Solutions (Yorkshire) Limited

Harewood Court Nursing Home

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

Overall summary

This was an unannounced inspection carried out on the 22 April 2015. At the last inspection in July 2014 we found the provider had breached four regulations associated with the Health and Social Care Act 2008.

We found there were not sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity and that medicines were not managed safely. We saw there were not suitable arrangements in place to ensure the dignity, privacy and independence of people who used the service and that people were not protected against the risks of unsafe or inappropriate care or treatment arising from a lack of proper information about them by means of the maintenance of accurate records. We also found that the systems in place to monitor the quality of service delivery were not effective.

We told the provider they needed to take action and we received a report in December 2014 setting out the action they would take to meet the regulations. At this inspection we found improvements had been made with regard to these breaches. However, we found other areas where improvements were needed.

Summary of findings

Harewood Court provides nursing and personal care for up to 40 people. The service is divided into two units with the second floor accommodating people who are living with dementia.

At the time of the inspection there was no registered manager in post. 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 and associated Regulations about how the service is run.

We looked around the premises and found there were safety concerns regarding the premises. Window restrictors were not in place on windows that opened wide enough for people to fall out of and risk assessments had not been undertaken regarding the use of them. This was a breach of Regulation 12 (1) (d) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the end of this report.

There were systems in place to make sure people were not deprived of their liberty unlawfully. However, we found that mental capacity assessments were not specific to the decisions being assessed and did not show who had been involved in the assessments as is required by the Mental Capacity Act 2005. This was a breach of Regulation 11 (1) (3) Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the end of this report.

Although staffing levels were provided as the home's dependency assessment indicated, we found staff were not deployed efficiently at all times to ensure the needs of the people who used the service were fully met. We saw people had to wait for periods of time for their meals to be served and there were times when communal areas of the home were left unsupervised.

People who used the service told us they were overall, happy living at the service. They said they felt safe and overall, staff treated them well. We saw care practices were good. Staff respected people's choices and treated them with dignity and respect. We noted however, that people were not always involved in decisions affecting their care and support and care plans did not show how people had been involved in developing their plans of care.

People were encouraged to maintain good health and received the support they needed to do this. Overall, medication was managed safely and people received their medication when they needed it. People's views on food and menus in the home were mixed. We saw people received regular drinks and snacks to make sure their nutrition and hydration needs were met.

Robust recruitment procedures were in place and appropriate checks had been undertaken before staff began work. Staff said they felt well supported in their role and received the training and supervision they needed. Records we looked at showed a number of staff needed to update or complete their mandatory training. The manager had a plan in place to ensure this was done and staff's practice was up to date.

People who used the service were involved in a wide range of activities within the home. Most people we spoke with said they enjoyed these. However, some people said they would like to get out more often.

Staff spoke positively about the manager of the home saying they were approachable. They said they had confidence in the manager.

There were systems in place to assess and monitor the quality of the service; which included regular audits of the home. These were not always fully effective. Some of the records we looked at did not show evidence that improvements identified through audit were always completed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement 

The service was not consistently safe.

There were safety concerns relating to the premises. Window restrictors were not in place and risk assessments had not been undertaken regarding their use.

Staffing levels were provided as planned by the home. However, at times staff were not deployed efficiently to fully meet the needs of people who used the service.

Medicines were overall, managed safely for people.

Staff knew how to recognise and respond to abuse appropriately. They could describe the different types of abuse and had received training on safeguarding vulnerable adults. We saw the recruitment process for staff was robust.

Is the service effective?

Requires improvement 

The service was not always effective.

We found the service was not fully meeting the legal requirements relating to the Mental Capacity Act 2005. (MCA)

Health, care and support needs were assessed and met by regular contact with health professionals.

Staff said they received good training and support. However, there were a number of staff who needed to update or complete their mandatory training.

People's views on the meals in the home were mixed.

Is the service caring?

Requires improvement 

The service was not consistently caring

Staff understood how to treat people with dignity and respect and were confident people received good quality care. They were however, at times task focused and did not have time to sit and talk with people for meaningful periods of time.

Care records did not show how people who used the service were involved in planning their care and support needs.

Decisions regarding care practice changes had not been agreed with people who used the service thus causing unnecessary anxiety.

