Hayes Cottage Nursing Home Limited

Hayes Cottage Care Centre

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection was carried out on 27, 28 April and 6 May 2015 and the first day was unannounced. The third day of inspection was to speak with key staff who were not present on the previous inspection days. The last inspection took place on 28 September 2013 and the provider was compliant with the regulations we checked.

Hayes Cottage Nursing Centre is a care home that provides nursing care for up to 48 people. The home has a ten bedded palliative care unit and two units for general nursing care which cater for a range of needs, including dementia. The service is registered for 52 beds and at the time of inspection there were 44 people using the service.

The service is required to have a registered manager in post, and there is a registered manager for this service, whose registration was completed on 7 May 2015. 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. The new owners took over the service in March 2015.

The majority of people and their relatives were satisfied with the care being provided at the service and we

Summary of findings

observed staff cared for people in a gentle and respectful way. Some people and relatives expressed concerns and work was taking place to improve communication so concerns could be addressed.

We found although people were receiving their medicines appropriately, medicines were not always being stored securely at the service. Recruitment procedures were not being followed robustly which could place people at risk. Call bells were not consistently within easy reach. Some fire safety procedures needed reviewing to ensure current fire safety guidance was being followed.

Staff were aware of safeguarding and whistle blowing procedures and demonstrated a good understanding of what constituted abuse and were clear to report any concerns. We identified shortfalls in complaints management and people did not always know how to raise a concern.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA). DoLS are in place to ensure that people's freedom is not unduly restricted. Staff respected people's right to make decisions for themselves and to act in people's best interests. The registered manager understood when an application for DoLS should be made.

People had a choice of meals and staff were available to provide support and assistance with meals. People's food and fluid intake and weight were recorded and were being monitored. People were referred for input from healthcare professionals when required.

The majority of care records reflected people's needs and were reviewed, however more work was needed to ensure these were comprehensive and kept up to date. People's religious and cultural needs were considered and respected. The service had a palliative care unit and people and relatives were happy with the care being provided.

Due to staff vacancies the activity provision was limited at times and people told us they would like more activities to take part in. Action was being taken to address this.

The registered manager was knowledgeable about the service and the people who used it. Staff commented on recent improvements in the management of the service.

Although the service was being monitored, shortfalls we identified at the time of inspection showed the monitoring of the service had not been effective, which could have placed people at risk. This had been recognised by the new providers who were introducing new auditing processes to address this.

We found three breaches 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. Recruitment processes were not being followed robustly and shortfalls in recruitment records were identified. Medicines were being administered safety. A storage shortfall was identified on one unit.

Individual assessments were in place for identified areas of risk and these were reviewed monthly, so the information was kept up to date. Risk assessments for systems and equipment were also in place and reviewed annually.

We received comment that one unit was not always appropriately staffed to meet the people's needs. Work was ongoing to recruit staff and review people's needs to address these issues.

Call bells were not consistently within people's reach. Some fire safety procedures needed reviewing to ensure current fire safety guidance was being followed.

Is the service effective?

Good

The service was effective. Staff had received training and further training was scheduled to provide staff with the skills and knowledge they needed to care for people effectively.

We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). DoLS are in place to ensure that people's freedom is not unduly restricted. Staff understood people's rights to make choices about their care and demonstrated knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People received the support and assistance they needed with eating and drinking, so their dietary needs were met.

People were referred to the GP and other healthcare professionals in a timely way, so their healthcare needs could be met.

Is the service caring?

Good

The service was caring. Overall people said staff looked after them well and were caring towards them. We observed staff listening to people, communicating well with them and supporting them in a gentle and caring way.

Staff understood the individual care and support people required and treated them with dignity and respect. The palliative care unit was well run and people's needs were being met. We recommended improvements in the completion of care records on this unit.

Summary of findings

Is the service responsive?

Some aspects of service were not responsive. Care plans were in place and were reviewed monthly so staff had the information they needed to provide the care and support people needed. People had not always been involved in care reviews, and action was being taken to address this, so people's input would be sought.

Activities took place and work was ongoing to improve the activities provision in the service.

