

# Four Seasons (Bamford) Limited

## Laburnum Court Care Home

### Inspection report

18 Priory Grove  
Off Lower Broughton Road  
Salford  
Greater Manchester  
M7 2HT  
Tel: 001617080171  
Website: [www.fourseasons@fshc.co.uk](http://www.fourseasons@fshc.co.uk)

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### Ratings

#### Overall rating for this service

Requires improvement



Is the service safe?

Good



Is the service effective?

Good



Is the service caring?

Good



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



### Overall summary

This was an unannounced inspection carried out on the 03 November 2015.

Laburnum Court provides nursing and personal care. It is one of 43 locations registered under the provider, Four Seasons (Bamford) Limited. The home has a dedicated unit for dementia care on the ground floor called 'The Lowry.' On the first floor the service has a nursing and personal care unit, which is called 'The Priory.' The home is situated in a residential area of Salford.

At the time of our visit, the current home manager was in the process of registering with the Care Quality Commission as 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.

# Summary of findings

At the last comprehensive inspection carried out in January 2015, we found that the registered person had not protected people from the risks associated with infection control, because the service had not maintained appropriate standards of cleanliness and hygiene. Following a further focused inspection carried out in July 2015, we found that the service was then meeting the requirements of regulations.

During this inspection we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 (Part 3). You can see what action we told the provider to take at the back of the full version of this report.

We found care files were very cumbersome and not sequential in their presentation order. A number of care plans were incomplete and lacked up to date information, such as people's weights. We found instances where reviews had not been documented. A number of care plans did not contain any written consent for the care and treatment provided.

We found one care plan that did not accurately represent skin integrity issues for a person who used the service. We found a pressure sore had been recorded as a grade one sore, however, following our review it transpired the pressure sore should have been graded as a grade two sore. We also found that a duplicate care file had been created for one person who used the service.

This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 (Part 3), good governance, because the service had failed to maintain accurate and complete contemporaneous records for people who used the service.

People living at Laburnum Court Care Home and their relatives consistently told us that they or their loved ones were safe living at the home.

On the notice board in the main reception area, we saw illustrations and pictures representing safeguarding and what action to take. Contact details of the local safeguarding team were also displayed together with service's 'whistleblowing' policy and procedures.

As part of the inspection we checked to see how the service managed and administered medication safely. On

the whole, we found people were protected against the risks associated with medicines, because the provider had appropriate arrangements in place to manage medicines safely.

We found there were sufficient numbers of staff on duty during the day to support people who used the service.

Staff confirmed they received regular training in subjects such as safeguarding, first aid and the Mental Capacity Act, which we confirmed by viewing the training records.

People had access to healthcare professionals to make sure they received effective treatment to meet their specific needs.

We looked at a sample of 15 care files and found that individual nutritional needs were assessed and planned for by the home. We saw evidence that nutritional and hydration risk assessments had been undertaken by the service.

Everyone we spoke with thought the staff were kind and caring.

As part of the inspection we checked to see that people living at the home were treated with privacy, dignity and respect. People who used the service told us that their dignity and privacy was always respected.

People and relatives told us they were involved in making decisions about their care and were listened to by the service.

Though people told us that they were involved in determining the care their loved one's received, this was not clearly documented in their care plans.

During the inspection, we saw several examples of where staff at the home had been responsive to people's needs. For example where people were required to be weighed weekly or monthly, there were records to suggest this had taken place.

We found the provider had effective systems in place to record, respond to and investigate any complaints made about the service. The complaints procedures were on display in the reception area.

Since our last inspection in January 2015, we noted a number of improvements had been made by the service to address our concerns at that time. This included a new management structure involving the appointment of a

# Summary of findings

new manager, supported by a deputy manager and clinical lead. All staff we spoke with commented on the positive changes made to the service following the appointment of the new manager.

We found the service undertook a comprehensive range of audits and checks to monitor the quality of services provided.

We looked at how the service learnt from any incidents, complaints or safeguarding matters. The service demonstrated to us where lessons had been learnt, what immediate action had been taken and where action plans had been put in place to address deficiencies.