Is the service responsive?

Requires improvement 

The service was not always responsive

Summary of findings

There were systems in place to ensure complaints and concerns were fully investigated. However, some people felt reluctant to raise concerns.

People's needs were assessed before they moved in to the service and care plans developed from this information. However, there was little evidence of how people who used the service were involved in this process.

People were provided with a range of activity within the home. Some people said they would also like to get out on outings.

Is the service well-led?

Requires improvement 

The service was not consistently well-led.

Systems in place to assess and monitor the quality and safety of the service were not fully effective.

Staff said they felt well supported and found the manager approachable.

Records showed that people who used the service were asked for their views on the quality of care provided.

The provider had informed CQC about some significant events that had occurred but they had failed to inform CQC about all reportable events.

Harewood Court 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 22 April 2015 and was unannounced.

At the time of our inspection there were 35 people living at the service. During our visit we spoke with eight people who used the service, four relatives of people who used the service, ten members of staff which included the home manager, the previous manager who currently worked at a sister home and the activity co-ordinator. We spent some time looking at documents and records that related to people's care and the management of the service. We looked at eight people's care plans.

The inspection was carried out by two adult social care inspectors, an inspection manager, a specialist advisor (pharmacist) and an expert-by-experience who had experience of older people's care services and dementia care. 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 our inspection, we reviewed all the information we held about the home, including previous inspection reports. We contacted the local authority, NHS commissioners and Healthwatch. Healthwatch feedback stated they had no comments or concerns. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Requires improvement

Is the service safe?

Our findings

Most people we spoke with told us they felt safe or that they felt their relative was safe at the home. A person who used the service said, "I feel safe. The staff are good and they know what they're doing." One relative said, "I come every day at lunchtime. I feel happy that she's safe and well cared for." We saw positive interaction throughout our visit and people who used the service appeared happy and comfortable with the staff. One person however, said, "I don't feel safe here, because of the bells. Sometimes if you're wet at night they say 'What do you want?' and keep you waiting if you call them. Then they hide the bell from you or tie it up so you can't reach it. Sometimes when they say they're busy, they're just outside smoking." We discussed this with the manager who said they would monitor this and take any appropriate action if needed.

We saw staffing levels had been assessed using a dependency tool to ensure they were safe and there were sufficient staff to meet people's needs. We discussed this with the manager who was planning to carry out this assessment each month or whenever people's needs and dependency changed. The assessment considered people's dependency alongside the environment, layout of the building and any equipment used. The manager showed us recent records which indicated the home was currently staffed above requirements based on the calculations of the dependency tool.

Our observations showed that at times the lounge areas of the home were unsupervised for five or ten minute periods and it was unclear if people who used the service could summon the assistance of staff if needed. A relative said, "They're still leaving them alone in the lounge. I don't think there's enough staff." We also saw that staff were not deployed well at the lunchtime period. Staff were at times busy taking meals to people in their rooms or providing support in the dining room and didn't notice when a person touched another person's food. We pointed this out and another meal was brought for the person. Some people had to wait for up to 20 minutes for their meal as staff were not available to assist them. The manager said they would look at how staff were deployed at these times and spoke of introducing meal sittings to enable a more person centred approach.

Most of the staff we spoke with said they felt there were overall enough staff to enable them to meet people's needs well and they did not have concerns about staffing levels. Comments included: "We are fine with the current occupancy", "Most of the time we have enough staff" and "I think there's enough staff to help me." Care staff said they could easily access the nurse on duty if they needed to report changes in need or gain advice from them. One staff member said they thought the home would benefit from more care staff to enable more activity to be carried out. Staff also said that when sickness occurred this was usually always covered and they did not work short staffed.

We discussed staffing levels with the manager. We were told that there should be one nurse working between both floors of the home and one senior care staff member and two care staff on each floor 8am – 8pm. In addition to this, the manager, who was also a nurse, was on duty Monday - Friday through the day. We were told there was a housekeeper, cook and laundry assistant each day and an activity co-ordinator three days per week. The manager said the night staffing was one nurse and three care staff 8pm – 8am. We looked at the staffing rotas for the last four weeks and saw staffing was provided as this plan indicated.

