Cotswold Spa Retirement Hotels Limited

Rosemount Care Home

Inspection report

Sunningdale
West Monkseaton
Whitley Bay
Tyne and Wear
NE25 9YF

Tel: 01912510856
Website: www.fshc.co.uk

Date of inspection visit:
15 December 2016
19 December 2016
20 December 2016

Date of publication:
14 February 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Rosemount Care Home is a residential care home based in Whitley Bay, North Tyneside which provides both nursing and personal care for up to 60 older people. People are accommodated over one floor; there is a mixed residential and nursing care unit and in addition, a unit for people living with dementia. There were 53 people in receipt of care from the service at the time of our visit.

At the time of our inspection there was a registered manager in post, who had been in post since September 2016 and registered with the Commission to manage the carrying on of the regulated activities since October 2016. 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.

Our first comprehensive inspection of this service took place in May 2015 where we identified the provider was in breach of multiple regulations of the Health and Social Care Act 2008. The provider achieved compliance with legal requirements following subsequent inspections in December 2015 and April 2016, as they had taken steps to make the necessary improvements.

This inspection took place on the 15, 19 and 20 December 2016 and was unannounced. The inspection team consisted of one inspector. It was carried out in line with re-inspecting timeframes based on the rating allotted to the service following our last inspection.

At this inspection we found improvements to the service overall had been made and there was a positive feeling amongst people, relatives and staff about the home and service delivered. However, we found some shortfalls did exist.

People were complimentary about the service and told us they felt safe living at the home. Their relatives told us they had not seen anything of concern about how people were treated when they visited the service. People were supported appropriately with their mobility and staff adopted safe practices when assisting them. However, we found shortfalls with the management of medicines that put people's health and wellbeing at risk. Stocks of medicines were not well managed and several people did not have their prescribed medicines available to them. Recording around the administration of medicines was also not robust.

Risks that people were exposed to in their daily lives because of their physical and mental health conditions had been assessed and measures were in place to minimise people's exposure to risk. Environmental risks had been appropriately assessed and these were regularly reviewed. Checks on equipment and the premises were carried out regularly. Accidents and incidents were recorded and monitored for any emerging patterns and trends so that preventative measures could be put in place where needed. Emergency planning had also been considered and guidance was in place for staff to follow about how to support

people in the event of, for example, a fire or flood.

Safeguarding policies and procedures were in place and records showed that historic safeguarding matters had been referred to the local authority safeguarding teams in line with protocols. Staff were aware of their own personal responsibility to report matters of a safeguarding nature in order to protect vulnerable people from harm or abuse.

Recruitment procedures were robust and staffing levels at the time of our inspection were appropriate to meet people's needs. Staff had been trained in key areas relevant to their roles and also in specific areas related to the needs of the people that they supported. Staff supervisions, appraisals and competency assessments were carried out regularly to ensure that staff remained competent in their roles and that they were fully supported to deliver good standards of care.

Staff and people enjoyed good relationships. People and their relatives reflected that staff were kind and patient in their approach. People's needs were met and they were supported to access routine medical healthcare services to promote their health and wellbeing. Where necessary referrals to specialists such as speech and language therapists had been arranged. When people were ill external healthcare support was obtained promptly.

CQC monitors the application of the Mental Capacity Act (2005) and deprivation of liberty safeguards. The Mental Capacity Act (MCA) was appropriately applied and applications to deprive people of their liberty lawfully had been made to prevent them from coming to any harm where they lacked capacity. The service understood their legal responsibility under this act; they assessed people's capacity when their care commenced and on an on-going basis when necessary. Decisions that needed to be made in people's best interests had been undertaken and records about such decision making were maintained. We observed people were asked for their consent during the course of care being delivered.

People were supported to eat and drink in sufficient amounts to remain healthy. There were monitoring tools in place which ensured that where there were changes in people's health and wellbeing this was identified and actions were taken to prevent any deterioration in people's conditions. For example, food and fluid charts and positional change charts were used where people were at risk of malnutrition and pressure damage. However, we found that some of these records were not fully and appropriately maintained.

