Amore Elderly Care Limited

Atkinson Court Care Home

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
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 20 January 2016. Our last inspection took place on 15 October 2014 when we gave an overall rating of the service as 'Requires Improvement'. We found two breaches of the legal requirements in relation to management of medicines and staffing levels.

On 04 June 2015 we carried out a focused inspection to look at the breaches we found at the inspection in October 2014. We found the provider had followed their action plan and saw medication was administered safely and people were supported by suitably qualified and skilled staff. Recruitment practices were safe. There were sufficient numbers of staff on duty to ensure people's safety. We rated the service as 'Requires Improvement' against 'safe' domain.

Atkinson Court is a purpose built care home for older people requiring general or specialist dementia nursing care. The home is conveniently located in the residential area of Leeds and is easily accessible. Atkinson Court provides a modern environment with 75 single en-suite

Summary of findings

bedrooms with shower facilities arranged over three floors. The home has 19 intermediate care beds for people discharged from hospital who need more support before returning home.

At the time of our inspection the manager was in the process of registering to become registered manager of this service. 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.

Medicines were not always safely managed as there were some gaps in the recording of medicine administration and the supply of a key medicine for one person was allowed to run out.

Staffing levels were not sufficient to meet the needs of the people who lived in the home. Nurse calls bells were continuously ringing and staff switched them off without providing assistance to people as they were busy.

The home was found to be clean and without malodours, although some people expressed concerns about infection control.

People enjoyed the food and drink on offer, although we saw some people had their drinks placed in areas which were out of reach. Some people who needed assistance with eating and drinking did not receive adequate support.

People told us they felt safe in the home and we saw there were systems and processes in place to protect people from the risk of harm. Staff knew how to identify abuse and where they should report their concerns to. Recruitment procedures used by the provider were found to be safe.

Staff were satisfied with the induction they received and refresher training was provided. Staff received support through the use of supervisions and appraisals. Staff were aware and knew how to respect people's privacy and dignity. Staff were kind, caring and patient when they were assisting people. Care plans contained sufficient detail which allowed staff to provide person centred care.

The records we looked at showed staff had completed training about the Mental Capacity Act. Care plans reflected the choices people were able to make and we saw evidence of applications for Deprivation of Liberty Safeguards (DoLS) and authorisations in place.

Staff felt appreciated by the home manager who they liked. The home manager was supported through regular visits and audits carried out by the senior management team. Confidentiality was not well managed as sensitive information was left in communal areas by staff which put information security at risk. The unit managers in the home needed more time to be able to manage their staff teams.

We found breaches of regulations 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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?

Inadequate

The service was not safe

There were insufficient numbers of staff to meet the needs of people living in the home. Call bells were continuously ringing and were switched off by staff who later returned to provide assistance to the person.

There were some gaps in the recording of medicines and one medicine had run out for one person which resulted in them missing doses.

People told us they felt safe. Staff knew how to recognise and respond to abuse correctly.

Is the service effective?

Requires improvement

The service was not always effective

People enjoyed the food and drink on offer, although staff did not always provide adequate support to ensure all people had access to nutrition and hydration.

The records we looked showed staff had completed training about the Mental Capacity Act (2005) and care plans contained evidence of mental capacity assessments and details of people's ability to make day-to-day decisions.

Staff received support through their induction, refresher training, supervision and appraisal meetings.

Is the service caring?

Good

The service was caring

The support staff provided to people was caring, compassionate and showed they knew people's likes and dislikes and how to approach them.

Staff knew how to protect people's privacy and dignity and this was also evident in their actions.

Is the service responsive?

Requires improvement

The service was not always responsive to people's needs

Care plans contained sufficient detail to allow staff to provide care for people. There was evidence of regular reviews.

The home had a range of activities, but planned to provide more person centred stimulation.

Complaints were managed thoroughly by the provider who sent letters of acknowledgement, carried out investigations and followed up with response letters and action plans.

Summary of findings

Is the service well-led?

The service was not always well-led

The unit managers were occupied with the administration of medicines and did not have sufficient time to manage their teams. There was a lack of consistency in the way different floors were managed.

Confidentiality of information was not well managed by some staff who left sensitive documents in communal areas.

