Hazelroyd Limited

Hazelroyd Nursing Home

Inspection report

31-33 Savile Road
Halifax
West Yorkshire
HX1 2EN

Tel: 01422362325

Date of inspection visit:
28 June 2017

Date of publication:
02 August 2017

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 inspection was unannounced and took place on 28 July 2017. There were 30 people living in the home when we visited.

Hazelroyd Nursing Home provides residential and nursing care for up to 30 older people some of who may be living with dementia.

The last inspection was in August 2015. At that time we gave the service a rating of 'Good' but found breaches relating to consent and management of Deprivation of Liberty Safeguards (DoLS). We found improvements had been made in this area but recommend care files are updated to make sure people's consent to sharing information with family is sought and clearly recorded.

Since the last inspection the registered manager retired and a new manager was appointed. The new manager was currently going through application to CQC to become the 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.

People who used the service told us they felt safe and staff knew how to recognise and report abuse.

Systems were in place to promote safety within the home. This included checks on the environment and review of accidents and incidents. However more work was needed on plans for supporting people in the event of an emergency.

Improvements were needed to make sure the home was clean and the risk of cross infection was minimised.

We recommended the provider addressed specific areas we had identified, and ensured their refurbishment programme was put into immediate action so that good infection control measures were in place.

People's medicines were for the most part managed safely. However, procedures for use and storage of prescribed thickening agents needed to be improved. We made a recommendation in relation to this.

Risks to people's personal safety were assessed and plans put in place to mitigate the risk.

People spoke very highly of the staff but we found there were not always enough staff available to meet people's needs safely.

We found staff were being recruited safely. Staff received appropriate training and they told us the training

was good. Staff told us they enjoyed working at the home, felt supported by the manager and received supervision and appraisals.

We heard staff asking people for consent and giving explanations before supporting them. We found the service had made improvements to make sure they were working in line with the requirements of the Mental Capacity Act 2005 and the requirements relating to Deprivation of Liberty Safeguards (DoLS). However staff needed to be sure about people's consent to share information with families.

People told us they enjoyed the food and we saw people were offered a choice of food and drinks which took account of their likes, dislikes and nutritional needs. However, clearer actions needed to be recorded when people's dietary intake was not sufficient to maintain their health.

We saw people were supported to maintain their health and had access to the full range of NHS services.

People told us staff treated them with dignity and respect and whilst we observed some good practice, we also observed some examples of where improvements were needed.

People told us their family and friends were made welcome in the home and were offered refreshments during their visits. We saw staff encouraged the involvement of people's families and friends in the home.

Staff knew people well and we saw some good examples of care and consideration of people's privacy and dignity. However we also noted some examples of where better practice was needed to make sure people were cared for in a way that met their privacy and dignity needs.

People were supported to take part in a variety of in house activities but there was little interaction for those who were unable or chose not to take part in the activities.

There was a complaints procedure in place and we saw action was taken in response to complaints or concerns.

People who used the service and their relatives had the opportunity to share their views by means of meetings and surveys.

Systems were in place to monitor, assess and improve the quality of the services and a comprehensive refurbishment plan was in place.

We found the provider was in breach of Regulation 18 (Staffing).

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

The service was not consistently safe.

There were not enough staff available to meet the needs of people who used the service.

Staff knew how to recognise and report abuse and this helped to keep people safe.

Medicines were managed safely but thickening agents were not used or stored safely. Improvements were needed to make sure the home was clean and the risk of cross infection minimised.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received the training they needed to carry out their duties.

Staff understood their responsibilities in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards but did not always check people's consent to information sharing.

People's dietary preferences were catered for and their nutritional needs were met. However, actions where people were not taking sufficient nutrition to maintain their health needed to be clearly recorded. People were supported to access the full range of NHS services to ensure their healthcare needs were met.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Improvements were needed to make sure people were consistently treated with care and respect and to ensure people's privacy and dignity.