People and their relatives did not always know how to raise concerns and complaints had not always been responded to in a timely way.

Requires improvement

Is the service well-led?

Some aspects of the service were not well-led. The service had recently changed provider, and work was ongoing to review practices and processes to improve the service provision.

The monitoring systems previously used had not been effective in identifying shortfalls. The new providers were introducing a new system to address this and this was work in progress to be reviewed at future inspections.

Requires improvement

Hayes Cottage Care Centre

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.

The inspection was carried out on 27, 28 April and 6 May 2015 and the first day was unannounced. The third day of inspection was to speak with key staff who were not present on the previous inspection days. The inspection was carried out by three inspectors, including a pharmacist inspector, a specialist advisor in palliative care and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. They had experience with older people and those with dementia care needs.

Before the inspection we reviewed the information we held about the service including notifications and information received from the local authority.

During the inspection we viewed a variety of records including eleven people's care records, twenty two medicines administration record charts, four staff files, servicing and maintenance records for equipment and the premises, risk assessments, audit reports and policies and procedures. We used the Short Observational Framework for Inspection (SOFI) during the lunchtime on the first day. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed interaction between people using the service and staff throughout the inspection.

We spoke with twelve people using the service, thirteen relatives, the registered manager, the nominated individual, the clinical nurse manager, the residents and relatives liaison officer, the hotel services manager, four registered nurses, ten care staff, the housekeeper, the maintenance person and three health and social care professionals, including a community matron, a Mental Capacity Act assessor, a palliative care nurse specialist and a fire inspection officer.

Inadequate

Is the service safe?

Our findings

We asked people if they felt safe at the service. Comments included. “It’s OK here, I feel safe.” “Very, very kind and helpful, I feel very safe.” And “It’s very good. I feel safe here.”

We checked to see if appropriate arrangements were in place for obtaining medicines. Staff told us how medicines were obtained and we saw that supplies were available to enable people to have their medicines when they needed them. However, the system used to reorder peoples medicines meant they were not checked by staff at the home before being dispensed by the supplying pharmacy which meant any errors or omissions could not be identified at this stage. As part of this inspection we looked at the medicine administration records. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed .The records showed people were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving people their medicines were recorded. Some people understood what medicines they were taking and others did not, but they confirmed they were given their medicines. Care plans for medicine administration were in place and recorded the action to be taken if, for example, someone refused their medicines, so the staff were aware.

Medicines requiring cool storage where stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use.

We saw that controlled drugs were not managed appropriately. We saw the administration records and stock levels were accurate however controlled drugs were not being stored correctly on the unit on the ground floor. Action was taken to address following our medicines inspection, however the fault had not been identified through the services medicines auditing process.

We also saw the provider did monthly audits to check the administration of medicines was being recorded correctly. Records showed any concerns were highlighted and action taken. However we saw the home did not have a robust system in place to monitor the stock levels of medicines which were not supplied in the monitored dose system and therefore it was not possible to do accurate stock checks to confirm medicines were being given appropriately.

This was in breach of regulation 12(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected because recruitment practices were not robust. In the staff records we saw application forms had been completed. In two instances a full employment history was not available and gaps in employment had not been explained. References had been obtained, however for two staff these did not include their most recent healthcare employer and there was no explanation recorded for this. Disclosure and Barring Service initial checks had been carried out and the result was available on the staff files, however the reference numbers for the full checks were not recorded, so it was not clear if these had been received. We were told staff were not employed until these checks had been completed, however this needed to be evidenced in the recruitment records. Proof of identity was not available on two of the files seen. Staff had completed health questionnaires. Initially photographs were not available on three of the files viewed and this was addressed promptly.

This was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Policies for safeguarding and whistle blowing were in place and a flow chart for reporting of incidents was displayed in the service. Staff were able to describe the risks that people living at the service could be exposed to and understood the protection of people's dignity was an important aspect of safeguarding in addition to protection against neglect and other forms of abuse. We asked staff to describe what they would do if they were concerned about another member of staff's behaviour or if they noticed marks on a person. Staff were clear about reporting procedures and said that they would report and record any concerns promptly. Accidents and incidents were being recorded and there was a reporting protocol in place, which was being followed. Staff knew about safeguarding and whistleblowing procedures and said they would report concerns to outside agencies, for example, the local authority or CQC if necessary.