Staff were satisfied with the support they received from the home manager. The provider carried out regular visits and undertook a series of quality monitoring audits.

Requires improvement

Atkinson 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 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 20 January 2016 and was unannounced. The inspection team consisted of two adult social care inspectors, a specialist advisor in nursing and two experts-by-experience with a background in 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.

At the time of our inspection there were 74 people living in the home. During our visit we spoke with the finance director, operations director, home manager, three unit managers and a further 12 members of staff. We also spoke with 27 people and seven visitors. We spent some time looking at the documents and records that related to people's care and the management of the service. We looked at six people's care plans.

Before our inspections we usually ask the provider to send us provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not ask the provider to complete a PIR prior to this inspection.

Before our inspection, we reviewed all the information we held about the home. We contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Inadequate

Is the service safe?

Our findings

We looked at the medication administration record (MAR) for one person and found evidence which showed their supply of a medicine used to prevent nausea and vomiting had run out the day before our inspection. The person's daily progress notes dated 16 January 2016 showed they had run out of the medicine, although staff had managed to obtain the same treatment in a different form.

We looked at the nurse's communication diary which showed the GP practice should be contacted to dispense a prescription. A staff member told us, "It doesn't look like this was done. They must have been busy and I wasn't in yesterday." The records we looked at showed steps had not been taken to obtain a supply of this medicine.

During the morning medication round the person whose medicine had run out told staff, "I'm feeling quite sick today." In the afternoon we were told by the nurse the medication had arrived at the home. This meant the person was able to have just one of the prescribed three doses that day. We made the home manager, operations director and finance director aware of our concerns. The home manager told us they would investigate this matter immediately.

We looked at four people's MAR's and found these contained a photograph of the person and any allergies they had. We found three of the MAR's we looked at had missing signatures. For example, one person's MAR had a missed signature dated 16 January 2016 for a folic acid tablet. We asked the staff member if any action needed to be taken if a missed signature was found. They told us they were not aware of any process in place but had not realised the signature was missing. The unit manager told us an incident report should be completed when missed signatures were identified. However, they said the report for this incident was missing.

At lunch time on the top floor a relative found a white tablet on the floor in the lounge area. This was given to the nurse who told us they would destroy it. We asked if there was a procedure to follow or if an incident report needed to be completed, they said they would just destroy it.

Staff told us the early morning medicines were administered by the night staff. On the day of our inspection the morning medication round which started at 08:00am on the second floor took over two and a half hours to complete. The unit manager told us the lunch time medication round was due to begin between at 12:30pm. The unit manager told us the medication round took a long time due the turnover of people receiving intermediate care. One staff member told us the medication round always took a long time because they had to count people's boxed medicines on this floor.

One nurse told us they had arranged for a pharmacist to visit the home the following week to carry out a complete medication review for each person. They told us, "We have so many interim medications due to the respite and recent admissions that the stock levels are all different and we need to have a consistent full monthly supply."

We observed medicines being administered to people on each floor. We saw medication trolleys were locked securely whilst staff administered medicines to people. We noted that not all the nurses washed their hands or used gel after assisting each individual resident. We observed nurses being kind and patient, allowing people time to take their medication and to have a chat about their night's sleep or breakfast. We saw where a person refused their medication, the nurse reassured them and returned 10 minutes later and the person took their medication.

We concluded this was a breach of Regulation 12(2)(f), (Safe care and treatment);of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a 'self- medication assessment' had been completed for one person who preferred to administer their own inhalers. We saw protocols were in place for PRN (as and when required) medicines. We observed staff checking with people, "How are you feeling today [name of person]?" and, "Do you need any paracetamol this morning?"

Medication fridge temperatures were seen to be documented daily and within safe limits. Boxed and bottled medications were seen to be in date, clean and dry with all names and dosage clear and legible with dates opened stated. Controlled drugs were locked securely and staff told us they were checked weekly. We saw the controlled drugs register was signed and dated by two nurses at each administration with continuous running totals recorded. We saw topical medication charts used to record the administration of creams and ointments were signed and dated.

Inadequate

Is the service safe?