People's friends and relatives were welcomed and encouraged

to participate in activities and other aspects of the service.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were receiving care and support to meet their needs. However, this was not always done in a timely manner. Care plans were not always up to date and there was a lack of involvement of people in the development and review of their care plans.

Activities were available for people to join in but there was little engagement for those who were unable or chose not to join in the activity.

There was a complaints procedure in place to make sure complaints or concerns were dealt with in an appropriate way. People had complimented the service on the care provided.

Is the service well-led?

Requires Improvement

The service was not consistently well led

Quality assurance systems were in place which identified issues were actions were needed and were effective in making on-going improvements to the service. However sufficient action had not been taken to address the issues we found during the inspection.

The views of people using the service were sought and valued.

Hazelroyd Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 28 June 2017 and was unannounced. The inspection was carried out by three inspectors and an expert by experience with experience of services for older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioning and safeguarding teams and the clinical commissioning group (CCG).

On this occasion we had not asked the provider to complete a Provider Information Return (PIR) which 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 observed how care and support was provided for people. We spoke with nine people who were living at the home, four relatives, two nurses, seven care workers, the cook, the activities coordinator and the manager.

We looked at three people's care records, three staff files, six medicine administration records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms and communal areas.

Requires Improvement

Is the service safe?

Our findings

The manager told us they used a dependency tool to calculate the numbers of staff needed to ensure people's care and support was safe. We looked at the calculation for June 2017, which showed, according to the tool used; that the home was staffed below the required numbers of hours for nursing. We made observations during our inspection which evidenced a lack of staff. For example, lounges were left for long periods of time with no member of care staff present and staff had little time to chat to people. We saw there was no access to call bells when people were in the lounges or conservatory.

One visiting relative told us staff were not always able to spend a lot of time with people. They said, "They are always having to be off somewhere, cleaning rooms or something. They should be able to be in here [a lounge] but they just don't have the time." Another relative said "Generally there are enough staff."

The manager told us there were two care staff and one nurse at night, covering four floors. Most people who used the service required two members of staff to provide assistance, meaning staff would not be able to respond to more than one person needing assistance at a time. Staff had no means of communicating to each other between floors. We raised this with the manager who told us new cabling had been installed to enable an internal phone system to be fitted, and they showed us walkie talkies which had been purchased for staff use.

We discussed staffing levels with the manager, and they told us they had identified this as an issue and had discussed it with the provider. We saw meeting minutes which confirmed this, although no action had been taken as this required permission from the provider.

When we spoke with staff they told us they struggled to meet people's needs at times and felt more staff were needed to make sure people were safe.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations.

We reviewed the recruitment files of two care staff and one nurse. We saw the provider kept records which evidenced a safe recruitment process was followed. Written applications and notes made at interview evidenced people's suitability for their role. The provider made checks including those relating to identity, references from previous employers and contacted the Disclosure and Barring Service (DBS). The DBS is a national agency which holds information about people who may be barred from working with vulnerable people, and making checks with them helps employers make safer recruitment decisions.

When we asked people if they felt safe living at the service they told us "Yes, it's a care home and I do feel safe here. There are enough staff on to look after us." and "I do feel safe, yes. A lot safer than the flats I was living in that's for sure. There are enough staff, and when there aren't they get in people from the agencies."

We saw there were safeguarding policies and procedures in place and these were also on display. We spoke

with two members of staff about their understanding of safeguarding and what they would do if they thought people who lived at the home were at risk. Both of them told us they would not hesitate to report any concerns to the manager, senior people within the organisation or the local adult protection unit. We saw the registered manager had made appropriate referrals to the safeguarding team when this had been needed. This showed staff understood how to keep people safe.

We saw Personal Emergency Evacuation Plans (PEEPs) were contained within care files. However, the ones we looked at included only the detail of people's usual mobility needs. The manager told us they had recognised this and had developed a spread sheet which was located in the evacuation box at the front door and included information about how people would respond to fire alarms and how they would need to be evacuated in an emergency. The manager told us that the information in the spread sheet was to be transferred to new PEEP forms which they were about to introduce.