Where risks associated with people’s care were identified there were specific instructions for staff to protect people against the risk. For example, risks of falls and pressure sores had been assessed and care plans were in place when these risks were identified. We spoke with staff about the risks associated with people’s care needs. We found

Is the service safe?

they were knowledgeable about each person's risks and how these were being managed. However, we observed one incident of where a person was being supported by one member of staff when the care plan identified that two staff were required. We received feedback that this had occurred on another occasion also. We discussed these findings with the registered manager who said she would investigate this and discuss with staff to ensure the correct number of staff cared for the needs of each person. Risk assessments were in place for equipment and safe working practices and had been reviewed in March 2014. These were revised every 3 years unless there was a change. We sampled the servicing and maintenance records. These showed that equipment including lifts, gas appliances, the fire alarm and emergency lighting systems had been checked and maintained at the required intervals, to ensure these were safe.

We saw an emergency planning policy dated 2013, for action to be taken in the event of an emergency. We noted personal emergency evacuation plans (PEEPs) were not in place for people living at the home, and the expectation of staff was that the fire brigade would evacuate the building if necessary. A fire officer visited the premises during our inspection and said this needed to be clarified to ensure current guidance and practice was followed. Following the fire officers visit, action was taken to complete PEEPs and update the fire risk assessment during our inspection. The nominated individual said once the fire officers report was received action would be taken to address any shortfalls identified.

Most of the people living at the home had a portable call bell unit which had an emergency button as well as a button to request general assistance. We saw people who spent time out of their rooms or were sitting out of bed in their rooms had these with them at all times. Some of the people in bed did not have their call bell units near them and it was not clear from the care records if there was a specific reason for this. We saw staff responded promptly to people who called out for attention. For example, we noted one person who had a call bell unit near them preferred to call out for assistance. Staff arrived within a reasonable period of time to assist the person. Another person who did not have a call bell was attended to promptly when they called for assistance. Staff responded in a timely way to answer call bells and when a person used the emergency button on their call bell unit a number of staff attended immediately. The registered manager followed up on this to ensure everyone who required a call bell had it in reach.

During the inspection there were appropriate numbers of staff on each unit in the morning, afternoon and night shifts. All the staff we spoke with felt there were usually enough staff on duty to meet people's needs as long as the full complement of staff for each shift was present. We were told that there had sometimes been difficulties in obtaining emergency cover when staff called in sick but that the new management were rapidly making improvements to this. The registered manager confirmed recruitment for new staff had taken place and would be ongoing, until all vacancies were filled. We noted staff seemed stretched on one of the units and on discussing this with staff they identified people's dependency levels had increased over time and staffing levels had not been reviewed to reflect this. Comments from people about the staffing included, "They haven't got enough staff, it's not fair to them and it's not fair to residents." And "I know they don't have enough staff, they're always in a hurry, the care doesn't go though." A relative said ''they seemed under staffed in the afternoons a couple of times. A lot of people require two carers so if they are busy with a person there is no one else around to help." One of the healthcare professionals also identified this unit appeared short of staff at times, which could cause a delay in people's needs being met. Two relatives told us between 8.30pm and 9.30pm the staff were busy and not out on the floor, so people were not being monitored. We fed this back to the registered manager who reviewed the staff handover process so two staff would be present on the floor. A new dependency tool was being introduced and the registered manager said this would be used to review dependency levels of everyone using the service, and staffing levels would be reviewed in line with people's dependencies.

Good

Is the service effective?