One person said, “The staff are lovely. There's not enough of them. They're short staffed. You have to wait ages for a bed pan. Sometimes half an hour in the daytime.” Another person told us, “Sometimes when I'm buzzing they'll come and turn it off. They say they'll come back but they don't. They say they're too busy. I have to keep ringing” and “Breakfast was a bit late at 10:30am. But I think they're quite busy. I didn't really fancy lunch because I wasn't really hungry.”

One relative told us, “It's better than some places we've been, but she isn't normally incontinent and she's messed the bed three times since she's been here. When you need to go you need to go. It's degrading for her. It's the waiting.”

We asked staff about staffing levels. One staff member told us, “It’s getting too much. There’s a lot of agency now.” Another staff member said, “I think it’s ridiculous we have to work with five staff on a dementia floor.” A third staff member said, “When people turn up it’s a good staffing level.”

We found calls bells were very busy, most notably on the top floor which provided intermediate care. When we arrived there were only two staff answering them. The staff were responding to people using call bells in a kind and professional manner, however, some of the call bells were turned off by staff saying they would return to help them as they were just helping another person. We observed one member of staff approaching someone who had been waiting. The staff member told the person, “I’m going to help you get up. Sorry for this. We’re really busy.”

One staff member told us the call bells were always busy. We found this was particularly noticeable in the morning when people required assistance with personal care and other tasks. We carried out an observation on the first floor and timed a nurse call buzzer ringing for seven and a half minutes before it was answered. We observed the manager ringing staff on the floors where buzzers were sounding to prompt staff to respond. One staff member we spoke with told us they felt under pressure to stop the call bells ringing. We noted the physiotherapist was answering call bells and helping people to the toilet. They told us, “This is not a usual morning. It is about the duty of care and that is what I am doing.”

On the morning of our inspection we found two members of staff had taken sick leave. The manager arranged for both positions to be covered by agency staff, although one worker arrived at 10:00am and the other at midday. When new agency staff members arrived they completed an induction to the home, but it was not clear what they were expected to do when on the floor. There was no clear guidance to follow or pen pictures/profiles for each person who used the service. We observed the agency staff shadowing more experienced workers, but not undertaking tasks themselves. The unit managers were busy administering medicines and did not have time to provide direction to the agency staff.

We saw one returned relative survey dated 01 May 2015. The survey asked ‘what could be improved at the home?’ and the relative’s response was ‘floor cleaned and attention to buzzers’.

We spoke with the home manager who told us, “We are mindful we need to look at nurse call response times, particularly on a morning.” The manager told us under normal circumstances, either they or the assistant manager would be providing support on floors. We were told the deputy manager had temporarily transferred to working nights to provide additional cover. We saw the provider was working through a programme of recruitment to fill nursing, care and maintenance positions in the home. The operations director told us, “It’s the manager’s home. They can decide staffing levels.” We concluded this was a breach of Regulation 18(1), (Staffing); of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they felt safe and secure living in the home. One person said, “I feel very safe here. No one comes in or out.” Another person told us, “I am very well looked after the carers are excellent. You never get a nasty one.” One relative we spoke with told us, “I haven’t seen anything at all that would make me worried over the last three years.” Another relative said, “Staff haven’t done or said anything to make us worry.”

Staff we spoke with were able to identify the different signs which could suggest a person was being abused. They knew who to report their concerns to and felt confident the management team would take any concerns seriously. Staff told us they had received safeguarding training and the records we looked at confirmed this. This helped ensure staff had the necessary knowledge and information to make sure people were protected from abuse. The provider had a safeguarding policy and records of incidents they had investigated were maintained.

Inadequate

Is the service safe?

We saw the home's fire risk assessment and records, which showed fire safety equipment was tested and fire evacuation procedures were practiced. We saw fire extinguishers and fire blankets were present and in date. There were clear directions for fire exits. We saw a notice on the board in the corridor on the second floor stated fire alarms were tested every Tuesday. The fire alarm test records we looked at showed the last test was carried out on 15 December 2015. The homes manager told us they were a little behind with the fire alarms tests as they were in the process of recruiting a new maintenance person but said they would address this immediately.

We saw people had personal emergency evacuation plans so staff were aware of the level of support people living at the home required should the building need to be evacuated in an emergency. We saw equipment had been regularly tested and all the certificates we saw were in date.