People told us they felt fully involved in the service and they were kept informed by the manager through meetings and general feedback. Staff promoted people's independence, privacy and dignity and they demonstrated respect towards people at all times. Care was person-centred and care records were individualised containing a range of information about each person's needs and preferences. The provider supported social inclusion through providing a range of activities for people to enjoy. People were afforded the right to make their own choices in their daily lives and staff facilitated these choices wherever possible.

Complaints were recorded and well managed and feedback was sought from people, relatives, staff and external healthcare professionals on a regular basis so that improvements in the service could be made.

People, their relatives and staff gave positive feedback about the registered manager and deputy manager who were relatively new to the service, whom they said had instigated positive change. The provider had a range of quality assurance systems and processes in place but these were not always followed effectively by staff and there was insufficient management oversight to ensure that they were. As a result, the shortfalls we identified in medicines and records at this inspection were not identified and brought to the registered manager's attention.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, namely Regulation 12, entitled Safe care and treatment and Regulation 17, entitled Good governance. You can see the action we have asked the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The management of medicines was not robust and some people's medicines were not available to them when they required them as they had gone out of stock. Recording around the administration of medicines was not always good.

Risks that people were exposed to in their daily lives had been assessed and were regularly reviewed. Environmental risks were also well managed.

Safeguarding policies and procedures were in place and staff demonstrated they were knowledgeable about how to protect vulnerable people.

Staffing levels were appropriate on the days that we visited to meet people's needs.

Recruitment procedures were robust.

Is the service effective?

Good

The service was effective.

People were appropriately supported. Their nutritional and general healthcare needs were met.

Communication within the service was good.

Staff were suitably trained and regularly supervised and appraised to ensure they were equipped with the relevant skills to deliver safe and effective care.

The Mental Capacity Act 2005 (MCA) was appropriately applied and the provider understood their legal responsibilities in line with this Act.

Is the service caring?

Good

The service was caring.

People and staff enjoyed good relationships. Staff supported people with patience and kindness.

People's privacy, dignity and independence were respected and promoted by staff.

Systems were in place to keep people and their relatives informed about their care and the operation of the service.

Advocacy services were available to those people who needed this support.

Is the service responsive?

Good

The service was responsive.

Care was person-centred and changed as people's needs altered.

Care delivery was monitored and measures were in place to handover key information to ensure consistency of care.

Activities were provided to promote social inclusion.

Complaints were appropriately responded to and feedback about the service was gathered regularly from people, relatives, visitors and staff.

Is the service well-led?

Requires Improvement

The service was not always well led.

Audits and other quality assurance systems were in place but these were not always effective in identifying shortfalls and failings within the service.

Overall records were well maintained but there was evidence of some shortfalls in recording about people's care.

There was a lack of management oversight and checking that auditing was carried out accurately to ensure a true and accurate picture of the service was obtained.

The registered manager and deputy manager had brought about positive changes within the service since their arrival in post. They were responsive to the shortfalls that we identified and sought to rectify these as soon as possible.

The registration requirements of the service were met.

Rosemount 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 15, 19 and 20 December 2016 and was unannounced. The inspection was carried out by one inspector.

We did not request a Provider Information Return (PIR) in advance of this inspection. A PIR 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 reviewed statutory notifications that the service had submitted since our last inspection in April 2016 and obtained feedback about the service from North Tyneside local authority contracts and commissioning team, and safeguarding adults team. Statutory notifications are submitted to the Commission by registered persons in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. They are reports of deaths and other incidents that have occurred within the service. We used the information that we had gathered to inform the planning of this inspection.