We saw the home used the 'Herbert Protocol' for missing persons. This is a joint protocol with local police and includes a form held within care records to give a description of the person should they be missing from the home.

We checked the systems in place for receipt, storage and administration of medicines. We saw two medicine trolleys were stored in the main hallway of the service. Whilst these were locked and safely chained to the wall the storage of the trolleys in this area detracted from the homely environment. The manager confirmed to us that ambient temperatures of this area were not taken and therefore we could not be assured that the medicines contained within the trolleys were stored within the temperature recommended by the manufacturers. Temperatures of the medicines fridge were recorded daily.

We looked at a sample of medication administration Records (MARs). We saw times of administration had been highlighted for ease of reference and signatures of administration had been made appropriately. Where the medicine had not been given, an explanatory code had been used.

Most medicines prescribed on an 'as required' (PRN) basis had a protocol in place to say when and in what circumstances the medicine should be given. However, for one person we saw a PRN protocol was in place for a medicine not prescribed on a PRN basis and a protocol was not in place for the PRN pain reliving medicine. This was immediately recognised by the manager who asked the nurse to make the necessary changes.

Some prescription medicines contain drugs which are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CDs). We saw controlled drugs were stored appropriately and records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff. In addition, twice daily checks were made of the balances and a monthly manager's check made. We checked three CDs and found the balances to be correct.

We saw some people had been prescribed a thickening agent to minimise the risks of choking on fluids. We saw a tub of thickening agent on top of the medicine trolley in the hallway leaving it accessible to people who used the service. Thickening agents are prescribed medicines for individual use only and need to be kept securely. An NHS England patient safety alert in January 2015 identified the risks of asphyxiation if the powder was accidentally swallowed. The thickening agent was removed during the inspection and safely stored.

We saw two tubs of different thickening agents in the kitchen cupboard. Staff told us they used these for all of the people who needed it rather than using the individually prescribed tubs. Additionally, when we asked

staff who had which thickening agent they gave us different answers. This meant people were not always being given the correct thickening agent and individual prescriptions were used for different people. We recommend that the service considers the National Institute for Health and Care Excellence (NICE) Guidelines for Managing Medicines in Care Homes.

Although many areas of the home were clean, we identified some items which were not. For example, there were tears in the fabric of some chairs and damage to the covering of a metal frame used in one toilet which meant cleaning and infection control practices would not always be safe. We saw these issues had been identified within the manager's audit and refurbishment programme.

We recommended the provider address specific areas we had identified, and ensured their refurbishment programme was put into immediate action to ensure good infection control measures were in place.

None of the people we spoke with raised any concern in relation to cleanliness. One relative told us, "If anything, they change the bed more often than they need to. At the last place (relative) was at, they waited until the bedding was, well, dirty. Here, they do it when they don't really need to."

Risks to people's personal safety were assessed and plans put in place to mitigate the risk. This included a falls risk assessment which we saw in one file, had been updated following a recent fall.

The provider ensured appropriate testing and certification of equipment and fittings was carried out. For example, we saw regular testing of portable electrical equipment, lifting and hoisting equipment, fire safety systems and equipment such as fire extinguishers, and electrical and gas systems. In addition we saw a number of environmental and task risk assessments were in place. Where risk assessments showed improvements could be made we saw action was taken. For example, the provider had ensured a fire risk assessment had been carried out and the manager had developed and completed an action plan to ensure all recommended improvements had been made. Records showed staff took part in regular fire drills.

