Mr & Mrs M Jingree

Norfolk House

Inspection report

34 Norfolk Street
Springfield
Wigan
WN6 7BJ
Tel: 01942 495777

Date of inspection visit: 8th January 2015
Date of publication: 13/05/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

We carried out this unannounced inspection on 08 January 2015. Norfolk House is a privately owned care home that offers personal care and support for up to18 older people. At the time of the inspection there were 16 people using the service. The last inspection and follow up took place in April and June 2014 and the home was found to be meeting all the regulatory requirements.

There was an acting manager at the home who was in the process of registering with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond to breaches of the Health and Social Care Act 2008 (Regulated Activities)Regulations 2014. These breaches related to safety and suitability of premises, meeting nutritional needs, cleanliness and infection

Summary of findings

control, respecting and involving people who use services and receiving and acting on complaints. You can see what action we told the provider to take at the back of the full version of the report.

We found that there was good security at the front of the building, but the back was not secure and people who used the service may be able to leave the building, unseen by staff, by that route. This could put people at risk of harm. People who used the service were also able to walk into the kitchen and office and at risk of harming themselves on objects they may pick up.

The main meal was provided from outside caterers and nutritionally balanced, but the other meals, supplied by the home were of poor quality and we saw little food on the premises on the day of the inspection.

Three of the toilets, for people who used the service, did not contain any liquid soap or paper towels, putting people at risk of infection. There was also no liquid soap in the staff toilet. We asked the acting manager if they had supplies of these, which she said they did. We asked why they had not been refilled when supplies ran out, but she could not give an answer to this question.

We observed a member of staff take a person to the toilet and leave the toilet door open whilst they went to get continence products, affording them no dignity or privacy. The staff member returned, and then closed the door.

Staff meetings were held on a regular basis, but the minutes depicted a list of directions from the owner and the manager, with little opportunity for staff to participate and voice their opinions. We were told residents' meetings were held on a six monthly basis but no minutes were produced for these. We were told that complaints and concerns were not responded to well, and we saw some evidence of this. People felt they were not listened to.

Staff were recruited safely and there were adequate staffing levels on the day of the inspection. However, there was a high turnover of staff and people who used the service could be put at risk due to staff possibly being unfamiliar with people's needs.

We observed good interactions between staff and people who used the service during the day. People generally felt staff were kind and considerate.

The environment was in need of some refurbishment and provided little stimulation for people living with dementia. Some areas, for example the conservatory, were not fit for purpose.

People's health needs were responded to promptly and professionals contacted appropriately. Records included information about people's likes and dislikes and we observed that people had choices, for example, about when to get up and when and where to eat.

We saw evidence within the records of appropriate assessments, carried out by the acting manager or owner. There were appropriate risk assessments within the files and these were regularly reviewed and updated.

Staff members told us the acting manager was approachable but staff and other people felt the owners were difficult to speak to.

We saw that audits were undertaken regularly to help ensure quality. However, the results were not analysed and follow up was inconsistent.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

People we spoke with who used the service said they did not feel safe.

Staff turnover was substantial and relatives were concerned that the staff did not understand their loved ones' needs.

Although there was good security at the front of the building the back was not secure and people who used the service who could be at risk of danger had been able to get out unaccompanied. People who used the service could walk into the kitchen and office and may suffer harm from objects they may pick up.

Staffing levels adequate on the day of the inspection, but a staff member was required to attend to kitchen duties. This meant that staff were sometimes tied up with food preparation.

Recruitment was robust.

Medication systems were in place and were effective.

Is the service effective?

Requires Improvement

The service was not effective.

Although the main meal was provided from outside caterers and nutritionally balanced, the other meals, supplied by the home were of poor quality and there were few supplies kept.

The environment was in need of some refurbishment and provided little stimulation for people living with dementia. Some areas, for example the conservatory, were not fit for purpose.

Staff undertook regular training and demonstrated a general understanding of the Mental Capacity Act (2005). There was evidence of appropriate best interests decision making.