During our inspection we spoke with the regional manager, registered manager, deputy manager, seven members of the care staff team, six people who used the service and five visiting relatives. We carried out observations around the premises and reviewed records related to health and safety matters, infection control, medicines management, governance and quality assurance. We also reviewed six people's care records to establish if they were appropriate and well maintained, and we looked at five staff files to review recruitment processes, training and the level of support staff received to fulfil their roles.

Requires Improvement

Is the service safe?

Our findings

The management of medicines was not always safe. We observed the administration of medicines and found that staff followed best practice guidelines when they assisted people to take their medicines. People told us that staff supported them appropriately and stayed with them to ensure they took their medicines as prescribed to promote their health and wellbeing. The storage and disposal of medicines was appropriate. However, arrangements around stocks and ordering of medicines fell short of standards.

Some people's medicines had run out of stock and they had missed doses of their prescribed medicines as they were not available for administration. Stocks had run out the day before our second visit and staff had not informed the registered manager or deputy manager about this, although repeat orders had been placed. The regional manager and registered manager told us they had had some issues with the supplying pharmacy and they needed to address these and decide whether the electronic medicines ordering system that was in place was meeting the needs of the service.

We looked back at historic medicines administration record sheets (MARs) and saw that the availability of people's medicines was a long standing issue within the service. Records from two months prior to this inspection showed repetitive days where people's medicines had been out of stock and staff recorded this on the reverse of the MARs as a reason for non-administration. The registered manager was not aware that staff were recording medicines were out of stock repeatedly. We found no major impact on people due to the types of medicines that they had not received, but this demonstrated that medicines systems and processes within the service were not robust.

We looked at the recording around the administration of medicines and found some gaps existed where we were not able to reconcile if people had received their medicines or not. Some medicines were missing from their monitored dosage system packets, and there was no entry in the person's corresponding medicines administration record sheet (MARs) to indicate if, for example, medicines had been given, refused, destroyed, the person was hospitalised or some other reason.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Safe care and treatment.

At our last comprehensive inspection of this service we found that appropriate risk assessments related to people's individual care needs were well maintained and at this inspection these standards continued. People had risk assessments in place related to, for example, their nutritional needs, moving and handling, their mobility and skin integrity. These were regularly reviewed and updated as required.

Environmental risks around the building continued to be regularly monitored and reviewed through weekly, monthly and annual checks, for example those related to fire safety, equipment and the premises overall. Accident and incidents continued to be recorded electronically and monitored and analysed to ensure that preventative measures could be put in place where necessary to keep people safe from any risk of future harm.

Emergency planning remained in place including plans about business continuity matters in the event of, for example, a loss of power or unusually high levels of staff sickness. Personal emergency evacuation plans (PEEPs) were retained in people's bedrooms detailing the levels of support people would need individually should they be required to evacuate the building in the event of, for example, a fire or flood.

People told us they felt safe living at the home and relatives echoed that they had not seen anything that concerned them when visiting. One person said, "Oh I feel very safe here. The girls (staff) are lovely". Another person told us, "They (staff) would always treat me right". One relative said, "I have never seen anything that worries me here with staff interactions with people".

We observed staff delivered care that was both appropriate and safe. For example, staff supported people to move around the home safely, either with walking aids or without, depending on their dependencies and abilities.

The provider had safeguarding and whistleblowing policies and procedures in place to protect vulnerable adults. Staff displayed an in-depth knowledge of safeguarding procedures and the different types of abuse and harm that people could potentially be exposed to. They were aware of their own personal responsibility to report matters of a safeguarding nature. All of the staff we spoke with told us they would not hesitate to escalate their concerns, should they not be dealt with appropriately by the manager of the home, or the provider. The local authority safeguarding team confirmed that matters of a safeguarding nature were reported to them by the management team at the home and records held within the home and our own databases confirmed this.

Staffing levels within the home were appropriate to peoples' needs on the days that we visited and we did not observe people waiting for assistance. Staff told us they felt staffing numbers on each unit were appropriate, although at some times throughout the day they were very busy, for example, in the mornings when people were rising from bed. When people asked for assistance or used their call bells to summon staff, these calls were answered promptly by staff who were pleased to assist. Some people and relatives told us that there had been occasions where they had had to wait some time for assistance but that improvements had been made over the last six months and this was no longer a concern.