Accidents and incidents within the home were managed well. We saw reports detailed the time, place and date of each incident, together with a description of the incident, actions taken at the time and recommendations for further actions. This showed the manager was able to ensure lessons learnt improved the care and support provided in the home. Referrals to safeguarding authorities and the CQC were made as required. We saw copies of guidance used in the investigating of incidents were kept in the file. These included Calderdale Council's falls protocols for care homes and NHS England safeguarding guidance. Accidents and incidents were reviewed at the end of each month to help identify any emerging trends.

Requires Improvement

Is the service effective?

Our findings

We looked at the support staff received to help them remain effective in their roles. We looked at the training matrix, which showed what training staff had received and when. We saw this included fire safety (theory and practice), safe manual handling, Mental Capacity Act (MCA), falls management, equality and diversity, and safeguarding for care staff. Nurse training included person-centred planning, diabetes, skin integrity and end of life care. We saw most dates were recent, and the manager confirmed they had worked to bring training up to date since they started in post.

The manager told us they aimed to provide staff with supervision every six to eight weeks, although the provider's target as stated on the matrix was a minimum of six sessions per year. We looked at the records of this, and saw supervisions were carried out for a variety of reasons, described as 'themed', 'clinical' or 'situational'. Themed supervisions were planned to meet a variety of training refresher needs. We saw plans to deliver these for subjects including infection control, MCA and Deprivation of Liberty Safeguards (DoLS), communication and teamwork, and fall prevention. Situational supervisions were held to react to situations which staff had faced in their work.

We looked at the records relating to supervision and appraisal activities. We saw staff had received supervisions during the year, and this had happened in a way that showed the manager would meet the provider's target.

The appraisal matrix recorded when staff had received an appraisal, but did not show advance planning for supervisions that would be due later in the year. All nursing staff had received an appraisal during the present year.

Care staff told us that nursing staff rarely worked with them in the delivery of care and they appreciated the manager working some shifts alongside them. They felt this was supportive and helped them in their learning.

The Mental Capacity Act 2005 (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 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 are called the Deprivation of Liberty Safeguards (DoLS).

We saw mental capacity assessments had been undertaken for people who used the service. Where people had been assessed as not having capacity, DoLS applications had been made appropriately. We looked at the DOLS authorisation for one person and saw there were two conditions applied which detailed actions staff had to take. We saw both of these conditions had been complied with through the best interest process.

The manager told us they maintained a record of which people had DoLS authorisations and when they were due for renewal if needed. They also told us they had arranged for a member of the local authority DoLS team to come to the home to speak with staff. Staff we spoke with understood about the MCA and DoLS. This meant the service was working within the principles of the MCA.

We saw various consent forms within care files. These were for such as use of photographs and administration of medicine. We looked at one which had been appropriately signed by the person's relative as they were the named nominated person in the person's DoLS.

However, we saw from one person's file that a telephone call had been made to a person's relative to tell them the GP had been to see their relation. We saw the person was assessed as having full capacity but could not see they had consented to their relative being informed of the GP visit. When we asked the nurse about this they told us they always informed people's family about medical visits as that is what they had been instructed to do by previous management.

We recommend care files are updated to make sure people's consent to sharing information with family is sought and clearly recorded.

People told us they enjoyed their meals. One person said "The food is good. You get a good choice as well. There are certain meals that they do every day, like sausage and mash, but you don't have to have it. There's a choice. I like it that they know how I like foods, such as eggs, they know that I don't like fried eggs to be hard, I prefer a soft yolk and the staff here know that's how I like them." Another person told us they could choose whatever they liked for breakfast.

The Manager told us they had prioritised the dining experience and good nutrition, they said "We are working all the time on producing a balanced, nutritious diet for all our residents." This was confirmed by a member of care staff who told us "The new manager though has put a better diet in place and there is a lot more emphasis on nutrition and giving the residents a much more balanced diet."

We spoke with the cook who told us about the new four week menu rolling menu that was about to be introduced. They told us menus would be available on dining tables with an alternative option menu. We saw samples of the new menus.