Providers are required by law to notify CQC of certain events in the service such as serious injuries, deaths and deprivation of liberty safeguard applications. Records we looked at confirmed that CQC had received all the required notifications in a timely way from the service.

# 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?

We found the service was safe. We found people were protected against the risks of abuse, because the home had appropriate recruitment procedures in place. Appropriate checks were carried out before staff began work at the home to ensure they were fit to work with vulnerable adults.

We found people were protected against the risks associated with medicines, because the provider had appropriate arrangements in place to manage medicines safely.

We found there were sufficient numbers of staff on duty during the day to support people who used the service.

Good



### Is the service effective?

We found the service was effective. Staff confirmed they received regular training in subjects such as safeguarding, first aid and the Mental Capacity Act, which we confirmed by viewing the training records.

All staff we spoke with confirmed they received supervision and appraisals, which we verified by looking at supervision records and a supervision matrix.

We looked at a sample of 15 care files and found that individual nutritional needs were assessed and planned for by the home.

Good



### Is the service caring?

We found the service was caring. Everyone we spoke with thought the staff were kind and caring.

Throughout our inspection, where we observed interaction between staff and people who used the service, it was kind and caring.

People and relatives told us they were involved in making decisions about their care and were listened to by the service. They told us they had been involved in determining the care they needed and had been consulted and involved when reviews of care had taken place.

Good



### Is the service responsive?

Not all aspects of the service were responsive. Care plans appeared to have a standard one monthly review, though this was not always documented. These reviews were very brief and non-informative in terms of the effectiveness of the prescribed care being delivered.

During the inspection we saw several examples of where staff at the home had been responsive to people's needs. For example where people were required to be weighed weekly or monthly, there were records to suggest this had taken place.

Requires improvement



# Summary of findings

We found the provider had effective systems in place to record, respond to and investigate any complaints made about the service. The complaints procedures were on display in the reception area.

## Is the service well-led?

Not all aspects of the service were well-led. We found care files were very cumbersome and not sequential in presentation order. A number of care plans were incomplete and lacked up to date information, such as people's weights. We found instances where reviews had not been documented.

Since our last inspection in January 2015, we noted a number of improvements had been made by the service to address our concerns at that time. This included a new management structure involving the appointment of a new manager, supported by a deputy manager and clinical lead.

We found the service undertook a comprehensive range of audits and checks to monitor the quality of services provided.

**Requires improvement**



# Laburnum Court Care Home

## Detailed findings

### Background to this inspection

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

This inspection took place on 03 November and was unannounced. The inspection was carried out by one adult social care inspector, a specialist advisor in nursing 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.

We reviewed information we held about the home. We reviewed statutory notifications and safeguarding referrals. We also liaised with external professionals including the local authority, local commissioning teams and infection control. We reviewed previous inspection reports and other information we held about the service.

At the time of our inspection there were 65 people living at the home. We found that there were 29 people staying on The Lowry unit and 36 people on The Priory unit. We spoke with seven people who lived at the home, nine visiting relatives one visiting health care professional and one visiting social worker. We also spoke with six nurses, which included the clinical lead and deputy manager. We spoke to eight members of care staff, the kitchen manager, the maintenance person and the activities coordinator. We also spoke to the home manager who was present throughout the inspection.

Throughout the day, we observed care and treatment being delivered in communal areas that included lounges and dining areas. We also looked at the kitchen, bathrooms and external grounds. We looked at people's care records, staff supervision and training records, medication records and the quality assurance audits that were undertaken by the service.

# Is the service safe?

## Our findings

People living at Laburnum Court Care Home and their relatives consistently told us that they or their loved ones were safe living at the home. One person who used the service told us; “I am here on respite as my family have gone on holiday and chose this home. I feel safe in my room at night, sometimes if I am awake the night staff pop in and ask if I need anything. If I press the buzzer the staff come quickly and they are very helpful and friendly.” Another person said “When I have needed the staff they have always been there for me.”