At our last comprehensive inspection of this service, robust and appropriate recruitment procedures were in place. These were still being followed at the time of this inspection and demonstrated the provider continued to follow safe systems and processes when recruiting new staff, which included appropriate vetting checks, to ensure vulnerable people who lived at the home were protected.

Good

Is the service effective?

Our findings

Feedback about the effectiveness of the service was positive. People told us they enjoyed living at the home and they were very satisfied with the standards of care and support they received. One person told us, "I think they are looking after me quite well. They would get me a doctor if I was not well". Another person told us, "There is nothing for me to complain about". Relatives spoke highly of the service their family members received and the numerous positive changes that had been introduced in the three months prior to our visit. One relative said, "The home is improving. I have no concerns about the care". Another relative said, "The care is very good on the whole. The feel of the place is better than it used to be. (Person's name) has a sensor mat in place now; (deputy manager's name) got that. (Person's name) steps on it and it goes off to tell staff".

People were supported to access routine medical support, or more specialist support such as that from a speech and language therapist, physiotherapists or psychologist, should this be necessary. In addition, people's nutritional needs were met and managed well. People were weighed monthly or more regularly if required, to ensure that any significant fluctuations in their weight were identified and could be investigated. Any weight losses and gains were recorded and staff were required to report these to the registered manager, who then took appropriate action to mitigate the risk of any weight changes. Where necessary, food and fluid charts were used to monitor that people ate and drank in sufficient amounts to remain healthy, although some repetitive recording in different records was taking place so records were not clear. The registered manager said this would be addressed promptly with staff. Some people required thickener in their fluids where they were at risk of choking as they had swallowing difficulties, and staff were well aware of who these people were.

The provider had a varied, rotating menu in operation and it showed people had many healthy food options available to them. People's dietary requirements and preferences were detailed within their care records. Any key information related to, for example, people who suffered with allergies, diabetes or swallowing difficulties was shared with kitchen staff and regularly updated. People reported that the food they were served was tasty and plentiful. One person commented, "The food is nice" and another person told us, "I like the food". Staff showed an awareness of supporting people with their nutritional needs as they encouraged people who were not eating or feeling sleepy at mealtimes to continue to eat their meals. Where necessary staff sat with people and assisted them to eat. People were regularly asked if they wanted any more food to eat, if they required another drink or if they were finished.

The environment within the home was clean tidy and well maintained. Visitors, people, relatives and staff told us that since our last inspection the home had undergone a refurbishment and redecoration programme which had resulted in it becoming more welcoming, light and airy. The registered manager and deputy manager shared with us their, and the provider's, future plans for developing the environment within the dementia care unit of the home, to more fully support the needs of those people living at the home with dementia.

Records showed that staff received regular training via e-learning and face to face courses, which were

relevant to their roles. The registered manager and administrator monitored training requirements via a matrix grid and arrangements were made for training to be refreshed as and when required. This ensured that staff were supported to deliver effective care as their skills were kept up to date. Staff had completed training in a number of key areas such as safeguarding and infection control, as well as some more specialised training relevant to their roles, such as training in pressure ulcer prevention and dementia.

A detailed induction programme was in place which incorporated the Care Certificate, and this was completed by new members of staff at the point they commenced employment with the service. The Care Certificate was developed jointly by Skills for Care, Health Education England and Skills for Health and brought into force in April 2015. It is a set of minimum standards that social care and health workers stick to in their daily working life and sets the new minimum standards that should be covered as part of induction training of new care workers.

Staff confirmed that supervisions took place regularly and appraisals annually. All of the staff we spoke with said they found these one to one sessions with their manager useful and supportive. Supervisions and appraisals are important as they are a two-way feedback tool through which managers and individual staff can discuss work related issues, training needs and personal matters if necessary.