The cook told us they were informed of people's nutritional requirements through forms completed by care staff. We saw a file containing these forms in the kitchen. The cook told us they used various means of fortifying food for people who needed a high calorie diet due to weight loss or being nutritionally at risk.

We sampled the midday meal and found it to nicely cooked, appetising and tasty.

We saw a dining table had been set up in the conservatory with a notice on it advising visitors that they were welcome to come and enjoy a meal with their relative. We considered this to be a positive way to assist people living at the home to maintain relationships with people important to them.

We saw plans for the refurbishment of the dining room which included new crockery and table wear. The manager told us they had recognised dignity issues with the use of plastic beakers and were in the process of ordering new mugs and cups.

Although people were provided with drinks and snacks at various times during the day, we had to ask staff

on two occasions for drinks for people who told us they were thirsty.

We saw a spread sheet maintained by the manager which clearly identified people's weights, dietary requirements, results of nutritional assessments and the level of risk.

However, we saw food and fluid intake charts for people who needed their intake monitoring were not always completed in a timely manner and where the charts showed very minimal intake, there were no recorded actions other than such as to encourage fluids.

In the three care records we looked at we saw people had been seen by a range of health care professionals, including GPs, community matrons, district nurses, dieticians and opticians. Records showed staff requested visits from health care professionals as the need arose. We saw from one person's records that the community matron had given advice about a person's nutritional requirements. This advice had been incorporated in their care plan and on their nutritional needs form. This showed staff acted upon advice from healthcare professionals and we concluded people's health care needs were being met

In addition to this the manager told us staff were working with the 'Dementia Alliance' to support people living with dementia and their relatives.

Requires Improvement

Is the service caring?

Our findings

People told us they felt well cared for. One person said, "The staff are very good really. I always get my medication on time and they do ask my permission before giving me care" and another told us "It's lovely here. The staff are really nice. Although it's a home, it's better than living on my own. I have friends here that I see every day and although the staff sometimes are busy, they do care about us."

Another person told us "The staff are very good with my (relative) when (they) visit. (Relative) can pop in anytime and they make (them) welcome." Although this person had only lived at the home for a couple of months, we observed staff were on first name terms with their relative and offered her tea and biscuits on arrival. Another person said "My (relative) visited early today as (they) had to go to work from here. The staff made (them) some breakfast which I thought was very nice.
Although staff did not have time to sit and chat with people, we observed a number of warm and caring interactions as part of meeting people's care and support needs. One member of staff told us, "I was going to go and study for my nurses exams, but I love working here. You get to properly care for people."

However, we also saw occasions when staff were not as caring. For example, one person was assisted to move from the dining room to a lounge in their wheelchair. The person was holding a mug of tea and expressed concern they would spill it as they were moving. The member of staff told them not to worry and carried on.

We also noted long periods of time when there were no care staff present in lounges, and people using these did not have access to call bells. This meant people may not always be able to ask for assistance when they needed it.

We saw examples of staff being respectful of people's privacy and dignity. For example, when supporting people to use the bathroom, we observed staff asking permission before supporting people from armchair to wheelchair via the hoist. They asked permission and gave an explanation before attaching the sling and moving the person in the hoist. Once the person was in the bathroom, staff showed the person where the nurse call was and told them they would wait outside until they had finished. Staff knocked and asked permission before re-entering the room.

However we also observed occasions when staff spoke about people who lived at the home in front of others. On another occasion we heard a person asking to be taken to the toilet. There were no care staff available in any of the main communal areas and the activity co-ordinator told the person they could not help them but would find staff to do so. After half an hour we heard the person asking again for help to go to the toilet. We asked the activities co-ordinator why they hadn't found staff to help the person and they told us they couldn't leave the area. We told them we would make sure people were safe whilst they found staff. We observed the person waited for over 45 minutes until they were assisted to the toilet. This further demonstrated the lack of appropriate staffing.

