about the principles of the MCA and the need for a 'best interest' decision but told us most people consented to support with their personal care. One relative told us, "Mum has made her own decisions about her health but we make all her financial decisions."

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. An application had been sent for an urgent authorisation for a person at risk living with dementia who required supervision when they wanted to leave the home. The 'best interest' and least restrictive decision was to always have staff with them in the gardens and in the community. The conditions for the Deprivation of Liberty Safeguards (DoLS) had not been authorised yet but staff were keeping the person safe when we visited. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). None of the ten DoLS applications for people living with dementia had been authorised yet.

The environment was not dementia friendly when people living with dementia moved around the home. The manager told us ten people were living with dementia. Staff told us the home needed more colour to aid people living with dementia. There was an area wallpapered near the front door but most walls were a neutral colour. The steps leading down to the front door were a risk hazard for falling when people living with dementia continually walked passed. The corridors upstairs had dim lighting which would not aid people with sight impairment. The lounge/dining area was confusing with a television on each end of the room on different channels and a radio playing in the middle area. Some furniture required replacement. Some bedrooms had institutionalised notices on the wall to remind staff about fall prevention and a call bell monthly tick list check. Bathrooms required updating, there was no shower or bath on the ground floor and

no shower on the first floor. The maintenance person told us the shower had been disconnected there. There were checklists on the bathroom walls to aid staff which looked institutionalised. We recommend that the service explores the relevant guidance on how to make environments used by people with dementia more 'dementia friendly'.

People were supported by staff with access to a range of training to develop the skills and knowledge they needed to meet people's needs. One staff member told us their training was up to date. A senior member of staff told us they had completed all mandatory training updates for example moving and handling, first aid, fire safety and Mental Capacity Act. They had a NVQ level three qualification in health and social care. They told us they were the Care Certificate assessor for the service and knew about the new induction staff had to complete. They told us they knew a lot about dementia care and how to support people when they were anxious. The senior staff member gave an example of how they supported a person when they become anxious on their own. The senior staff member had completed medicine competency checks with staff and checked their medicine training self-assessments with them.

A programme of training to maintain and update staff knowledge and skills was in place and staff were informed when their training was due. Staff had completed a range of training to include dignity, health and safety, infection control, and food hygiene. Staff told us the manager ensured all their training was updated when required. One staff member told us they were starting diabetes training. The training record informed us that of the 26 care staff 23 had completed NVQ level 2 in health and social care. Training was planned and staff were able to request additional training during their individual meetings with the manager. One care staff member had requested additional dementia care training and he manager was organising it for them and other staff.

People were supported by staff that had individual supervision meetings and appraisals. Staff told us the individual meetings with the manager allowed them to discuss anything including their training needs. One staff member told us they had individual supervision meetings with the manager every three to six months. They had found them beneficial with regard to improving their practice by giving people more time to engage with them. Staff also completed an annual appraisal of their work with the manager.

People's dietary needs and preferences were recorded. The chef had a good understanding of people's dietary needs and kept a record of their likes, dislikes and any food allergies. People had a nutritional care plan with specific information. Where necessary people had their food and fluid intake monitored. The fluid charts were well recorded and included a daily target amount. The care staff knew which people were at risk nutritionally and had some weight loss. They had diet fortification to improve their nutrition. Milk shakes fortified with cream were provided twice a day. People's daily records had information about what they had eaten and complementary food drinks given were recorded. There was a choice of food for lunch and supper on the four week menu plan people had chosen from the night before. The menu was displayed in the dining room and people could also choose what they wanted at point of service. People could have what they wanted for breakfast including a cooked breakfast. The chef provided home cooked cakes and pastries which included finger food for example, sausage rolls and vol-au-vents for people reluctant to sit down and eat with a knife and fork. One person told us about the food, "Very nice, X [the chef] does us proud, we choose the day before and X makes us lovely sponge cakes and stews."