Staff, people and their relatives told us that communication within the service was very good. All parties said they felt fully informed and there were communication tools in place, for example, to share messages amongst the staff team. Meetings with people and their relatives took place and also regular staff meetings, in which the registered manager passed on relevant and appropriate messages about changes within the home and service. Records were maintained within people's care files which demonstrated there were good levels of communication about people's care with external healthcare professionals, their relatives and any associated visitors. Relatives told us they enjoyed good relationships with the registered manager and deputy manager, and they were kept fully informed and up to date with any developments or changes in their family member's care. One relative commented, "They always ring me and keep me informed if there is anything wrong or any changes with my mam".

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 so that they can 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 service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Information in people's care records indicated consideration had been given to people's levels of capacity and their ability to make their own choices and decisions in respect of the MCA. For example, capacity assessments and then best interest decision making had taken place for some people related to them coming to live at the home and receive care. DoLS applications had been made to the local authority safeguarding team in accordance with legal requirements. There was evidence the principals of the 'best interests' decision-making process had been followed in practice and records were retained about these decisions. 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) forms were in place where people had consented to these, and where they were unable to consent, a communal decision instigated by a clinician had been made.

We observed people being asked to consent to their care and treatment throughout our visits. For example,

we heard staff asking people if they wanted their medicines, if they wanted drinks or food and if they needed any help with transferring around the home. Staff waited for people to respond and agree before carrying out any tasks for them, or providing them with any practical help and support. This showed that staff understood people's right to consent to care and they respected this right.

Good

Is the service caring?

Our findings

People and their relatives told us the home had a positive atmosphere and the staff team were caring. One relative told us, "The atmosphere here is much better than it was. Everything is lovely here, it really is. The staff are lovely and caring towards mum". A person commented, "I am very happy here. The staff are really nice". Another person said, "The staff are pleasant".

Our observations confirmed that staff and people enjoyed good relationships. Staff approached and supported people in a gentle and kind way, displaying a patient manner. They told people who had had their hair done by the visiting hairdresser how nice it looked and people smiled with appreciation and thanks. We observed staff comforting and supporting people when they became frustrated or upset, and appropriately reassuring them if they were distressed. One person living with dementia was distressed at the thought of having lost a personal item and staff supported them to look for this, then employed distraction techniques to refocus their thoughts elsewhere when it could not be found. Another person was concerned that their family member may not visit them and staff again dealt with this matter in a sympathetic and caring way, talking through the situation with the person, with patience.

Staff displayed a desire to support people in any way they could. They interacted with people respectfully, pleasantly and politely. They regularly asked people if they were alright and if there was anything they could do for them. Relatives too told us they enjoyed support from the registered manager and deputy manager, both of whom they could comfortably relay any concerns to, if necessary.

Information was readily available throughout the home and shared with people and staff via notice boards and in the reception area. In communal areas the registered manager had displayed any analysis of incidents and falls she had done, so that people and their relatives were fully informed and could pose questions if they wished. There was also information posted communally about overall feedback gathered about the service and any actions that had been taken in response to any issues raised. In people's rooms they had a 'My Journal' to encourage communication to and from visitors and relatives. There was also key information about people's social needs and how to support them.

During care delivery we saw that staff offered explanations about what they were doing in advance of assisting people. For example, at lunchtime, one member of staff went over to a person who could not communicate, and before sitting down next to them, they explained they were going to assist them to eat. People were asked if they were finished and wanted any more food or drink before their plates and cups were taken away, and when they were given medicines, explanations about the medicines and what they were for, were given to them in advance. We observed on moving and handling transfer where staff talked to the person before and throughout, so that they were fully aware at each stage about what they needed to do to assist, and how they would be supported.