We looked around several areas of the home; this included communal areas, bathrooms and toilets and people's bedrooms. We saw the home was clean, tidy and homely. There were no malodours. We looked at a random sample of windows in the home. Health and Safety Executive guidance states that 'where assessment identifies that people using care services are at risk from falling from windows or balconies at a height likely to cause harm, suitable precautions must be taken. Windows that are large enough to allow people to fall out should be restrained sufficiently to prevent such falls. The opening should be restricted to 100 mm or less. Window restrictors should only be able to be disengaged using a special tool or key'. We saw there were no window restrictors in place on any of the windows we looked at and they could be opened with a width more than 100mm. The manager also confirmed there were no window restrictors in place. The manager also confirmed that no risk assessments had been carried out and it was therefore unclear if people who used the service were at risk from falls from these windows that did not have restrictors in place.

Requires improvement

Is the service safe?

This evidence showed a breach of Regulation 12 (1) (d) Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the end of this report.

We saw medicines were stored in locked cupboards fixed to the wall in each person's bedroom. Some additional stock medicines and Controlled Drugs (CD's) were stored in a locked treatment room on the ground floor. We were told that the home was moving to a new system involving removing medicines from people's rooms and storing them in medicines trolleys. The nurse and manager said this would speed up medicine rounds and enable the nurse to plan workload more efficiently. The manager confirmed that medicines trolleys were on order and that a new pharmacy contractor had been appointed to supply medicines to the home and provide medication use reviews and training.

We inspected the treatment room and found that all cupboards and the drugs refrigerator were locked on the day of our visit. We saw that temperature records for the refrigerator were recorded daily and showed that all temperatures were within limits. However, ambient room temperature within the treatment room was not recorded to ensure that other medicines were not stored in temperatures exceeding 25 degrees celsius as per manufacturer's instructions. The CD cupboard was locked and there was one CD record book to record receipts and administration records. We examined the book and found it to be comprehensively and accurately completed. A sample of three CD medicines were checked against stock levels in the CD record book and found to be correct. Samples of four CD's and four non-CD were also examined and shown to be in date and stored in the correct cupboards. It was noted that opened bottles of liquid medicines were not always marked with the date of opening to ensure they were used within the correct time limits.

We looked at the medication care plans and medicine records for people who used the service. A sample of five medication administration record (MAR) sheets were examined and found to be accurately and correctly completed. The MAR forms had codes to record reasons for non-administration of medicines but we noted that these codes were not the same as the codes described in the home's medicines management policies and procedures.

We raised this with the manager who said this would be reviewed. We noted that body maps were in use for people receiving medication patches and regular insulin injections to ensure the site of these was rotated to protect people's skin. We saw that one person had been receiving medicines covertly and we examined the relevant documentation which showed that all correct procedures had been followed. We also saw that medicines risk assessments had been carried out for people who used the service and that capacity assessments had been completed when relevant.

We observed medicines administration to three people who used the service and noted that there was a good rapport between the nurse and the people and that all necessary procedures and records were carried out by the nurse. The nurse told us that there were four medicines rounds per day and we saw that records were kept to ensure that doses of paracetamol were not administered within four hours of each other. We saw that separate records were kept for administration of creams and ointments by care staff and that these records were checked by the nurse in charge who then made the appropriate additional record in the MAR.

We saw that the home had introduced a new revised medicines management policies and procedures in March 2015. We examined these documents and found them to be comprehensive and appropriate. We noted that memorandums had been issued to staff requiring them to be familiar with the new documents and in particular to ensure that medication for newly admitted people was obtained promptly and that requests for further supplies of medicines were initiated well in advance.

We spoke with staff about their understanding of protecting vulnerable adults. Staff had an understanding of safeguarding adults, could identify types of abuse and knew what to do if they witnessed any incidents. Staff we spoke with told us they had received training in safeguarding vulnerable adults. Records we looked at confirmed most staff were up to date with this training. Seven staff were identified as needing to update their training and the manager said arrangements were in place to ensure this. The home had up to date policies and procedures for safeguarding vulnerable adults and these were available and accessible to members of staff.