In the care plans we looked at we saw relevant risk assessments had been completed. However, one person had experienced a recent fall which required treatment in hospital. There was no evidence of a risk assessment despite the type of treatment they had received which would require staff to check, for example, for the signs of infection. We spoke with a member of staff who said, "I have to admit he doesn't have one but we are improving the care plans now. It's just in the early stages yet."

We looked at the recruitment practices for four members of staff and found the systems and processes were safe. We found evidence of references being taken, along with professional registrations and checks with the Disclosure and Barring Service check (DBS). The DBS is a national agency that holds information about criminal records. This helped to ensure people who lived at the home were protected from individuals who had been identified as unsuitable to work with vulnerable people.

One person we spoke with told us, "It's very clean and there's no smell about it at all." However, another person we spoke with told us, "Between you and me, there isn't enough hygiene. A lot of the night staff are agency. They put my soiled pad and wipes on the tv table and they don't clean it after. I eat off that table." A third person told us, "It's funny how they never wash my hands. My hands only get washed when I get a full wash." During our inspection we observed the home environment was clean and hand gel was available from dispensers on each floor.

Requires improvement

Is the service effective?

Our findings

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 in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found mental capacity assessments had been completed in people's care plans where needed. We also saw evidence of family involvement. One care plan we looked at stated 'The 'resident's' husband is fully involved in all decisions'. We spoke with staff who were able to demonstrate a knowledge of MCA and DoLS and the training records we looked at confirmed most staff had received training in these areas.

The home manager told us new paperwork to record the status of DoLS applications and authorisations was being introduced. We saw DoLS applications had been submitted for people and where authorisations were due to expire, staff had submitted new DoLS applications.

We asked people how they were supported to make their own decisions and maintain their independence. One person we spoke with told us, "Staff are friendly and I do what I want to do." Another person said, "I can go to the toilet and dress myself and they help to get me up in the morning." One of the care plans we looked at stated [name of person] has short term memory loss and often repeats herself. [Name of person] to be involved and supported as much as possible in making decisions about how they spend their day'.

People told us they thought most of the staff were well trained. One person commented, "All the staff are well trained. I trust them all and all are easy to understand." People appeared well dressed and groomed, although one person said, "The girls do try, but they don't know how to shave a man. They need training. My chin is a bit of a mess." Another person said, "The only trouble is transferring me from bed to chair and my leg was hurt. I don't think they have been trained properly." A third person said, "They use a lot of agency staff and I don't think they're well trained."

We looked at the training records and found staff received a range of mandatory and non-mandatory training including; safeguarding, fire safety, food safety, moving and handling, health and safety and awareness of the equality act.

One staff member told us, "When I got my induction, it was enough." Another staff member said, "Although I have only been here a few weeks, I have been to quite a few training courses, including train the trainers so that I can teach other staff what I learnt."

The home manager informed us supervisions were scheduled to take place every six weeks and appraisals were held annually. We looked at the records for both supervisions and appraisals and found staff had received this support regularly throughout 2015.

One person told us, "It's great. The food's good and I'm comfy. It's got the thumbs up from me." Another person said, "Food is amazing it is really good." A third person said commented, "I've been here too long for them not to notice me. They look after me well. They know I don't have a big appetite. The food is just right." A fourth person told us the tea was always cold and there wasn't enough milk on their cereal. They said, "It's too dry today. I can't eat it."

During our inspection we saw staff had not always left drinks for people in their rooms where they could reach them. We discussed this with the home manager who agreed to look at this.

We observed the lunchtime experience on each of the floors and found a mixed experience for people. On the ground floor lunch started 45 minutes later than planned, but we saw people were talking amongst themselves and to a member of staff which made for a pleasant atmosphere.

On the second floor people told us they selected meals from a menu which came around the evening before. The dining room was nicely laid out with table cloths and place settings. However, the tables in the first floor dining room were not laid or place set as on the other two floors. For example, there were no tablecloths or cutlery.

Requires improvement

Is the service effective?

We saw people were given cups of tea, although some of these were returned as they were cold. There were also jugs of water on tables. The food looked well-presented and hot.