People's privacy and dignity was protected and promoted by staff. Staff had been trained in equality and diversity and they applied this in their roles. People were well presented and particularly for those people living with dementia who could not always dress and wash themselves, consideration had been given to

their appearance by staff. We saw staff knocked on people's doors to respect their right to privacy where their doors were closed or where they had visitors in their rooms. Conversations of a confidential nature were held discreetly by staff either in quiet areas around the home or in offices behind closed doors.

Staff promoted people's independence in all aspects of their daily lives. There was equipment available to aid people to eat and drink independently. For example, people who needed them had specialised drinking cups with handles, and plates with guarded edges, so that food remained on the plate. People were supported with mobility appropriately but they were encouraged by staff to do as much as possible for themselves. Staff asked if people could manage alone or if they wanted support without simply assisting first. This showed people were empowered to retain their independence, for as long as possible. One relative told us, "My mum tries to do everything for herself. She is really independent even though she is in this home".

One person's care records showed they had an independent mental health advocate in place to support them in decision making, at the time of our inspection. An independent mental health advocate (IMHA) is a specially trained person who supports and protects the rights of vulnerable people within the framework of the Mental Health Act. The registered manager told us there were clear procedures in place should they need to arrange any form of advocacy support for other people in the future. Most people's relatives advocated on their behalf and where they did not, or people did not have family members to advocate for them, the staff team and management at the service took on this role.

Good

Is the service responsive?

Our findings

People and their relatives told us they found the service to be responsive to their needs and any issues that they raised. They portrayed that care delivered was appropriate and it was adapted as their needs changed. One person said, "They do everything I need them to and they get a doctor if I am not well". Another person told us, "There is nothing that I have got to complain about". A relative commented, "Mum is not very well today and they are looking after her really well". We saw staff were responsive to people's changing needs and where they needed interventions into their care from external healthcare professionals this was arranged and doctors or district nurse appointments were made.

Care records were individualised and contained information for staff to refer to about how best to support people. They were personalised with information about people's likes and dislikes and their personal choices about how they liked to dress, sleep patterns, life histories and their preferred activities. Pre-admission assessments had been carried out before people started using the service to determine their levels of dependency in key areas and risks associated with their daily lives. Care plans and risk assessments were regularly reviewed and updated to ensure that instructions about the care people needed to receive remained current. People had care plans and risk assessments in place for a range of needs such as personal hygiene, skin integrity, nutrition and medicines.

Care monitoring tools were used as a way of overseeing that the care people received was appropriate and any changes in their health and presentation were identified promptly. For example, positional change charts were used to record when people were repositioned, where there were concerns about their skin integrity. In addition food and fluid charts were used to monitor people's daily food and fluid intake if that was necessary. We found some recording in these tools was not being kept up to date and we relayed our concerns about the maintenance of people's care records to the registered manager and deputy manager. They told us that it was something they would review and reiterate to staff as soon as practicable.

Records and systems were in place to support continuity of care. A walk-around verbal handover took place when staff shifts ended and began, and this was supported by a handover booklet which listed actions to complete and any areas of concern or on-going monitoring of people's conditions. In addition, a diary system was used to pass key information between the staff team when shifts changed. Daily notes were maintained which showed evidence of personal care delivered, activities people had undertaken, their general mood and any issues, amongst other things. We found some minor issues with recording in daily notes where some entries had not been made and we relayed these shortfalls to the registered manager and deputy manager for action to be taken. Staff told us on the third day that we visited that a new notebook recording system had been introduced to record people's food and fluid intake and positional changes, which was much improved and allowed them to keep accurate timely records at the point of care delivery, that they then transferred into people's care records at the end of the day.

People's care was person-centred. They experienced positive outcomes and their care needs were met. Staff were clear about people's needs and how to support them effectively. For example, when we asked staff about particular people's needs and/or behaviours they were able to explain these in detail to us and they

clarified how they would support these people to manage their needs. The information they gave us tallied with information held in these people's care records and our own observations. We saw staff used distraction techniques to good effect when assisting people with dementia and they encouraged them to assist in tasks where they were both willing and able. This gave these people a sense of purpose and they outwardly displayed signs of happiness and enjoyment, which indicated they were being supported effectively. Records showed staff were responsive and had involved GP's and specialists in people's care when needed, to maintain their health and wellbeing.