A visiting relative told us; “The care is safe here, any problems are addressed immediately. My relative’s belongings are kept safe.” Another relative said “Since coming here my relative has settled down well, staff are great, clean and no smells. We are made to feel very welcome. We can come anytime to see him, our relative is safe.” Other comments included; “I feel safe here, because I have plenty of company. The activities lad is so lovely he talks to me and he knows when I like a cup of tea, because I am always thirsty. If I was worried about something I would tell him he is wonderful.” “The home is clean and I am happy with my bedding. If I have an accident in the night they change my bed, they are very understanding.”

We found people were protected against the risks of abuse, because the home had appropriate recruitment procedures in place. Appropriate checks were carried out before staff began work at the home to ensure they were fit to work with vulnerable adults. During the inspection we looked at ten staff personnel files. Each file contained job application forms, interview questions, proof of identification, a contract of employment and suitable references. A CRB or DBS (Criminal Records Bureau or Disclosure Barring Service) check had been undertaken before staff commenced in employment. CRB and DBS checks help employers make safer recruiting decisions and prevents unsuitable people from working with vulnerable adults.

During the inspection we checked to see how people who lived at the home were protected from abuse. One person who used the service told us; “There is no bullying either from staff or other residents I feel very safe here”. We found the home had suitable safeguarding procedures in place, which were designed to protect vulnerable people from

abuse and the risk of abuse. We looked at the service’s safeguarding adult’s policy and procedure, which described the procedure staff could follow if they suspected abuse had taken place.

We spoke to staff about their understanding of Safeguarding Vulnerable Adults. One member of staff told us; “I have been involved in safeguarding referrals, so I’m confident in recognising the signs of abuse. Furthermore, I’m confident that management would take the appropriate action.” Another member of staff said “I find management very approachable and supportive and I feel I can speak to them about anything including any abuse. When I started here, the current manager stated that they had an open door policy, they have remained true to that promise.”

On the notice board in the main reception area, we saw illustrations and pictures representing safeguarding and what action to take. Contact details of the local safeguarding team were also displayed together with service ‘whistleblowing’ policy and procedures.

As part of the inspection we checked to see how the service managed and administered medication safely. On the whole, we found people were protected against the risks associated with medicines, because the provider had appropriate arrangements in place to manage medicines safely. We found that records supporting and evidencing the safe administration were complete and accurate. We looked at a sample medication administration records (MAR), which recorded when and by whom medicines were administered to people who used the service. These records were up to date without any omissions. We found that all the medication records we looked at had photographs and people’s allergies recorded. This reduced the risk of medicines being given to the wrong person or to someone with an allergy and was in line with current guidance.

Controlled Drugs (prescription medicines that are controlled under the Misuse of Drugs legislation) were checked and found to be correct. The stock was minimal and their were sufficient to meets people’s current needs. Where medicines required cold storage, daily records of temperatures were maintained.

## Is the service safe?

Nursing staff confirmed that additional nursing cover was available during medication rounds by the clinical lead or deputy manager, so that rounds were completed efficiently with the least amount of disruption.

We found some examples where medicines were not always given as prescribed by the doctor. For example, where some medicines required a gap of several hours before administering a further dose, this instruction was not always followed. We spoke to the manager about this concern, who assured us immediate step would be taken to address this deficiency.

We looked at a sample of 15 care files to understand how the service managed risk. We found the service undertook a range of risk assessments to ensure people remained safe. These included long term care falls risk assessment, moving and handling, choking, nutritional, continence, skin integrity and mental capacity assessments. Risk assessments provided clear guidance to staff as to what action to take to ensure people remained safe.

We looked at how the service ensured there were sufficient numbers of staff on duty to meet people's needs and keep them safe. We told by the clinical lead that the service used a dependency tool to determine staffing numbers. During our visit people we spoke with did not raise any concerns about inadequate staffing levels. One person who used the service told us; "If I wanted to go to the toilet the staff take me straight away I do not have to wait, the staff are competent and friendly." One visiting relative said "We haven't any issues. If we ask for anything like my relative spills a drink for example, they were in straight away to sort it out."