There were effective procedures in place to make sure that any concerns about the safety of people who used the service were appropriately reported. This included detailed

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Is the service safe?

written handovers and meetings where aspects of care were discussed. Risks to people who used the service were assessed and staff were aware of how to manage risks to ensure people's safety, for example, by the use of bed rails, pressure sensor mats or pressure relieving equipment. However, we saw in one person's care records that it was not evident that risk assessments had been updated in response to a fall, therefore, it was unclear if the management plan in place was current to meet the person's needs.

Appropriate checks were undertaken before staff began work, this included records of Disclosure and Barring Service (DBS) checks. The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people. We looked at the recruitment process for four members of staff and saw this was properly managed.

There were systems in place to monitor accidents or incidents and we saw that the service learnt from incidents and made appropriate referrals to protect people from harm such as falls. We noted, however, that there were heavily patterned carpets in the communal areas of the home and one of the lounges had poor lighting which could both pose trip hazards to people who used the service, especially those living with dementia.

Requires improvement

Is the service effective?

Our findings

Staff we spoke with said they felt well supported. They said they received regular supervision meetings where they had opportunity to discuss their job role and receive feedback on their performance. Staff also said they had an annual appraisal which they found helpful. One staff member said, "Had appraisal last year, find them useful, it lifts my spirits." Records we looked at showed that staff had regular supervision meetings. We saw that annual appraisals had got behind schedule. However, the new manager had put a plan in place to rectify this. We saw the schedule that had been drawn up to make sure all staff received an appraisal.

We looked at the training records and saw staff had received a range of training which included; fire training, moving and handling, safeguarding vulnerable adults, food safety, infection control, health and safety, person centred care and dementia. A training matrix was in place which clearly identified where training updates were required. However, 15 out of 33 staff needed to complete or update on food safety, 15 out of 33 staff needed to complete or update on infection control and health and safety training and only two staff had completed dementia training. The new manager was in the process of reviewing staff's training and was aware of the training that needed to be provided. An action plan had been developed. We also noted that medicines competency checks had been recently carried out for two nurses but could not see any evidence that all nurses and care staff who administered medication had received medicines management training. The manager and the nurse on duty confirmed this training was booked with the new pharmacy who were contracted to provide medicines services to the home.

Staff spoke highly of the training they received and demonstrated good knowledge of how they put their training in to practice. They spoke confidently about the individual care needs of people living with dementia. One staff member said, "The dementia training was really good, you can relate it to certain residents."

Throughout our inspection we saw that people who used the service were able to express their choices and make decisions about their care and support. We saw people were asked for their consent before any care interventions took place. People were given time to consider options and staff understood the ways in which people indicated their consent. We saw staff explained moving and handling procedures to people and checked they were comfortable throughout. Staff we spoke with showed a good understanding of protecting people's rights to refuse care and support. They said they would always explain the risks from refusing care or support and try to discuss alternative options to give people more choice and control over their decisions.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. (DoLS) which provide legal protection for vulnerable people if there are restrictions on their freedom and liberty. At the time of our visit five people at the home were subject to DoLS. Documentation we looked at showed the appropriate authorisations were in place and the manager was in the process of assessing others who may be at risk of having their liberty deprived. The manager was in consultation with the local authority regarding this. However, no notification of the DoLS approval had been made to the CQC. The regulation requires any request to the supervisory body made by the registered person for a standard authorisation to be made known to the CQC without delay. The new manager agreed to make sure these notifications were made to the CQC.

We asked staff about the Mental Capacity Act 2005 (MCA) and DoLS. They were able to give us an overview of their meaning and could talk about how they assisted and encouraged people to make choices and decisions to enhance their capacity. Staff we spoke with confirmed they had received training on the MCA and DoLS. We noted that seven staff still needed to complete this training and the manager said training was being arranged for the near future.

Care plans showed information regarding people's capacity to make decisions had been assessed. However, some of the assessments were not specific to the decision that was being assessed and did not show who had been involved in the assessment as is required by the MCA. An assessment for one person was not up to date as care records stated the person had capacity yet they had a DoLS in place stating they didn't. This information needed to be recorded more accurately to give full assurance that the principles and legal requirements of the MCA had been met.

Requires improvement

Is the service effective?

The above evidence demonstrated a breach of Regulation 11 (1) (3) Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the end of this report.