A range of activities were available to people within the home and included external entertainers singing and performing. An activities co-ordinator was employed by the service to support people with their social needs, spending time with people in groups doing activities, or on a one to one basis as necessary. Plans were in place for a Christmas party on the first day that we visited and people and their families were looking forward to this event with enthusiasm. On the second day that we visited people said they had thoroughly enjoyed the party. This showed the registered manager and provider promoted social inclusion.

People were encouraged and supported to make choices for themselves. We heard staff ask people where they wanted to eat their dinner, where they wanted to sit, if they wanted to partake in any activities and what they wanted to eat and drink. People told us that they were always able to make choices and they had as much control and independence in their lives as possible.

People and their relatives told us they would not hesitate to raise a complaint with the registered manager should they have any issues or concerns. All of the people and relatives told us that they had not had any reason to complain in recent months. One person commented, "There is nothing for me to complain about". A relative told us, "I have absolutely no concerns or complaints". Where people or their relatives had raised any low level concerns or issues with the new management team, they said these had been addressed promptly. The complaints policy was displayed in the foyer of the home and a log of any complaints received was maintained electronically and were analysed for patterns by the registered manager and provider quality assurance personnel. Historic complaints had been handled appropriately and where relevant, paperwork related to the complaint and investigation had been retained. The registered manager told us they liked to gather regular feedback from people, relatives and visitors so that they could deal with any issues or complaints at an early stage before they had a chance to escalate.

The provider had systems in place to gather the views of people, their relatives and staff on a regular and on-going basis. For example, an electronic pad was situated at the entrance of the home where visitors, relatives and healthcare professionals could record their experiences either on entry or when exiting the home. The registered manager told us that each month every person was asked for their feedback about a particular area of the service, for example, about the environment, food, activities or housekeeping. We saw there were also core questions at the end of each of these topical monthly feedback questionnaires, that asked people if they felt safe and happy living at the home. Extremely positive or negative feedback was flagged on the system in red and this had to be reviewed by the registered manager and an entry made about any action taken, before being closed off. An overall annual analysis of the feedback obtained monthly was also carried out. 'Residents and Relatives' meetings were held within the home monthly, as were staff meetings. Minutes showed these meetings were an additional channel through which the provider obtained the views and opinions of people, relatives and staff, in order to review, reflect and improve on satisfaction levels within the service.

Requires Improvement

Is the service well-led?

Our findings

The provider had a number of structured quality assurance systems and processes in place. However, the findings of our inspection evidenced that these were not always effective in identifying shortfalls and failings within the service.

Audits related to medicines, infection control, the dining experience, nurse registration and numerous checks on the environment, equipment and people's skin integrity, weight and mobility were carried out weekly or monthly and the results analysed. The registered manager showed us evidence of a daily walk-around audit that she carried out. This checked that the environment was appropriately clean and safe, gauged staff morale, people's presentation and the standard of record-keeping in a sample care file. In addition to daily and monthly internal audits, the regional manager told us they visited the home on a monthly basis to carry out their own audits and checks on the performance of the service. The registered manager told us that internal audits and those carried out by the regional manager were inputted to the provider's electronic quality assurance system. This information fed into dashboards that were viewed by the managing director and director of quality and safety employed by the provider organisation.

However, the issues we identified where medicines were regularly going out of stock, was not picked up via the daily auditing of medicines or the monthly medicines audit. The daily medicines audits relied on nursing staff accurately completing electronic audits on an iPad (electronic device). This included answering questions about current stocks of medicines and the completion of MARs to reflect the administration or non-administration of medicines. We found that in practice staff did not complete these daily medicines audits accurately. On one of the days that we visited the daily medicines audit showed that there was no issue with stocks of medicines within the home, when in fact several people's medicines were actually out of stock. This showed that even though there was a specific question about medicine stocks on the daily medicines audit, nursing staff did not answer this accurately.