We saw one person in their room who was unsupervised trying to eat cereal whilst lying flat in bed. There were cornflakes all over him. We discussed this with the home manager as this person was at risk of choking. One person had their breakfast without their teeth in. This person told us, “Some of them put my teeth in, but not all. It's no good ringing for them cos’ they're busy. Anyway, it's alright cos’ it was weetabix, so I just wait till it goes soggy.” At lunchtime we saw the same person had their teeth in. They told us, “I feel more like myself now.”

We found people had individual records showing their likes, dislikes, allergies and the texture of the food they needed.

People told us they received support from staff if they wanted to see a health professional. One person said, “The doctor comes on Wednesday if I need him.”

We saw where a person assessed as being at high risk of pressure sores had a completed and signed ‘turn chart’ in their care plan. Body maps had also been completed for this person. We saw where a person had been discharged from hospital with a pressure sore, they were seen by the tissue viability nurse and an air mattress was in use.

We saw completed nutritional assessment tools recorded actions’. We saw nutrition and fluid charts were completed and we also saw evidence of people maintaining their weight. One relative told us, “She has lost some weight which is worrying me as she isn’t very big anyway, but the unit lead has given me an information booklet today about weight loss and dementia.” Another relative told us, “She has increased weight since she got here.”

We saw where a person assessed as being at high risk of pressure sores had a completed and signed ‘turn chart’ in their care plan. Body maps had also been completed for this person. We saw where a person had been discharged from hospital with a pressure sore, they were seen by the tissue viability nurse and an air mattress was in use.

A bed rails assessment had been completed for one person stating ‘As [name of person] constantly tries to climb out of bed this would be unsuitable as puts at higher risk of falling’. We saw following a person’s recent fall, staff had taken appropriate action and requested a GP to attend which resulted in a fracture being diagnosed and the person receiving treatment in hospital.

Good

Is the service caring?

Our findings

There was an inconsistent approach to memory boxes on the first floor for people living with Dementia. Some people had one or two items inside such as a photograph, whilst some rooms had none at all. We observed some doors had names on them whilst other rooms which were occupied did not.

We asked people about staff and they told us, “I couldn’t fault them I am well looked after. I would definitely recommend to others.” Another person said, “I am very satisfied here. I came to try it out on a visit and I really liked it. I am here and I wouldn’t want to go anywhere else.” A third person told us, “I have a lot of friends here and I really enjoy it.” A fourth person said, “I’ve been here four years and I like it a lot. It’s’ just like being at home.”

One relative told us, “Most of the carers are so lovely with her. They hold her hand and sing to her.” Another relative said, “Residents swear and sometimes push and shove, but the staff never retaliate or lose their tempers. They are very good.” We observed staff talking to people in a kind and respectful manner, including whilst caring for people who displayed behaviours that challenged, they remained calm and pleasant.

One staff member we spoke with told us, “It’s a really nice home and they care for people. I would recommend a family member coming here.” During our discussions with staff we found they knew about the people they were caring for. They were able to tell us about the life histories, likes and dislikes and preferences as to how people wanted to receive their care.

We spoke with one person who was finishing their porridge and commented they would like some more. Just as they said this a staff member entered the room and asked, “Do you want some more porridge then?” They both laughed and the staff member went away and promptly came back with a full bowl of porridge and said, “She loves her porridge, she always has two or three bowls.” We found staff had built positive relationships with people and were able to demonstrate knowledge of the individual preferences of people they cared for.

We observed a staff member assisting a person to the bathroom. The staff member spoke to the person in a quiet relaxed tone, encouraging them to use their walking frame. We saw this assistance was unhurried and the staff member kept checking if the person wanted to stop and rest. We saw where a staff member was assisting another person they commented, “Your hair looks so beautiful today [name of person] have you been to the hairdresser?” The person smiled at the staff member and nodded to confirm.

During lunchtime we saw staff providing compassionate care to one person who became very tearful. A staff member responded by providing reassurance and empathy. The same member of staff was seen complimenting another person saying, “Do you know, I do love that colour blue on you.” We saw another staff member helping a person to wash their hands after they had eaten and we saw other staff engaging with people.