We found there were sufficient numbers of staff on duty during the day to support people who used the service. Comments from staff included; "There has been a lot of change since the last inspection, such as more staff." "I have no concerns about staffing levels, things have really improved and a lot less pressure as a result." "I have no concerns about staffing, the home has improved a lot." "The new deputy manager and clinical lead have taken the pressure off nurses on the floor. Day time staffing levels are much improved. The manager uses a dependency tool to determine staffing levels and I think it is able to meet the needs of the unit adequately than previously."

During our last inspection in January 2015, we identified concerns about appropriate standards of cleanliness and hygiene. During this inspection we found the home to be clean, which included both communal areas and bedrooms that were free of unpleasant odours. We observed staff wearing appropriate aprons and gloves when dealing with people's needs. Domestic staff we spoke to had a clear sense of priorities in relation to their cleaning duties and were visible throughout our visit. A number of staff told us how the new manager had taken steps to improve the environment within the home.

A visiting social worker told us that the environment had improved and it was now clean and homely. One relative told us; "We looked at three care homes before this one, which we found was the best. The place is clean and staff deal with issues straight away." One member of staff said "The new manager and management team have made massive improvements in the environment, including individual bedrooms, which has involved residents and relatives."



# Is the service effective?

## Our findings

As part of this inspection we looked at the training staff received to ensure they were fully supported and qualified to undertake their roles. We were told by the recently appointed clinical lead that new staff underwent an induction, which consisted of training in areas such as fire safety and safeguarding and a period of shadowing senior staff. A mentor was also appointed to support new staff during this period. We were also told that the service was introducing training in the 'care certificate' as part of training for all staff.

We looked at new staff monitoring records, which detailed progress made during the induction programme. One new member of staff told us; "I had training included in my induction programme, such as manual handling, safeguarding and dignity. I also spent time shadowing an experienced nurse." Another member of staff said "I had a four day induction, which included working alongside a nurse. As I had recently qualified as a nurse, I asked for an extended period of a week, which was catered for. I had to complete medication training in which I was assessed. I also completed e-learning in a number of subjects including manual handling, infection control and safeguarding."

Staff confirmed they received regular training in subjects such as safeguarding, first aid and the Mental Capacity Act, which we confirmed by viewing the training records. One member of staff told us; "I have just completed a National Vocational Qualification (NVQ) level two in care. I have also recently done refresher training in manual handling and the Mental Capacity Act. Another member of staff said "I feel I do receive a lot of training, the management are very pro-active in getting training courses booked."

Other comments from staff about training included; "We have e-learning training, which we have to complete. We also have a member of care staff who does all the manual handling training on a regular basis." "I think e-learning is ok for experienced staff, not so sure about new staff though." We spoke to the manual handling coordinator for the home, who confirmed they provided a practical input for all staff, which was monitored by a training matrix.

All staff we spoke with confirmed they received supervision and appraisals, which we verified by looking at supervision records and a supervision matrix. Supervisions and

appraisals enabled managers to assess the development needs of their staff and to address training and personal needs in a timely manner. The clinical lead told us that they intended to be initially responsible for all supervision with nurses and care staff, but with nurses assuming responsibility for care staff in time. The clinical lead told us this was work currently in progress. We were also told that the service had been actively engaged in addressing attitudes of staff in order to improve standards throughout the home, following the last inspection.

We looked at what systems were in place to ensure that people who used the service were asked for their consent before any care or support was delivered. Throughout our inspection, we observed staff seeking consent from people before delivering any care or treatment such as medication, personal hygiene or support with eating. This interaction was patient and kind.

We asked staff how they sought consent from people who could not communicate. One member of staff told us; "You can tell by their expression, you get to know people and how they respond if they aren't consenting. I wouldn't undertake any tasks without their consent." Another member of staff said "The way you approach people is very important and having worked with these people, you can see whether they are providing consent to things. Sometimes when they refuse you come back five minutes later and get a different response. I wouldn't do anything unless I was sure people were consenting. Whilst reviewing care files, we found that written consent from people who used the service was not always obtained. We have addressed this matter under the well-led domain of this report.

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. At the time of our inspection, there were a number of people living at the home who were subject of a Deprivation of Liberty Safeguards (DoLS), which was monitored by way of a DoLS check list.