We observed people having lunch and good interactions were seen between people and the staff. People had a choice of drinks and staff promoted a calm unhurried atmosphere and assisted people when necessary. The home had the highest 5 stars hygiene rating from the food standards agency in 2015. Most people told us they liked the food and had a choice of meals. One person told us, "The food is lovely here, plain cooked meals not fancy food and I get a good choice and my favourite meal is roast dinners, we get a

lot of roast dinners here and it's edible, at night I drink water and I have biscuits." Another person said, "The food is generally very good and we get a choice." One relative told us. "Mum loves the food here she likes meat and two veg and she has no problem what she eats."

People had access to health and social care professionals. Records confirmed people had access to a GP, dentist, an optician, a chiropodist, continence assessor and mental healthcare professionals. Staff also accompanied people to hospital appointments when required. The district nurses regularly visited to complete wound care and take blood samples which were all recorded in the care plans. One relative said, "The doctor comes here to see her and mum doesn't see the dentist as she has false teeth and the chiropodist comes in about every six weeks."

Requires Improvement

Is the service caring?

Our findings

People were usually treated with kindness and compassion. One person told us, "The girls are nice, there is one that isn't and its always my fault", another person said "Staff are kind" and "one is bossy and says go back to your room." We discussed with the manager where staff had not treated two people with respect and compassion and she told us it would be investigated and additional training may be given to all staff. One relative told us, "They treat my mother fabulously they always knock on her door before they come in." One person told us, "Yes they treat me with kindness and respect and I think they are caring towards me and they always knock on my door before they come in to make sure I'm dressed." We observed staff speaking to people and their relatives in a friendly and welcoming manner. One person told us, "They [relatives] can come in anytime they like and go when they like."

People were encouraged to be independent. One person told us, "Like I said I clean my room, well bits of it and I manage to get around ok on my own". One relative told us "Yes they do [encourage independence], she still feeds herself and she goes to the toilet on her own." People got up and went go to bed when they wanted to. When staff engaged with people they used age appropriate language and the person's preferred term of address. One person told us. "They [staff] come and talk to me and I talk to them and they call me by my first name and they always knock on my door before they come in."

People were not always treated in a dignified way. People and relatives were asked about their choice of bathing and one person told us, "I don't like showers I like a bath which is just across the landing to me and I get a bath once a week, I have a strip wash every day." A relative said, "Mum has a shower every week and I'm happy with that and they give her a strip wash every day." There was no bath or shower on the ground floor and six people there had to travel in the lift to the second floor for a bath or shower. This was undignified when people were in their night clothes and one person said, "We used to have a day when we could have a shower, I don't like baths but now it's changed and I don't know when I get one now. I have to ask for it now and we have to go up by lift to the top floor and I don't like lifts and everything is old fashioned in the bathrooms." This was discussed with the manager who agreed having no shower or bath on the ground floor was not acceptable and they would discuss with the provider how to improve this for people's choice and dignity.

People's bedrooms were personalised and had photographs of their family and friends and their own treasured possessions in the bedrooms. A member of staff told us they always ate their lunch with one person to encourage them to eat as they had often refused to eat. They said when they take people out the person always goes with them as they don't like to be alone.

There was information in the entrance to the home for people and their relatives which included the services Statement of Purpose and the service users handbook all about the home. Other information informed people about safeguarding adults and children. A sample of menus and activities completed in February 2016 were available. Part of the first and second floor was no longer used so this had reduced the size of the home and the information supplied required updating. The latest CQC inspection report was available for people to see. There was no information about bereavement to assist relatives when required.

One person had an end of life care plan and was monitored for any signs of pain to ensure appropriate pain relief was given when required. Any changes were reported to the GP who had visited. Currently the person did not have any pain. The person's wishes had been discussed with their relatives and recorded. Healthcare professionals were involved in their care and the district nurses had visited. There was a detailed record of what the professionals had advised. The manager told us they were an end of life trainer and had chosen two staff to be champions for people's care during this time of their life.