Our findings

We spoke with staff about the training they had received. Staff who were relatively new all said that their induction training was thorough and they were required to shadow an experienced member of staff for a week before working independently. Staff said that they were happy with the training provided and recent courses had included manual handling, infection control, safeguarding and dementia care. Registered nurses had received training in the use of specialist topics including syringe drivers, tube feeding and equipment to assist people with breathing. We observed staff understood how to use equipment and that it was being appropriately maintained. Training records confirmed the training staff had undertaken and also recorded what was planned. Dates for forthcoming training were displayed and staff were required to sign up for training and updates in a wide range of topics, being provided in May and June 2015. In addition to this the nominated individual had sourced external training for key members of staff and this included information technology, infection control, end of life, dignity and safeguarding and dementia awareness, which was planned for June 2015. Dementia care training had been undertaken by some staff, including more in depth 3 day courses, and more training sessions were planned. One member of staff told us this training had been very good and helped them to better understand the behaviours and how to meet the needs of people with dementia. Staff told us that they had regular supervision from their line manager and were able to tell us what had been useful about these meetings. Staff confirmed that they received annual appraisals. A supervision plan was in place and this was being followed, so staff received regular supervisions.

There was guidance available for staff on each floor about the importance of seeking people's consent before providing care. The staff we spoke with were clear about the need to ask people before they provided care and could describe how they insured consent when providing personal care. We overheard staff asking people before they supported them throughout our visit. People confirmed staff asked permission before supporting them. In the care records we saw people's capacity to make informed decisions about their care had been undertaken.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). This is where the provider must ensure that people's freedom was not unduly restricted. Where restrictions have been put in place for a person's safety or if it has been deemed in their best interests, then there must be evidence that the person, their representatives and professionals involved in their lives have all agreed on the least restrictive way to support the person. Policies and procedures in relation to the Mental Capacity Act 2005 (MCA) and DoLS were in place and staff training had been scheduled for May and June 2015. The registered manager understood the criteria and process for making a DoLS application. The service had arrangements in place for identifying and requesting assessments for DoLS which were ongoing at the time of our inspection. Eighteen requests for assessments had been sent to the local authority. We met an independent officer commissioned by the local authority to complete these assessments. The officer was able to confirm the service was proactive in requesting assessments for DoLS to be carried out when required.

We asked people what they thought of the food. Comments included, "The food is very good, considering they are doing it for a lot of people. They do their best to please, they are obliging. I get extra cups of tea if I ask for it." "The food is good, I get a choice." And, "The food is moderately tasty." People's care plans included information about their food preferences, whether they needed food pureed or drinks thickened, whether they preferred tea or coffee or took sugar and what sort of help they needed to eat and drink. We saw people were supported to make choices about the food they ate. We observed staff taking breakfast slips from people's rooms with their choices to the server to collect breakfasts for those eating in their rooms. We saw catering staff going around after breakfast asking people about their lunch preferences. We observed one person being supported with a meal saying that they did not like it. Staff suggested alternatives and the person choose ham sandwiches which we later saw being delivered by the catering staff.

We discussed meeting the dietary needs of people with religious or cultural needs with the hotel services manager. They were knowledgeable about people's needs and explained how the service met them. For example, by providing Asian meals for two people using the service and giving them the option to choose the vegetarian option on the menu, if they so wished. They were knowledgeable about any food intolerances and we viewed the resident

Good

Is the service effective?

meal preferences forms which were completed and a copy provided for the kitchen staff. As well as identifying people's likes and dislikes these also recorded any special dietary requirements, portion size and any special cutlery or equipment to be used. We saw people were given the meals of their choice and observed people using equipment, for example, plate guards, and it assisted them to maintain their independence when eating.

Where people were at risk and needed their intake monitored, we saw staff recorded their food and fluid intake throughout the day. People were weighed monthly and if concerns were raised they were referred to a healthcare professional for input. If people experienced problems with eating and drinking input from the speech and language therapist was sought, and we saw people received pureed food and thickened fluids in line with their instructions. We saw that people were regularly offered drinks throughout the day and fruit was freely available. We observed the lunchtime meal in the dining room. Staff were available to support people with their meals and did so in a gentle and unhurried way.