We saw that some staff had received training in MCA and staff we spoke to were able to describe the principals of the

## Is the service effective?

legislation to us. We spoke to the clinical lead about training in MCA and DoLS, who told us that as a priority, they were currently ensuring all staff were aware of the legal framework of the MCA and that staff fully understood its implications. They were currently arranging for groups of staff to be provided with additional inputs on the legislation by trained staff as a supplement to any previous training received.

People had access to healthcare professionals to make sure they received effective treatment to meet their specific needs. Care plans contained professional communication records, which detailed engagement with other health care professionals such as GP's, district nurses and Speech and Language Therapist (SaLT) and dieticians.

During our inspection we checked to see how people's nutritional needs were met. Since our last inspection in January 2015, we found improvements had been made in the manner in which people received their meals. The home now employed the services of an external catering service, which prepared meals within the home. We looked at a four week menu, which was also in pictorial form to enable people to make choices. We observed the meal time experience to be calm, relaxed and well managed. We

saw staff supporting people to eat in a patient and unhurried manner, where people were encouraged to eat and drink. The kitchen manager told us that a list was provided by the home for people with special diets and we saw puréed meals were presented in a manner to look more appetising for people.

One person who used the service said "I make my own choices, the food is superb I cannot fault it if I do not like what is on the menu they will give me something else." One visiting relative told us; "My relative has been referred to a dietician, but staff have tried many different way to get him to eat meals and always encourage him to eat more. They are very nice with him and speak to him very respectfully."

We looked at a sample of 15 care files and found that individual nutritional needs were assessed and planned for by the home. We saw evidence that nutritional and hydration risk assessments had been undertaken by the service, which detailed any risks and level of support required such as with the possibility of choking. We looked at weight monitoring that was undertaken by the service. People at risk of malnutrition had been referred to dietician services for further advice.

# Is the service caring?

## Our findings

Everyone we spoke with thought the staff were kind and caring. One person who used the service told us; “The staff are kind and caring they cannot do enough for you and they listen to me.” Another person who used the service said “The staff are kind, caring and reliable, the staff treat me with dignity when I am having a shower. they make sure the door is closed. I am on the toilet they make sure the door is closed and help me when I am ready.”

Other comments included; “The staff are person centred. My legs get swollen and when I come into the lounge they get me a chair so I can put my feet up they know me well and I have not been here a long time.” “The staff are caring and considerate, they listen and are very approachable and friendly.” “My relative always looks clean and has had a shave, the staff keep my him as independent as possible the staff are friendly and welcoming and the home is spotless.” “If I wanted to go to the toilet the staff take me straight away I do not have to wait. The staff are competent and friendly I can go out for a smoke in the wheelchair when I want to.” “Some staff are better than others they do their job with careful consideration. Staff listen and are approachable. They are welcoming and friendly.”

Throughout our inspection, where we observed interaction between staff and people who used the service, it was kind and caring. We witnessed a very caring environment where people were well cared for. People looked clean and well groomed. We witnessed a person who used the service being hoisted into a chair. The staff were gentle, kind and patient with this person. Staff knew people well and there was a friendly atmosphere between staff and people living at the home.

As part of the inspection we checked to see that people living at the home were treated with privacy, dignity and respect. People who used the service told us that their dignity and privacy was always respected. We asked staff how they respected people’s dignity and privacy. One member of staff told us; “I always knock on doors and never enter without knocking and getting a reply. I always explain to people what I need to do.” Another member of staff said “I’m always mindful of ensuring people are properly dressed covered up. I ensure doors are closed and curtains drawn when delivering personal care.”

One visiting relative told us; “I think staff are very respectfully of my relative’s privacy and dignity. When we have visited, we have found staff changing him and we have been asked to wait outside his room.” Other comments included; “We have seen people having an accident with incontinence and noticed how effectively staff have supported and changed the person.”