Requires Improvement

Is the service responsive?

Our findings

People's care plans were not always reviewed and updated to ensure their current needs were met. Some care plans had not been adequately reviewed and did not include the person or their relatives in the reviews. Records we looked at required updating. For example a person with type two diabetes no longer required their blood glucose to be checked on alternate days. They had an annual blood test which checked their results during a three month period. Another person living with dementia was not communicating well as the care plan stated. This information had not been updated in their care plans. Some care plan reviews were signed by staff but were not checked to see whether they remained relevant. However, one relative told us, "Yes we get to see the care plan and its reviewed every three months." Where necessary health and social care professionals were involved.

People had their needs assessed before they moved into the home. Information had been sought from the person, their relatives and other professionals involved in their care. Information from the assessment had informed the plan of care and risk profiles. Care, treatment and support plans were personalised. The examples seen had detailed information and identified people's needs and choices. One relative told us, "They check on my mother every two hours she has fallen over a couple of times a month and usually at night but it has been during the day as well."

One person told us their fluid intake was monitored because of sodium levels and the staff told them when they had sufficient fluids. They had a well recorded fluid intake chart with a daily fluid target and the chart was totalled daily by the night staff. Another person told us they had requested to see their GP about a painful knee and the GP arrived the same day.

One new person recently admitted had been assessed by an occupational therapist, a continence assessor and the district nurses had visited to complete wound care. There was detailed information about continence and skin care. Food and fluid intake was recorded which included the daily target of fluid for staff to monitor. There was a detailed nutritional care plan as the person had lost some weight and the chef had been informed about the persons likes and dislikes. The person was living with dementia and they had a mental health assessment and the care plan outlined what they enjoyed and wanted to do. People had a night time care plan to ensure continuity of care during the night.

People's daily notes recorded their mood, what activity they were involved in, who had visited including professionals and relatives and their food and fluid progress. Staff also completed a monthly welfare record of personal care and related activities to include elimination and oral hygiene when applicable. A healthcare professional told us the care plans were really easy to read and the staff were helpful. The person they were visiting told them they really liked the home and the professional had observed staff and people were laughing and there was a positive atmosphere.

Handover between staff at the start of each shift helped to ensure that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. We found a handover record where a person had been identified as 'confused' and staff had been advised to send a

urine sample for analysis in case they had a urinary tract infection. We checked and the sample had been sent for analysis.

The home had been without an activity coordinator organiser for some time. We spoke with the activity coordinator who had recently returned from planned leave. They worked four days each week which sometimes included Saturdays. They had completed an activity training day the previous week called "Therapeutic Activities " and were very enthusiastic about their role. There was a two week activity plan which included pet therapy, arts and crafts, exercises, nail care, quizzes and music therapy.

The activity organiser told us they tried to ensure activities were person centred and included everyone. The care plans contained people's life histories which helped staff to know what they had enjoyed and might still be interested in. They had raised funds to take people out in a taxi or a mini bus to a local garden centre or shopping. One relative told us, "Mum likes painting, crafts, mind games and quizzes and there's always something to do here." One person told us, "There's hardly any activities to do we have our lunch and then just sit here doing nothing and we only get an entertainer in once a month I've only seen the activities lady once and never seen her again." We discussed activities with the manager. They told us the activity co-ordinator had returned two weeks ago so they were certain activities would improve now.

We observed the care staff enthusiastically completing an activity with people when the activity coordinator was not there and they told us how much they liked doing art with people and taking them out. During the inspection there was Fete to raise funds for charity and the local press were involved. Relatives and friends came and there was a lively atmosphere in the communal room with a singer, tombola stall and families had donated cakes to sell.

One person told us their family took them out and they used to like gardening. They kept an eye on the garden at the home and told us someone had trimmed the mint - too short. The staff told us the person goes out in the garden a lot and has a bird book they refer to. They also planted seeds in March 2016. The grounds were well kept and there was seating around the gardens for people to use.