Deprivation of Liberty Safeguards applications were made appropriately. The home were to make further applications in line with the local authority's procedure.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Most people we spoke with felt the staff were kind and caring and we observed staff delivering care in a compassionate manner. However, the high turnover of staff could mean that staff were not always familiar with people's choices and preferences.

Summary of findings

Dignity and privacy were respected by most staff, but we witnessed one incident where someone's privacy was compromised.

There was some evidence of relatives' involvement in care planning and on-going decision making, but this was inconsistent.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's health needs were responded to in a timely and appropriate manner.

There was good documentation about people's likes and dislikes and we observed that people could choose when to get up and when and where to eat.

There was an activities plan but we saw little evidence of any activities taking place. People told us there was little in the way of activities in the home.

Complaints and concerns were not always responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not well led.

The acting manager was approachable but people told us the owners were difficult to deal with and did not respond appropriately to concerns.

Staff meetings took place regularly but staff did not feel they were listened to or were free to voice their opinions.

Audits were undertaken regularly to help ensure quality, but analysis and follow up was inconsistent.

Norfolk House

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 unannounced inspection took place on 08 January 2015. The inspection team consisted of a lead inspector 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.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to the inspection we reviewed information we held about the home in the form of notifications received from the service. We also contacted Wigan Local authority Quality Assurance Team, who regularly monitor the service and the local Healthwatch. Healthwatch England is the national consumer champion in health and care.

We spoke with three people who used the service, six visitors and several members of staff including the manager. We also looked at records held by the service, including three care plans and four staff files, we undertook some pathway tracking, that is cross referencing care records, via the home's documentation and we observed care within the home throughout the day.

Requires Improvement

Is the service safe?

Our findings

One person who used the service said, "I can lock myself in not out of my room. I would like a key and be able to lock the door both ways. People wander about here, they go in all the rooms, office, kitchen; they come out of the kitchen with all sorts of things in their hands. Do I feel safe? No. It's a good job I can look after myself."

None of the people who used the service or visitors we spoke with had ever seen or heard any practice at the home that could impact on people's safety.

There had been a number of incidents where people who used the service had left the premises. This could have compromised their safety. The last incident occurred on 01 January 2015 when a person who used the service left the home and staff were unaware of how this happened. The person was found by police some time later, a considerable distance away from the home, inappropriately dressed for the weather and having fallen. They were taken to hospital suffering from hypothermia and a low pulse. We spoke with this person's relative who told us that their loved one had been missing from 5-15pm until 7pm. After an investigation with the acting manager and the owner the family said they had still not received an explanation of how this could have happened, though the service had placed the person on thirty minute observations to help ensure their safety. This was recorded within their care plan.

Security on the front door was increased after this incident. Visitors and staff were subsequently required to ring the bell to be admitted, through two security doors and when exiting and required to ask a member of staff to let them out. However, the back door, which was accessed through the kitchen, was unlocked on the day of the inspection, as was the back gate. Once through the gate there was free access to the front path and on to the street. This meant the building was not secure and people who used the service were unsafe.

On leaving the building darkness had fallen and both lights outside on the drive and parking area were broken. This made negotiating our way very difficult and could have been hazardous for both staff and visitors entering or leaving the building in the dark.

We observed people who used the service throughout our visit and some spent the day walking around. We saw them go into the kitchen on a number of occasions throughout the day. This meant they were at risk of harm by being able to leave the building unobserved. There were also risks to people's welfare via kitchen equipment such as knives and a kettle. Staff members were in evidence around the home, but were often busy attending to the care needs of people who used the service, so may not have been able to prevent harm occurring.

We saw that the office was left unlocked on many occasions during the day. People who used the service were also able to walk into the office and may find items which could cause them harm.

We found that the provider had not protected people against the risk of being able to access areas where they may find items that would cause them harm. This was in breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 15 (1) (b) of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

The service had an up to date safeguarding policy and procedure, which included reference to relevant legislation and the referral process. The safeguarding log kept by the home was complete and up to date and safeguarding issues had been followed up appropriately.