As part of the inspection we checked to how people’s independence was promoted. We asked staff how they aimed to promote people’s independence. One member of staff told us; “I always encourage people to be independent as possible such as when eating and personal care. Otherwise it takes their independence away.” Another member of staff said “I will always encourage people to do as much as they can and they have good and bad days. With any intervention I will ask people directly what I want them to do and will always respect their choice.”

People and relatives told us they were involved in making decisions about their care and were listened to by the service. They told us they had been involved in determining the care they needed and had been consulted and involved when reviews of care had taken place. One relative told us; “I am involved in the care plan and reviews. I had no involvement with the assessment before my wife came here it was all done and dusted.” Another relative said “I am involved in care plans and reviews I was involved in pre assessment.” Other comments included “We were involved in deciding exactly what our relative needed and we are consulted about issues.”

The home was part of the North West End of Life Care Programme known as Six Steps to Success. Several members of staff had received training in this end of life care programme which enabled people to have a comfortable, dignified and pain free death. We were shown evidence that a member of staff (RGN) was a Six Steps coordinator within the home and that they worked closely with the District Nurse and McMillan Nurse Services. We were shown documentation used as part of end of life care and saw that people were regularly reviewed and assessed for pain and agitation. The Manager also told us that there were plans to roll the training to all staff early next year.

# Is the service responsive?

## Our findings

People told us that the service was responsive to their needs. One visiting relative told us; “The staff keep me informed. My wife has had a lot of falls in the past, because she kept trying to get up herself. When this happened I was notified immediately it was all sorted how I would have expected it to be, the staff are skilled in their role and I have always been asked my opinion whatever has been appropriate at the time we have meetings as needed”. Another relative said “The staff keep us informed they are very knowledgeable in knowing how to look after our relative we are included in best interests decisions.”

We found that each person who used the service had support plans in place that were personal to them. At the time of the inspection, the manager told us that all care file documentation was in the process of being transferred on to new paperwork. Care plans provided guidance on a number of areas of care and treatment, including mental capacity, mobility, nutrition, skin integrity, communication and incontinence. Though people told us that they were involved in determining the care their loved one’s received, this was not clearly documented in their care plans. Care plans appeared to have a standard one monthly review, though this was not always documented. These reviews were very brief and non-informative in terms of the effectiveness of prescribed care being delivered.

We found the service used a ‘Waterlow’ risk management and positional change charts for people who were deemed to be at risk of skin damage. In one care plan we looked at we found instructions prescribed positional changes for the person to be documented every two hours. However, on reviewing the positional change chart, it showed that the person was at times receiving positional changes between three to five hours rather than the recommended two hours. There was no adverse impact on the person at the time of our inspection. We spoke to the nurse, who assured us that immediate steps would be taken to ensure this concern was addressed.

During the inspection we saw several examples of where staff at the home had been responsive to people’s needs. For example where people were required to be weighed

weekly or monthly, there were records to suggest this had taken place. However, care plans did not always accurately reflect people’s current weights. When we spoke to the deputy manager about this, they were able to produce a weights book that demonstrated that people’s weights were being regularly monitored and recorded.

During our inspection, we checked to see how people were supported with interests and social activities. On the day of our inspection we observed a film being shown to people in one of the lounges using a projector. An activity noticeboard was on display in corridors. We spoke to the activities coordinator who showed us the activities room situated on the first floor, which was used for activities such as arts and crafts. This room was appropriately decorated and of a good standard. We were told that groups of people were taken out to lunch on a weekly basis or on trips using the home’s own mini bus. We saw evidence of activities having taken place such as flower arranging, entertainers and regular parties.

During our inspection, we did not witness other members of staff engaging in activities or stimulation with people who used the service. Though we found the activities coordinator very enthusiastic and committed to their role, one coordinator catering for the needs of 65 people over two floors raised concerns about the current effectiveness of this role in providing stimulation for so many people. We discussed these concerns with the manager.

We found the provider had effective systems in place to record, respond to and investigate any complaints made about the service. The complaints procedures were on display in the reception area. Both people and relatives we spoke to were unable to tell us what arrangements existed to encourage them to provide feedback about issues and where improvements could be made. Detailed analysis of a customer satisfaction survey for 2013 was on display in the reception. We were told by the manager a customer satisfaction survey had not been undertaken since then, however in the reception area we were shown an electronic touch-screen pad where people could provide feed-back about the service. We were told by the manager that there was no available data of the feed-back received to date as the service had not yet analysed results.