The care records identified a range of health and social care professionals who were involved with peoples care and wellbeing. We saw people were referred to the visiting GP, the tissue viability nurse, physiotherapist, social workers, dietitians, psychiatric services and other professionals as required and that referrals were made promptly when people's needs changed. Healthcare professionals confirmed staff were receptive and communicated any healthcare concerns to them, so action could be taken to address them. We saw one person was making good progress towards increasing their levels of independence and was actively engaged with their social worker and physiotherapist on a care plan aimed at them returning home to live independently. We saw that where people's health or mental wellbeing had deteriorated the involvement of other professionals was proactively sought. The residents and relatives liaison officer was responsible for arranging routine healthcare input, for example, the optician, dentist and chiropodist, and understood the importance of regular checks to maintain people's health.

Good

Is the service caring?

Our findings

We observed interactions between staff and the people using the service. Staff spoke to people in a kind manner, listening to them and involving them in choices about care. We saw staff explaining to people what was going on and offering them choices. Staff were respectful and warm towards people. There was a calm atmosphere in general and people told us they liked the staff and they were well treated. Comments from people included, "It's really good here. The staff are very helpful. If you want something they will help." "Staff are lovely, very good, very attentive, could not ask for more." and "If you ask what you want they will do it for you." The majority of relatives were very positive about the way people were treated. One relative told us, "The staff are lovely. They have a good rapport with my (relative). She doesn't want for anything." Another said, "They are really attentive. It's very nice. The staff are very caring." On one unit we found not all the people and relatives were happy with the standard of care. One person said, "Some carers are very good. [Carer] is wonderful, a lovely girl, you couldn't wish for anything better, she helps with the toilet very quickly. Some of the night staff aren't very good, one of them is very abrupt and doesn't help much." Another said they had found one night staff member to be "Not helpful." One relative said, "Some of the staff are kind and caring" but said some staff "do it their way whatever." Another relative said a member of staff had been quite offhand with them. We fed back the concerns to the registered manager so they could be looked into.

We saw care staff refer to people's records to find out information about people and their care needs when they needed to do so. On one unit the files contained good information about people background and past history which enabled more meaningful conversations to take place between people and those supporting them. However on another unit the files we looked at contained very little of this type of information. The residents and relatives liaison officer told us she was aware of this and was doing work on the records on this unit to include more of this information. We saw that people could bring their own belongings to the home and most rooms we looked at were personalised with ornaments, family photographs and other memorabilia, favourite objects and blankets.

All the files we reviewed set out information collected from people or their relatives about their likes and dislikes in respect of their care. One person told us, "I am quite happy. I tell them what I like and what I don't." One person's relative said, "They let [relative] choose as much as she is able to." Each person had a night time care plan which stated the time they preferred to go to bed, whether they had a hot drink to go to bed with, what they preferred to wear and whether they liked the light left on or off. We saw that this information was put into practice. We visited very early in the morning and saw some people's lights were on or a side light used, others were off, and doors were either open or ajar. One person confirmed they could choose if they wanted their door open or closed. We saw that people's preferences about being supported by male or female care staff was recorded and observed. For example we heard one member of staff asking another to attend to a person who did not like being supported by a male carer. People told us they could choose when they got up or went to bed and how they spent their day. Information about local advocacy services was displayed at the service, so people could access them if required.

One person told us, "The staff are very good, very polite and helpful, they definitely understand my needs." They said staff communicated and chatted with them and they respected their privacy and allowed them to maintain their dignity. Another person said, "Most of the carers are very good. They help me as much as they can." We observed care staff being careful about protecting people's dignity and privacy when delivering personal care. There were signs on each person's door reminding people to knock before entering and we saw care staff doing this throughout our visit. Personal care was carried out in the privacy of people's individual rooms and doors were closed and signs on the doors were turned to show 'engaged.'

On the palliative care unit people were assessed using the Gold Standards Framework holistic patient assessment tool. The nurse stated this should be updated weekly. One assessment had not been completed, one had been completed three weeks after admission and three had not been updated weekly, so information was not being completed in a timely way to ensure staff had information to enable them to meet people's needs. We reviewed five care records and found advance care plans had not been fully completed for two of the people, so their wishes had not all been recorded. However, people and relatives we spoke with on the unit were very happy with the care being provided and staff demonstrated an understanding of people's individual needs and respected their wishes. Two

Good

Is the service caring?

staff told us the allocation of care was organised around people's choice and one said, "If someone doesn't want a wash until the afternoon it is not a problem, we respect their wishes." Staff told us teamwork was good and we attended handover and saw staff interacted well and worked together effectively.