We spoke with a number of staff members who demonstrated an awareness of safeguarding issues and reporting mechanisms. The training matrix confirmed that most staff members had completed training in safeguarding.

Staff we spoke with were aware of the whistle blowing policy and the process to be followed. We saw the policy and saw that it had been reviewed in December 2013. Accidents and incidents were recorded appropriately and we saw these were audited and actions recorded.

We saw that emergency fire equipment was serviced regularly; there were reviews of safety equipment, weekly fire alarm tests, emergency lighting tests, reviews of fire doors and means of escape in an emergency. All these records were complete and up to date.

The home had a file with personal emergency evacuation plans for each person who used the service. These

Is the service safe?

indicated the level of assistance that would be required by each person in the event of an emergency. We saw that room risk assessments had been undertaken and actions recorded, as well as dates of completion of the actions.

We saw four staff files and there was evidence of robust recruitment procedures, including application forms, proof of identity and references. There were Disclosure and Barring Service (DBS) checks undertaken for staff in the files we looked at. A DBS check helps a service to ensure people's suitability to work with vulnerable people.

Prior to the inspection some whistle blowing concerns had been received about inadequate staffing levels and other staffing issues. We checked recent rotas and staff on duty on the day and levels were adequate, but we felt would be improved when a kitchen staff member was engaged.

We saw that a member of staff was required to attend to kitchen duties, such as serving breakfasts and clearing up and this meant there was less time for staff to provide care. We looked at recent staff rotas and compared these with staff signing in sheets to ensure these evidenced correct records, which they did.

We were told by a relative that on 03 January 2015 two staff on duty had left the lounge for about forty minutes while they attended to the personal care of a person who used the service. We asked the acting manager about ensuring staffing levels were sufficient, due to covering kitchen duties and possibly having to attend to personal care for long periods of time. She told us the service were in the process of recruiting a staff member for kitchen duties.

We saw that there was a high staff turnover, which was a concern reiterated by the majority of relatives we spoke with. The records showed that all except one member of staff had been at the home for less than a year.

The building was not very clean and one visitor pointed out a cobweb which they said had been there since May 2014. They also pointed out the dirty state of the window frames. We observed three walls in the lounge where pictures had been hung at some stage. These had been taken down and dirty marks and hooks had been left behind. Some of the bedrooms we saw were very small and poorly lit.

We looked into three of the toilets and none of these contained any liquid soap or paper towels. There was also no liquid soap in the staff toilet. We asked the acting manager if they had supplies of these, which she said they did. We asked why they had not been refilled when supplies ran out, but she could not give an answer to this question. This was not attended to promptly and we witnessed a person who used the service being taken to the toilet by a staff member, whilst there were no supplies in the toilet. This meant that neither the person who used the service nor the member of staff would have been able to wash their hands after the person had used the toilet.

We found that the provider had not protected people against the risk of infection. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the home's medication policy, which included guidance on self-medication, PRN medication, which is medication taken as and when required, guidance on transfer and discharge, medication errors, safe disposal of medication and arrangements for when people were going out of the home. There was no information on covert medication, that is medication given without the person's knowledge when they are unable to make an informed decision and the medication is given in their best interests.

We looked at the home's systems for ordering, storing and disposing of medication. There were robust systems in place and we saw that only appropriately trained staff were allowed to administer medication. We saw the medication was stored safely, in a locked trolley and a locked room. There was a lockable cupboard for controlled drugs, but the home were not using any controlled drugs at the time of the visit.

We saw that some of the medication administration records (MAR) did not have a photograph of the person attached to them. This could result in the wrong person receiving the medication, especially when there may be new staff. We spoke with the acting manager about this and she told us the photographs had been taken but had not yet been added to the sheets. We saw that a recent medication audit had highlighted this and the adding of photographs to the records was an action from the audit.

PRN medication was recorded separately with times of administration. This helped ensure people were given medication in a safe and timely manner. However, one relative told us their relative had arrived at the home from hospital and had asked for pain relief. This could not be

Requires Improvement

Is the service safe?

given as the acting manager told us the home do not keep a stock of homely remedies such as paracetamol. We were told that the home would implement a homely remedy policy following the inspection.