We also noticed that people in bed had their doors held open by door guards. This meant anybody walking

past the room had full view of the person. Staff told us this was so they could "keep an eye on people". When we looked at the care records for one of these people we did not see any evidence of the person being asked about their wishes in this regard.

We also noted that bathroom and toilet doors had frosted glass panels in them. Although this gave some privacy, it was possible to see the person through the glass panel. We also noticed the door to a bedroom leading from one of the lounges had a moveable screen placed in front of it. The door had clear glass panels and despite the screen it was possible to see into the bedroom.

One person told us staff respected their privacy, they said "Staff always knock before entering (the bedroom) and that hasn't been the case in other homes that I've lived in. If you don't answer, they don't come in either."

Religion or belief is one of the protected characteristics set out in the Equalities Act 2010. Other protected characteristics are age, disability, gender, gender reassignment, marital status, pregnancy and maternity status and race.

We saw one person living at the service was originally from another country and did not have English as their first language. Staff told us the person spoke English well; however we did not see any evidence of any consideration having been given to what staff might be able to do to recognise and celebrate this person's ethnicity, such as providing familiar food from their country of origin.

Following the inspection the provider informed us that staff have tried to speak with the person about their history and preferences but the person has declined to discuss this.

We saw plans were in place for end of life care and where appropriate 'Do not attempt resuscitation' (DNAR) directives were in place. The manager told us that the DNARs for people recently admitted to the home were being renewed by the appropriate health care professionals.

Requires Improvement

Is the service responsive?

Our findings

Each person had a care file in place which contained a range of assessments and care plans. Care plans were detailed and included people's preferences but lacked a person centred approach and evidence of the person or, where appropriate, their family being involved with the development and review of care plans.

Relatives we spoke with told us "I don't know anything about a care plan but my relative is quite new here. (Relative) only moved in this April but I haven't heard the mention of a plan of (relative's) care as yet" and "There has been no mention of a care plan since they've been here. I've spoken to no-one about it; I've just been given a booklet.

Reviews of care plans lacked consistency. For example we saw one person's care plan in relation to falls had been reviewed and re-written following a fall. However other care plan reviews just stated 'Care plan to continue' for several months rather than any review of the effectiveness of the care plan or any changes to the health and wellbeing of the person concerned.

We saw one person's continence care plan said they used a catheter. However, the word 'removed' had been written at the side of this. The person's care file also contained a catheter change book which indicated a change of the catheter had been due several months previously. This meant we could not be confident whether the person had a catheter or not. The registered manager confirmed to us that the person did not. It is important that care plans clearly detail the person's needs and circumstances and a new care plan put in place when changes have occurred.

When we asked care staff if they looked at care plans they told us they did not routinely do this and that only the nursing staff wrote in them. This meant care plans were not used effectively as a working document which made sure all staff were aware of people's needs and how they liked staff to support them

The manager told us they had recently introduced a key worker system and planned to involve key workers much more in care planning. They told us this should encourage a more person centred approach. A member of staff we spoke with told us they looked forward to this and said staff had been made key worker for people they felt responded well to them.

The activities coordinator showed us the 'All about me' booklets they had developed with people who lived at the home. These booklets are valuable in helping staff to get to know people, what they like and don't like, what they have done in their lives and people who are important to them.

However, the activities co-ordinator kept these documents in a file separate to care plans and care staff we spoke with were not aware of them.

During the morning of our visit we saw the activities coordinator engaging a number of people in watching a video about the Queen and answering questions about the royal family. There were cake stands with cakes and biscuits and people were being served drinks in china cups and saucers. People were clearly enjoying

this activity.

We also saw a notice advertising a singer coming to the home. Relatives were invited to join in and the notice said a family buffet would be served. The manager told us events such as this were held regularly.

However, we noticed that people who did not choose, or were not able to join in with the activity, spent long periods of time without any interaction. For example two people in the lounge where the activity was not taking place received little interaction from staff throughout the morning. The television was on which neither were watching. On speaking with them we found they communicated well and enjoyed our conversation.