How to raise a concern and the complaints procedure was on notice boards in the home and included the relevant agencies and CQC. There were no formal complaints recorded but a recent concern by a relative had been recorded in the person's daily record. We spoke with the relatives of the person and they had been included in a care plan review recently to discuss their concerns and told us staff were respectful and they were kept updated with their relative's progress. Two concerns were recorded as completed in December 2015. One person told us. "No never needed to complain but my daughter has about the skirting boards in my bedroom being dirty." Another person told us, "No never had to complain but if I did I wouldn't know who to."

Requires Improvement

Is the service well-led?

Our findings

Internal audits had identified shortfalls and action had not been taken to provide a clean environment for people. Quality assurance systems were in place to monitor the quality of the service being delivered and the running of the home but there were times when action had not been taken to improve the service. We looked at a sample of audits for example the quarterly environmental audit and the May 2016 improvement plan. The need for cleanliness and to decorate the home and replace carpets and furniture had been highlighted. Carpets were replaced when needed and two had recently been replaced. A medicine audit was completed monthly and the actions had been completed. Random checks on care plans were completed monthly, usually two care plans. The new manager would ensure all care plans were checked as there had been some shortfalls in record keeping.

The service had been without a manager for several months. A recently recruited manager had been appointed at the end of May 2016 and the intention was for them to become the registered manager for the service. The area operations manager, the provider's representative, had been supporting the service and was supporting the new manager to ensure a smooth transition for people and staff. The new manager was experienced and was enthusiastic about their new role. One relative told us, "The new manager and the old manager are very approachable and I can sit and talk to the manager." Staff told us the new manager was supportive and approachable. One staff told us, "The new manager listens" and "X [area operations manager] definitely listens." There was a plan to recruit a deputy manager to support the new manager.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. The latest Family Satisfaction Survey results had highlighted people were not satisfied with the cleanliness, laundry and activities. There were actions to improve these areas. People and relatives were most satisfied with the respect people and their relatives were given. One person told us, "Yes I'm happy with the care home and I can't fault them, the staff, always someone to talk to and always someone to help and you can see for yourself they're fantastic.

In the entrance hall there was a meal time survey people and their relatives could complete and post in the box provided. Ten people had completed the meal time satisfaction survey this year. People had commented there was no second helpings and they wanted more pasta dishes on the menu. A mealtime observation completed four monthly in April 2016 had recorded people were offered second helpings.

The service information review was completed monthly by the area operations manager. The latest review in May 2016 identified areas for improvement and this was ongoing and would be checked at the next review. For example, the operations manager wanted to ensure the service had copies of peoples Lasting Power of Attorneys to protect people when decisions were made on their behalf.

Meetings were held with staff, people and their relatives. We looked at the minutes for resident and relative's meetings for March and June 2016. Information was provided about the Queen's birthday garden party and special clothes tags to prevent items going missing. In June one relative commented the cleaning was 'pathetic' and the operations manager agreed to meet with the housekeepers to improve the cleanliness.

One person told us, "Well I like it here, the staff here are very good to me and I can't think of any changes I would make."

Staff meetings were held in May and June 2016. Staff were reminded to ensure there was meaningful engagement with people in the lounge and to communicate well during handover sessions to ensure people's progress was known by staff. In the June meeting the lack of care plan reviews with relative's was highlighted for improvement. The new manager had scheduled people's monthly care plan reviews and a date was added when the review was completed. One relative told us they were unaware a care plan review had recently been completed for their relative who was living with dementia.

The Quality Review team for Gloucestershire County Council had visited in May 2016 and required improvements. The area operations manager had provided them with an improvement plan where most areas would be completed by the end of June 2016 and some were ongoing.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who use services were not protected against the risks associated with inadequate cleaning and infection control procedures. Regulation 15 (1) (a).