Records showed that arrangements were in place that made sure people's health needs were met. We saw evidence that staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. For example, tissue viability nurses, chiropodists or the falls clinic. We saw people's nutritional needs were assessed and weights were monitored. Where people were nutritionally at risk we saw there were plans in place to ensure foods with enhanced nutritional value; such as 'smoothies' were offered and encouraged.

We observed the lunch time meal in the home. We saw people were asked if they needed the toilet before they were seated and offered hand wipes to freshen their hands. Interaction was positive and staff were sat chatting with people prior to the meal arriving. People were asked if they required clothes protectors and choices for these were respected. People were offered choices and alternatives were provided when they did not want what was on the menu. Staff assisted people to make choices by clearly explaining the choices or showing people the food on offer. The food was well presented and looked and smelt appetising. People were offered a choice of hot or cold drinks to go with their meal.

We saw staff were kind and supportive; encouraging people to eat and drink, but did not have the time to sit with people individually in a timely manner. We saw some people waited for up to 20 minutes for assistance with their meal. We observed a person who used the service picking food off another person's plate when there were no staff available to supervise them. This appeared to put the person off eating their food. When staff did sit with people, we saw they were respectful of dignity and did not rush people. The manager of the home said they were going to look at introducing two meal sittings to improve the dining experience for people who used the service.

People's views on the food in the home were mixed. One person told us they liked the food and got plenty to eat. Others were not as complimentary. Comments included; "Boring", "Veg is cooked too long" and "He doesn't enjoy the food. It's always mashed potato. Every day, it's mashed potato." We looked at the menus and saw mashed potato was an option each day. We also noted the home caters for a number of people from different cultural backgrounds; including African Caribbean people. We were told that African Caribbean food was available each Monday in the home. The menus we looked at did not accurately reflect this. A relative told us that they frequently brought African Caribbean food in for their family member. We discussed the menus with the manager who told us of the improvements they were making to the menus to ensure a better variety and choice of food. Staff told us that menu choices were much improved since our last visit to the service.

Requires improvement

Is the service caring?

Our findings

Throughout the inspection we observed staff interacting with people who used the service in a kind and respectful way. People appeared to feel comfortable with the staff. A number of staff we spoke with had worked at the home for a long time and showed a clear commitment to their jobs and the people who used the service. Staff clearly knew people well as individuals. One staff member said, "I love it. I really get to know the people well and it feels really rewarding if someone's upset and you can turn their mood around. It's really upsetting when people pass on, because, you know, they become friends, it's like family. You can't help feeling cut up." Another said, "We know people well, know lots about them." A relative told us; "Happy with care, can talk to them and ask them anything."

Our review of care plans did not show clear, consistent evidence of how people who used the service or their relatives were involved in the development of them. We were told there was a key worker system in operation. However, one relative we spoke with did not know the name of their family member's key member of staff. Care plans were not always signed by relatives or people who used the service to show they were in agreement with them. One relative said they were involved in the review of care plans and said they were always informed of any changes within them. We also saw a discussion with a relative had been recorded in a care plan we looked at.

Some people had been identified as needing a Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) order in place. There was evidence that the correct forms had been completed. However, we noted that on two of the forms we looked at, the person or their relative had not been consulted about this decision. The manager agreed to discuss this with the GP of the people who used the service to ensure this happened.

Staff engaged well with people who used the service. We saw cheerful, pleasant and friendly banter between staff and people who used the service. Throughout the day we observed staff knocking on doors, waiting for people to respond before entering bedrooms. We did at times observe that some staff interactions were task focussed and that staff only had time to speak with people when carrying out tasks such as moving and handling.

We saw staff were respectful of people's cultural needs. We saw a person who was Asian was called 'Auntyji' by staff. A staff member told us, "I call [Name of person] that. It's their culture, see. The older ladies are called Auntyji. It's respectful and she always smiles when you say it." African Caribbean people we spoke with told us that the staff put cream on their skin, and that they had their hair dealt with appropriately.

People looked well cared for. They were tidy and clean in their appearance which is achieved through good standards of care. People were dressed with thought for their individual needs and had their hair nicely styled. All the staff we spoke with were confident people received good care. One staff member said, "I treat people the way I would like to be treated." Staff gave examples of how they ensured people's privacy and dignity were respected. This included encouraging people to be as independent as they could and making sure care was delivered in private.