The registered manager and deputy manager were not aware of the issues we identified during our visits related to medicines and it was not until we discussed this with them that it came to their attention. MARs reflected that medicines could not be administered to some people because staff were awaiting incoming stocks and this issue had not been escalated directly to the registered manager by staff, despite a medicines daily audit being in place that was designed to highlight this. There was no management oversight of the completion of these daily medicines audits by nursing staff, and no separate checks carried out to ensure they were accurately completed. The monthly medicines audit that looked at medicines management within the service overall had not been completed since October 2016 due to workload issues. This meant the registered manager did not have a true and accurate picture about the failings with medicines management within the service.

Medication competency assessments were also carried out regularly but these did not prevent staff from making errors in recording about the administration of medicines and these errors were not picked up.

Overall records within the service were well maintained but we did find evidence of some shortfalls where

staff had not fully completed daily notes or records about positional changes that had taken place for those people at risk of damage to their skin due to poor skin integrity. Again in this area there was a lack of management oversight, as some of these shortfalls dated back weeks and they had not been identified or picked up by management or senior staff within the service. It was only when we identified these recording shortfalls that they were brought to the attention of the registered manager and deputy manager. Care file audits were in the process of being carried out at the time of our inspection and a matrix was in place to track progress with these audits.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Good governance.

At the time of our inspection there was a registered manager in post, who had been registered with the Commission to manage the carrying on of the regulated activities since October 2016. The registration requirements of the service had been met and we were satisfied that incidents had been reported to us in line with the requirements of the Care Quality Commission (Registration) Regulations 2009.

People, their relatives and staff told us the service was well-led. They said that recent changes in the leadership of the service had brought about positive improvements. They described the registered manager and deputy manager as approachable and caring. Staff informed us that morale amongst the staff team had improved with the change in management. A staff member said, "There has been a big change since (registered manager's name) came. It is much more organised and you know where you are and what you are supposed to be doing. It is definitely better than it was". A relative said, "(Registered manager's name) and (deputy manager's name) make a good team. I would definitely go to them about anything". Another relative said, "I definitely see a positive difference since they (registered manager and deputy manager) have come. It is running better (the home) and they (registered manager and deputy manager) are getting things done". A regular visitor to the home said, "Staff are a lot happier. It is calmer in the home and the manager (registered manager's name) is a breath of fresh air to be honest".

We spent time talking with the registered manager about her vision for the service. She told us that since her arrival at the home in September 2016 she had spent time addressing existing shortfalls which she had identified, and explained that there had been a turnover of staff which had resulted in some improved practice and improved morale. She explained that she operated an 'open door policy' where anyone could approach her at any time with feedback or concerns.

The registered manager shared with us her vision that the service would facilitate excellent care delivery for all people, with an emphasis on improved dementia care in line with best practice guidance. The registered manager and deputy manager were both passionate about their roles and both parties displayed a desire to drive through improvements within the service. They responded positively to the issues we raised and sort to rectify the shortfalls we identified as promptly as possible after we brought them to their attention.

The provider's aims and objectives recorded that they were committed to; providing good quality care to each and every person; listening to people and providing them with the care and support they say they need; keeping people informed; respecting choice; providing a welcoming, comfortable and safe environment; continually developing staff skills and knowledge; and believing staff work in what is the peoples' home not people living in their workplace. Despite the shortfalls identified in medicines management and governance at this inspection, we found the registered manager and staff team actively sought to fulfil these aims and objectives as much as possible.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The management of medicines within the service was not safe because people's medicines were not always in stock and available to them. Regulation 12(1)(2)(f)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems and oversight was not effective enough to identify the shortfalls found at this inspection in recording and medicines management. Regulation 17(1)(2)(c).