We recommend people's care, treatment and support is set out in a written plan that describes what staff need to do to make sure personalised care is provided.

The palliative care consultant visited the unit every week and reviewed all the people living there. There was also input from the GP and other healthcare professionals to ensure people's needs were being met. We spoke to a palliative care nurse specialist who told us, "We place lots of people here. We are 100% happy with it. Staff are very helpful. People improve considerably. Five weeks ago [person] was very confused and bedridden. She is now able to walk about a bit and is much better. Staff are always on top of the protocols whether or not people are on the palliative care unit or other units in the home. They feedback information very well. The feedback we receive from relatives that we follow up confirms that the care is very good." Staff had received training in end of life care and told us it was very helpful in understanding people's needs and also with supporting people and their families on the unit.

Requires improvement

Is the service responsive?

Our findings

Comments from relatives included, "We wanted [relative] to come back here as he always liked it and felt safe here. The staff are really good, very responsive. We chose it specifically." "My [relative] has really improved since she has been here. Her medicines are under control now and she is less depressed and much calmer."

Care records were comprehensive and provided a good picture of the person, their needs and how these were to be met. Where people had a complex care need, we saw specific instructions and care plans were in place, for example, for someone who was fed via a tube into their stomach. The care plan was clear and covered each aspect of the person's care in relation to this need. We asked staff about people's care needs and they were able to identify written information to verify aspects of the care provided. For example a risk assessment required one person's eyes and feet to be regularly checked because of their medical condition.

We saw records were kept about how people's day to day needs had been met. Staff were regularly monitoring people's health and care and responding appropriately. There were a number of examples of people admitted for palliative care living longer than had been expected, and they had moved from the palliative care unit onto a long stay unit. We were told of two people whose mental wellbeing and physical capability had improved during their stay. A relative told us they were kept informed of any significant changes in their family member's condition.

Monthly reviews of the care records were carried out with varying levels of detail included. One person confirmed they were involved with their care records and it was reviewed with them every 3-4 months. One relative also said they had been involved in a care review for their family member. Other people and relatives we asked said they had not been involved with care reviews. We spoke with the registered manager and the nominated individual about reviews and they said they had plans to ask people and their relatives to participate in care reviews. It was recognised this would provide people and relatives with the opportunity to discuss any concerns or questions they might have and promote good communication. On the last day of inspection we saw posters on display inviting people and relatives to participate in care reviews and the registered manager said they were writing to people's next of kin, so they could be involved if they and their family member so wished.

We asked people about the activities provided at the service. One person said, "I would like more activities to keep me occupied." Two relatives told us the activities room on one unit was not used, and that there was no stimulation for the residents in that unit. One told us, "About 7-8 weeks ago we got a sheet saying that there would be stimulation and activities and there are none." The registered manager explained the role of activities coordinator had been vacant, however they had successfully recruited and a new person was due to start in the next few weeks. An activities board was displayed by the main entrance setting out planned activities for the week. During our visit we saw staff engaged with people doing manicures whilst listening to music in one of the communal rooms. We also saw a bingo session being held which people seemed to be happily engaged with. The session was followed by strawberries and chocolate cake. During the day we noted staff ensured people were able to have the books they liked to read, or their Sudoku and puzzle books or knitting with them. There was a pleasant garden which people told us was used in fine weather and one relative told us their family member missed the company of peers to talk to but said, "[Relative] likes to go down for keep fit; she plays cards and has her hair done on Friday." The residents and relatives liaison officer said work was being done to improve the activities provision in the service, which had their own minibus. She said more trips were being arranged and staff were being encouraged to incorporate activities into the daily routines. People told us festival days were celebrated, for example, St Georges Day and Diwali, and musical entertainers visited the service regularly. We were given a copy of the activities programme for May 2015, which was varied. Representatives of the Roman Catholic and Baptist churches attended the service regularly for routine visits and also came in if people needed their care and support at other times. The residents and relatives liaison officer was able to access representatives from other religions if people wanted this, for example, Hindu and Jewish faiths, so their spiritual needs could be met.