On the first floor one staff member said to a person, “I will take you for a little walk if that’s okay with you?” The person started to sing a song and the staff member joined in as they went down the corridor singing and dancing together.

Relatives we spoke with told us they could come and go without restriction. One relative said, “I like the idea I can come in anytime and I can’t fault the care he gets.” One staff member told us, “We’ve had visitors here when we’ve left at 8pm.”

We saw staff knocking on people’s bedrooms doors before entering and say their name as they entered the bedroom so the person knew who was going into their room. Staff told us they helped to protect people’s privacy and dignity by closing doors and curtains when providing personal care.

We saw a compliment on display which noted ‘Thank you so much for your amazing care of our Mum. Although she was only with you a short while, you made her feel cared for and in her words, as if she had come home’.

Requires improvement

Is the service responsive?

Our findings

The care plans we looked at contained pre-admission assessments. This helped to ensure the home was able to meet the needs of people they were planning to admit to the home. This information was then used to complete a more detailed care plan which should have provided staff with the information to deliver appropriate care.

We saw care plans were reviewed on a monthly basis. Any changes to people's circumstances were reflected in the individual sections of their care plans. One relative we spoke with said, "We were all involved in the care plan and will meet [name of staff] to review it shortly." We saw 'Do Not Attempt Cardio Pulmonary Resuscitation' instructions were in place and they were completed and signed by the GP, the person and their relative.

We saw evidence of person centred care planning. For example, we saw notes recorded [name of person] enjoys talking about her family, family visits and looking at photographs and [name of person] likes to have handkerchiefs with her'.

We found people had record charts kept in their rooms. We saw staff completed the relevant form following any care given. For example, the 'personal hygiene record' for one person recorded '[name of person] really enjoyed her shower today and said she feels like a new woman'.

Several people we spoke with expressed they were bored. One person said, "There's nothing to do, so it's very boring." Another person commented, "Sometimes they have quizzes, but not very often. I wouldn't mind more activities. I would like to go out more. I used to love going to Tesco as I knew a lot of the staff and managers, but I have been told there is no one to take me." One relative told us, "She goes out with the co-ordinator all over. She does all sorts of things keep fit, painting and drawing." Another relative said, "The residents don't socialise much it is very quiet."

We saw a notice on display in the home which read 'Are there any activities you would like to do? Residents said they would like to go to the coast for a trip. We took residents to Blackpool and Bridlington for trips. More trips will be advertised'.

The home had two activities coordinators in place. During our inspection we spoke with a 'Dementia coach' who was visiting the home for three days. They told us they wanted to introduce a more personalised activities programme rather than traditional sessions of bingo and quizzes. They also said they were going to run a two day training programme for activities coordinators in the region and would carry out regular visits to keep in touch with progress.

The activity board on the top floor listed armchair exercise, trips out, arts and crafts, reading group, games, photography club and knitting sessions. We asked one staff member if any activity had taken place on the top floor during the morning and they say it had not. They said, "It is a little disorganised this morning."

We spoke with the activities coordinator who was enthusiastic about the stimulation they provide for people. They told us people who were unable to come out of their room were offered one to one support. We also saw an activities record, but found people some people taking part in activities once a week. Records kept were basic showing only the name of the activity and a mood score for the person.

We also saw a yearly planner of activity which included Valentine's Day, Easter and haggis tasting. There was also a weekly activity list which included for the weeks commencing 18 and 25 January 2016, ball therapy, dancing, bird feeder making and household therapy tasks.

There was a hairdresser on site with a dedicated hairdressing salon and people were having their hair done on the day of our inspection.

People told us they knew how to complain if they were unhappy with the service they received. One person said, "I'd tell nurses if I had a complaint, but I have never had any." Another person told us, "I have been here two years and I am very happy. Never had a problem, but if did I would go to the office."

On arrival we saw information on how to complain in the reception area. We looked at the procedure used by the provider to record complaints. We found the provider had robust systems in place to manage complaints received. We looked at the complaints file and found these were responded to as stated in the complaints policy.

On arrival we saw a sign in reception showing comments made by people. One question asked 'Are you happy with the furniture in the home?' The response from people stated 'It was felt Headingly House furniture needed

Requires improvement

Is the service responsive?

updating'. Headingly House was one of several names given to different parts of the home. As a result the provider took the following action 'Headingly House furniture has been replaced and new carpets ordered'.