# Is the service well-led?

## Our findings

A number of people who used the service were not aware of who the manager was, however one person who used the service told us; “I can talk to the manager she is approachable, her door is always open I have been asked about feedback.” A visiting relative told us; “The new manager is on the ball, her door is always open and we go to relatives meetings.” Other comments included; “I know the manager, she has helped me through a lot she has been very supportive to me.”

During our visit, we were told by the manager that the service was introducing new care file documentation. As part of the inspection we reviewed 15 care files for people who used the service. We found care files were very cumbersome and not sequential in presentation order. A number of care plans were incomplete and lacked up to date information, such as people’s weights and there were instances where reviews had not been documented. A number of care plans did not contain any written consent for the care and treatment provided. In some instances consent for care and treatment were signed by a staff member with no explanation provided. Though people told us they were involved in their loved one’s care there was no evidence of family involvement in the writing of care plans and in any reviews of care undertaken by the service.

In one instance, we found that a care plan did not accurately represent skin integrity issues for a person who used the service. We found a pressure sore had been recorded as a grade one sore, however, following our review it transpired the pressure sore should have been graded as a grade two sore. We found that a duplicate care file had been created for one person who used the service. We spoke to the deputy manager about which was in fact the current file and why there were two files in existence. They explained that in introducing the new documentation, different staff had started to transfer information without realising another file had already been started. Both files were not accurate and did not contain up to date information. The manager was very receptive to the concerns we raised and reassured us that immediate steps would be taken to address the quality of care files.

This is a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 (Part 3), good governance, because the service had failed to maintain accurate and complete contemporaneous records for people who used the service.

At the time of our visit, there was no registered manager in place, though the newly appointed manager was in the process of registering with the Care Quality Commission. 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.

Since our last inspection in January 2015, we noted a number of improvements had been made by the service to address our concerns at that time. This included a new management structure involving the appointment of a new manager, supported by a deputy manager and clinical lead. All staff we spoke with commented on the positive changes made to the service following the appointment of the new manager. Staff told us about deployment boards that had been introduced, that clearly set out staff member’s responsibility on a daily basis and were completed by the nurse on duty. One nurse told us; “We now have an allocation board, so each morning I will assign roles to specific staff throughout the day. Care staff now know what is expected of them and I always know where staff are.”

Other comments from staff included; “There has been lots of changes since the last inspection, such as more staff, new management, better environment, which is nice and calm.” “There is a good culture here, where you can be open and frank. Even the regional manager has a monthly surgery, where we can discuss any issues.” “I think things have improved for the better since the last inspection. The new manager is very open, you can speak to her about anything.” “The management is always very approachable and supportive.” “I have no concerns about the way the service is run, providing it continues to improve.”

We found the service undertook a comprehensive range of audits and checks to monitor the quality of services provided. These included weekly fire systems checks, Fire

## Is the service well-led?

Drills, weekly medication audits, environmental checks, staff feed-back, infection control, bedrails and weight monitoring. Checks were also maintained of any equipment used by the service such as slings and hoists.

We looked at how the service learnt from any incidents, complaints or safeguarding matters. The service demonstrated to us where lessons had been learnt, what immediate action had been taken and where action plans had been put in place to address deficiencies. We looked at minutes from staff meeting, which included nurse's meetings, dignity and infection control meetings. Both resident and relative meetings were also undertaken.

The home had policies and procedures in place, which covered all aspects of the service. The policies and procedures included; safeguarding, whistleblowing, and medication.

Providers are required by law to notify CQC of certain events in the service such as serious injuries, deaths and deprivation of liberty safeguard applications. Records we looked at confirmed that CQC had received all the required notifications in a timely way from the service.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance
Diagnostic and screening procedures	<b>The service had failed to maintain accurate and complete contemporaneous records for people who used the service.</b>
Treatment of disease, disorder or injury	