None of the relatives we spoke to had received information about how to make a complaint should they wish to do so. One person said she had no complaints and had been

Requires improvement

Is the service responsive?

given a leaflet about the complaints procedure. Others did not know how to make a formal complaint. One person said they had raised a concern with a member of staff but had heard nothing further. We saw a copy of the complaints procedure was available, however it was several pages long and it was not easy to access. Action was taken at the time of inspection to display a single page clear procedure for people and visitors to read. We viewed the complaints file and saw where people had raised complaints these had been investigated and responded to. We found a copy of a complaint that did not appear to have been looked into, and brought this to the attention of the nominated individual. The residents and relatives liaison officer explained she visited people for one to one sessions and if anyone raised a concern with her she would pass this onto the registered manager for investigation.

This is a breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Requires improvement

Is the service well-led?

Our findings

The registered manager had been in post since November 2014 and had worked at the service as a registered nurse for several years. She was registered with CQC on 7 May 2015 and said she had several years of experience in management and would be completing a management qualification. The nominated individual had recently taken over this role and the service had new providers who took over in March 2015. We spoke with them all and they were aware there had been issues with the overall management of the service and were working to address these issues. For example, the monitoring processes had not been robust, as evidenced by the shortfalls identified during our inspection. The providers had a development plan in place for the service and they were introducing new auditing tools. We saw templates of these, which covered each aspect of the service. These included audits of recruitment, training, medicines management and meaningful activities. We saw provider monitoring visits had been carried out each month for 2015 and where any concerns were identified, for example, the vacant activities coordinator post and shortfalls in the social profiles in people's care records, action was being taken to address them. Action plans were in place and the registered manager signed off each area as it was addressed, which showed she took note of the findings and took action to address them.

We saw minutes of staff meetings for all levels of staff. These included departmental meetings to discuss specific topics, for example, food and fluids and improvements required with documentation. They also included meetings for the senior team, nursing sisters, nurses and care staff and unit meetings to discuss individual people's care needs, the challenges and to work out the most effective way to meet these. Further meetings for all sectors were scheduled for the year. One person said, "The place has been taken over by new people, and they're very kind. We don't see them really." Two people said they had not been asked their opinion about the service and they would welcome the opportunity to do so and to meet with the management. The last meeting for people using the service had taken place in November 2014 and the registered manager said they would be arranging individual review meetings and group meetings for people using the service. The providers had introduced a suggestions box and satisfaction surveys for people, relatives, visiting professionals and staff were available. The residents and relatives liaison officer said these were in the process of being given and sent out, and the results would be collated. We saw some had been completed in April 2015, which confirmed the process of surveying people had commenced.

Staff said they liked working at the home and several had been working there for many years. One person said, "It's a job you have to do from the heart." Staff expressed support for the recent management changes and felt the home had improved. They particularly commented on the efforts to ensure the full staffing complement for each shift. Staff said the registered manager walked around the units each day and the nominated individual was also seen on the units. They said both were supportive and approachable.

Palliative care guidance on the unit dated 2006 and more up to date guidance under the Gold Standard Framework folder was seen in the registered manager's office. We viewed the nursing policies folder on one unit and it was out of date, with policies dated 2008 with a review date of 2009 had not been updated. The policy folder in the Registered Manager's office had up to date reviewed policies dated October 2014 and the registered manager said she would arrange for copies of relevant policies to be made available on all the units. Policies and procedures were based on relevant legislation and good practice guidance and this was recorded on the documents to evidence the source of the information.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The arrangements for safe keeping of medicines were not appropriate to ensure the proper and safe management of medicines.** **Regulation 12(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **Complaints had not always been investigated so the necessary and proportionate action could be taken in response to any failure identified by the complaint or investigation.** **Regulation 16(1) HSCA 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The registered person did not operate recruitment procedures effectively to ensure the required information was obtained for people employed at the service.** **Regulation 19(2),(3)(a) and Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**