Two staff members had been appointed Dignity Champions in the home and had undertaken training in person centred care to enable them to do this. The manager said the Dignity Champions would be expected to demonstrate good practice and challenge any bad practice with regards to respecting people's dignity at all times. We saw information on the dignity champions, including their photograph, was on display in the home. We spoke with one of the dignity champions and they told us they were available to speak with relatives or people who used the service if they had any concerns about dignity and respect. They also said, "We check if people are being treated like adults. Are curtains closed when care is delivered; it's our job to challenge where dignity is being compromised." We looked at the home's policy on dignity and saw this identified good and bad practice to guide staff on providing dignified care.

People who used the service and a relative spoke of recent correspondence received from the provider; informing them a weekly charge of £25 was to be introduced for personal laundry at the home. We were told there had not been any consultation about this or any explanation as to why it was being introduced. People told us they were feeling anxious about their ability to afford this or their ability to undertake their family member's laundry if they did not have it done at the home. We discussed this with

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Is the service caring?

the new manager who was aware that some people who used the service or their relative had complained about this issue. We were told that the provider had currently put the introduction of this charge on hold.

The manager was aware of how to assist people who used the service to access the advocacy service if needed. We saw that one person was supported by an IMCA (Independent Mental Capacity Advisor) to ensure them assistance in involvement in planning their care and support. We saw there was information on display in the home on the local advocacy service.

Visitors told us that they could visit without restriction at any time. One person visited daily and brought the family dog to visit. This was clearly enjoyed by their family member and other people who used the service.

Requires improvement

Is the service responsive?

Our findings

Records showed that people had their needs assessed before they moved into the service. This ensured the service was able to meet the needs of people they were planning to admit to the service. However, we noted these were not signed by people who used the service or their relative to show how they had been involved in this process.

Following this initial assessment, care plans were developed detailing the care and support people needed. Staff said they found the care plans useful and that they gave them enough information and guidance on how to provide the support people wanted and needed. Staff spoke confidently about the individual needs of people who used the service. One staff member said, "We look at the care plans every day, care plans contain good information and help us to deliver care." Another said, "The nurse will always go through care plans with us."

We saw care records had improved since the last time we visited the service. Audits had been carried out regularly to ensure this. However, some of the care files we looked at were still bulky and complex to navigate, with old out of date information still in the file, which could lead to confusion in care delivery and needs being missed or overlooked. We also saw there were inconsistencies and conflicting information in some of the care plans. For example, one person was noted as being born in both Jamaica and St Kitts in two separate care plans. Another person's care plan said they did not wear spectacles yet we saw they were wearing them. The manager was aware that further improvements were needed to the care plans to make sure they were reviewed and up to date. They had identified this as a priority in their plans for the home.

We saw people were offered a range of social activities which included quizzes, chairobics, music for health, massage, reminiscence and visiting singers/entertainers. During our visit we observed an activity with a visiting singer in one of the lounges. The singer engaged well with people who used the service; encouraging their involvement and acknowledging their individual contribution. The activity was clearly enjoyed by people who used the service. Some people were involved in drawing and colouring during the morning of our visit. Facilities for people to do this had been set up in one of the dining rooms in the home. During the morning in the upstairs lounge there was some reggae music playing which seemed to meet the needs of the people who spent time there.

We saw that quite a number of people engaged with the activities in the home. However, some people said they didn't do much, just sat in a chair. Some said they would love to go outside sometimes. One said, "You know, go out to a park or something." Staff said they wished they could get people out more. One said, "We get lots of visitors coming in but no trips out." Another said, "It would be nice to have the staff to take people out." One staff member said it would be easier to get people out if the home had a minibus.

We were told that a church group visits the home and gives a service on the first Sunday of the month. We were also told that a Catholic priest gives communion at the home every six weeks. People who used the service and staff in the home reflect the very mixed cultural make up of the area where the home was positioned. We noted however, that pictures on display in the home and the menu did not reflect this cultural mix.