Requires improvement

Is the service well-led?

Our findings

At the time of our inspection the home manager was in the process of registering to become registered manager of this service.

One relative we spoke with told us, "We are concerned that some of the agency staff don't know [name of person] and they don't seem to be told any details about what they need or like. Information is the biggest weakness in this home."

We found each floor had a unit manager, although they were occupied with providing nursing care and completing medication rounds. We found this affected the amount of time they were able to dedicate to managing the staff team, including agency workers. The home manager told us they were taking steps to increase the time the unit managers had to provide management support to staff.

During our inspection we found three care plans which were left in communal areas behind handrails and a supplementary chart left on a trolley. Lists of people's names were laid on the floor in a corridor area on the top floor. We asked one member of staff why the care plans were there and they were not able to give an explanation. The training records we looked at showed most staff had receiving training in 'confidentiality and data protection'. We discussed information security management arrangements with the manager, the operations director and the finance director. The home manager told us they would address this with staff immediately to ensure sensitive information was securely stored.

Relatives we spoke with were unsure about relatives meetings. One relative told us, "I don't know anything about relatives meetings." Another relative said, "I haven't heard about residents meetings." We did not see any meetings that had been held for people who used the service but a relatives meeting was held in September 2015. The home manager told us they had not carried out a resident or relative survey since 2014 and insufficient number of surveys had been returned for analysis to be carried out. The director of finance told us they were in the process of reviewing the gathering of feedback and a relaunch was due to take place in March 2016.

The unit manager told us a medication audit had been completed the day before our inspection but was unable to locate this. We saw medication audits had been completed in October, November and December 2015 which showed no concerns or issues with the medication administration procedures had been found. We saw the January 2016 medication audit had been completed for each floor and an action plan had been created. However, the missing signatures which had been identified during our inspection had not been identified through this audit.

We saw a monthly operations director visit report dated September 2015 which had identified in a list of action concerns regarding 'missing signatures' with the home manager having responsibility to address this.

We concluded this was a breach of Regulation 17, (Good governance); of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with staff who told us, "The manager is really supportive and I can go to them with anything." Another staff member said, "Things are much better with the new manager. We have made a lot of progress with improvements, particularly with care plans." A third staff member said, "I'm not happy with it. I don't think there's enough communication." A fourth staff member said, "The couple of times I've spoken with them, they've been lovely."

The home manager told us they received regular visits from the senior management team. They told us, "The restructure has definitely strengthened support for new people." We spoke with the finance director and the operations director who told us they visited every month. We spoke with two people from another one of the providers home who were helping support the unit manager on the top floor. They said they were spending four weeks at Atkinson Court and were looking at care plans and the destroyed medication procedure. The home manager also told us the chief executive officer for the provider had carried out a night time walk around two weeks prior to our inspection. Following this spot check they took steps to strengthen the unit management team.

We saw a range of quality audits had been completed by the home manager which included the kitchen area, the environment, bed rails and mattress, tissue viability and care plans. Where needed we saw action plans in place to address any concerns or issues raised. For example, new pillows were needed for four people following the mattress audit.

We saw a monthly operations director visit report dated October 2015, which included interviews with staff, people

Requires improvement

Is the service well-led?

who used the service and relatives, events, premises, fire records, maintenance and documentation. We saw actions had been identified, who was responsible for completing the action and a timescale for completion.

Records dated January 2016 showed the manager had systems in place to monitor accidents and incidents to minimise the risk of re-occurrence. This included a description of the incident, level of harm, investigation outcome and action taken.

We saw staff meetings were conducted on a regular basis. We looked at the 'head of department' meeting minutes for 18 January 2016 and saw discussions included supervisions, appraisals, activities, housekeeping and rotas. We saw the meeting minutes for 11 January 2016 included discussions about staffing levels. We saw general staff, managers and activity coordinators meetings were held regularly.

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 **There were insufficient quantities of medicines to ensure the safety of people and to meet their needs.**

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 **There were insufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the service.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The unit management arrangements were ineffective and confidential information was left in a communal area. Not all audits were effective.**