We met with another person who, through their own choice, spent all of their time in bed on the lower ground floor. They chose not to have any television or radio. We found they responded very well to us going into their room for a chat and we were concerned that if staff did not have the time to spend with this person there was a risk of them becoming socially isolated.

We saw 'Return from Hospital Assessments' were in place for people who had needed to leave the home for a hospital stay. This meant staff had knowledge of how the person's needs might have changed.

We looked at the care for a person who had recently moved into the service from another home. Daily records detailed the person's admission but no record, since their admission, had been made of staff spending time with the person to orientate them to their new surroundings or asking them how they were settling in.

We looked at records of complaints received by the home and saw there was a process in place to ensure these were managed and resolved in an appropriate manner. Complaints were investigated, and the outcome communicated in writing to the people concerned. In addition we saw the home had received a number of compliments. Comments included, 'It is a great comfort to know that during her last years, (name) was treated with compassion and kindness,' 'I would like to thank you for the care and kindness you all showed to my mum during her short stay with you,' and 'Your kindness can never be repaid.'

Requires Improvement

Is the service well-led?

Our findings

There was a manager in post on the day of our inspection; however they were not registered with the CQC. They told us their application had been submitted. The manager had support from nurses, care staff, ancillary staff and a care co-ordinator who split their time between administration and care delivery. In addition to the team at the home, the manager also had support from the provider and an independent consultant.

Staff we spoke with told us they had faith in the new manager and felt they were the right person to make improvements within the service. One staff member said (manager) is supportive of the staff and I feel the home is moving in the right direction"

We saw the manager followed a programme of governance that enabled them to monitor, measure and improve the quality of the service. Regular activity included audits of infection control practice, medicines, care plans, catering, health and safety and analysis of accidents and incidents. We saw action was taken where required. There was a home audit and service action plan which was used to manage this process. The manager told us they wanted to involve more staff in governance activities. They said they would start by involving heads of departments, but wanted to develop a 'quality forum' which would discuss ways in which the home could improve.

We saw the manager had audited the home and having identified issues within the service that needed to be resolved including the development of a comprehensive refurbishment plan, which had identified some issues. However sufficient action had not been taken to address the issues we found during the inspection, in particular staffing arrangements. The manager told us, "I have asked (the provider) for control of a budget to enable me to put this programme into action. This has been agreed." We saw the manager had identified high, medium and low priorities, and some redecoration of the home was in progress.

In addition to audit activity we saw the manager ensured regular checks and testing of equipment took place. This included wheelchairs, mattresses, fire systems and emergency lighting.

The manager told us their vision for the service was for one which focused on the safety and well-being of people in a person-centred way. They said they had communicated this to staff in a variety of ways, including at meetings and whilst working alongside them to deliver care. The manager told us they had begun to challenge some established attitudes which had made some staff resistant to change.

This showed us the manager was committed to development and improvement of the service.

The manager told us that visits were made to the home on a monthly basis by the provider and additional monthly visits were made by the independent consultant in order to complete audits of quality and safety.

There were meetings that residents and their relatives could attend in order to contribute to the running of the home. We looked at the minutes of the two meetings held most recently and saw areas of discussion

included asking for feedback about activities, an area where families could make drinks, introductions to the manager when they had taken up their post, and proposed changes to the environment and menus for meals. We saw the manager had also asked for volunteers to help start a committee to have more direct involvement with the running of the home, including participation in the recruitment of staff and giving presentations to staff on what it was like to have a relative using the service.

A further meeting was advertised with items for discussion outlined along with the opportunity for people to ask questions.

This meant the manager was seeking opinions of people in plans for improvements within the home.

We saw the last survey had been carried out in May 2016. The manager told us they had asked the provider to send out questionnaires again; however this had not yet taken place at the time of our inspection.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not available in sufficient number to meet the needs of the people living at the service in a timely manner