The home had systems in place to deal with concerns and complaints, which included providing people with information about the complaints process. Information on how to complain was very clearly displayed in the home, giving people the contact details they needed if they wished to do so. However, some visitors expressed hesitation about bringing up frustrations or complaints. One visitor said, "I don't want to get into trouble, I feel beholden. I know they wouldn't mistreat my relative, but I worry about saying anything. I hope I won't start trouble." People who used the service said they would speak to the manager if they had any worries, concerns or complaints.

Information was also on display to show how people could raise concerns with someone independent of the service if they wished. This person was known as 'Bob the Bobby' and the information posters gave contact details for how people could make contact with him.

We looked at records of complaints and concerns received in the last 12 months. It was clear from the records that people had their comments listened to and acted upon. This included written responses to people's concerns. The manager said any learning from complaints would be discussed with the staff team once any investigation had

Requires improvement

Is the service responsive?

concluded. We saw from staff meeting minutes that any feedback on concerns and complaints was discussed with staff in order to prevent re-occurrence of issues. We also saw that individual memorandums were sent to staff to inform them if complaints were received and what they needed to do to prevent future re-occurrence.

Requires improvement

Is the service well-led?

Our findings

At the time of this inspection there was no registered manager. A manager had very recently been appointed and was in post to manage the service. We saw the induction records of the manager which showed there had been a period of handover and support from the previous manager. The manager, supported by a team of nurses, senior care staff and care staff supervised the care given and provided support and guidance where needed. The manager said they were available to provide nursing care and advice when they were on duty to support the nurse who worked between each of the floors in the home.

Staff spoke highly of the manager and said they found them approachable. Comments included; "Supported by [Name of manager], she's a nurse so you understand each other", "New manager; I like her, seems strict but fair", "Just the few weeks we've had the new manager things are getting better" and "I like [Name of manager], she's really nice. Since she came she has always been approachable." Staff said they felt well supported in their role. They said the manager worked alongside them to ensure good standards were maintained and that the manager was aware of issues that affected the service. Staff described a happy team who enjoyed their work.

Staff said they felt listened to and could contribute ideas or raise concerns if they had any. They said they were encouraged to put forward their opinions and felt they were valued team members. One said, "I enjoy working here, I enjoy what I do. I can say what I think." We saw staff meetings were held on a regular basis which gave opportunities for staff to contribute to the running of the home. Topics for discussion included; training, feedback on care plans, handovers and sickness monitoring and rotas.

We were told that the provider visited the home regularly to check standards and the quality of care being provided. The manager and staff said they spoke with people who used the service, staff and the manager during these visits. We looked at the records of these visits and saw they took place regularly and included recent audits of care records, staff training and medication. Action plans had been developed from the visits and the manager was aware of these and the actions needed to improve the service.

The manager told us that there was a system of a continuous audit in place. These included audits on care plans, medication, health and safety, dignity, cleanliness and the premises. We saw documentary evidence that these took place at regular intervals and any issues were identified and then included in an action plan. However, it was not always clear if actions were addressed as the system to ensure this was not being applied consistently. For example, care plan audit action plans were not always signed off to say actions had been completed and therefore records improved. The manager agreed to ensure a consistent system was adhered to in the future. We noted that medicine audits were carried out at monthly intervals by a senior manager and that action plans were prepared and followed up at regular meetings with nursing staff.

People who used the service and their relatives were asked for their views about the care and support the service offered. The care provider sent out annual questionnaires for people who used the service and their relatives. These were collected and analysed to make sure people were satisfied with the service. We looked at the results of the last surveys in 2014. These showed a high degree of satisfaction with the service. The manager said any suggestions made through the use of future surveys would always be followed up to try and ensure the service was continually improving and responding to what people wanted.

There had not been any recent residents/relatives meetings at the home to ascertain people's views and communicate any changes at the home. People who used the service or their relatives could not recall any meetings. The manager said this was something they wanted to introduce to improve communication and involvement at the home.

The provider had informed CQC about a number of significant events that had occurred but they had failed to inform CQC about all reportable events which included the outcome of DoLS authorisations. The manager was aware of the need to do this and agreed to send in backdated notifications.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not have systems and processes in place to fully ensure the safety of the premises and assure compliance with national guidance and safety alerts.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Where people did not have the capacity to consent, the provider did not always act in accordance with the legal requirements of the MCA 2005.**