Requires Improvement

Is the service effective?

Our findings

We asked people if the food at the home was good. One person who used the service said, "It's like school dinners. I am looking at ways I can improve my diet I like olive oil, olives, tomatoes and salads. I need to try and eat healthy I have had five heart attacks". They went on to say, "If you don't like what is put in front of you get offered cheese on toast, beans on toast or chip butties. I asked for two boiled eggs one morning and they said they didn't have any. I gave one of the carers £1 to get me some honey for my porridge, the staff and the residents ate some so I will have to wait till I can get a taxi to town to get some for myself."

All the people who used the service and the visitors we spoke with said that the food especially the teas were poor. A staff member told us, "They get a lot of sandwiches, nearly every day at the weekend". A relative went on to say that, whilst they were visiting on 03 January 2015, staff had had to go out to purchase soup as there was no food in the home.

Lunch was bought in from the local hospital catering department and choice was limited. The only menu available was on the wall in the kitchen. All the visitors we spoke with said they had complained about the food and the time of serving the main meal. They had been told that the main meal could be moved to 4pm; however this had yet to be implemented.

We observed some of the lunch time meal. The tables had cloths, placemats and paper serviettes. No salt or pepper was available on any of the tables. Cold drinks were served in plastic beakers and people who used the service could have a choice of tea or coffee served in mugs. One person left all their food and they were offered jam and bread as an alternative. We observed drinks being offered though out the day and biscuits and chocolates were also left on a table for people who used the service to take if they wished. There were no healthy snacks in evidence, such as fruit.

The kitchen contained two fridges, a chest freezer and another small freezer. One of the fridges contained only a large tub of margarine. The other fridge had half a panatoni (cake) some opened jars of jam, bacon and some other cake. None of the food was dated and there were no records of fridge temperatures being checked regularly to ensure food was stored safely. The chest freezer contained six loaves of bread some frozen cauliflower cheese and garlic bread. The other freezer had bags of chips and fish fingers.

Although care plans contained nutritional assessments and special dietary needs were recorded, people commented that they did not get their preferred healthy diet. The food we saw at the home was poor in quality and there was little offered in the way of healthy snacks during the day.

We found that the provider had not ensured that people's nutritional requirements were met. This was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with six relatives. All the visitors spoken with felt the staff were sufficiently well trained and knowledgeable to carry out their caring duties.

The service user guide, a document with information about the home for people who may wish to become resident there, or their relatives, described the home as "Residential EMI". This indicated a specialism in caring for people living with dementia. However, the environment did not offer any evidence of dementia friendly resources or adaptations in the communal areas. We were taken on a tour of the premises and we saw there was no signage to help orientate people to place and direction. We saw a pin board with pictorial evidence of past events and birthday celebrations. Corridors were narrow. We observed one corridor getting congested which caused one person who used the service to get very upset. The walls did have hand rails to aid independence and freedom of movement.

The conservatory, which was described in the service user guide as an alternative place for people to take their meals, was not fit for purpose. There was no heating of any description and it was extremely cold. The room was full of clutter and the only chairs were old and had no cushions on them.

We looked at four staff files and saw evidence of a robust induction process. The files contained Common Induction Standards workbooks which people had completed in an agreed length of time. There was some evidence of

Requires Improvement

Is the service effective?

supervision and staff appraisal within the files and we saw a supervision chart which evidenced regular monthly supervision sessions with staff. All four files contained evidence of training and qualifications.

We looked at the training matrix and saw that most staff had completed training in mandatory areas, such as health and safety, first aid, safeguarding, fire awareness, dementia care, infection control and moving and handling. The matrix evidenced that some staff had also completed training in the Mental Capacity Act (MCA), which sets out the legal requirements and guidance around how to ascertain people's capacity to make particular decisions at certain times, and Deprivation of Liberty Safeguards (DoLS), which are part of the MCA and can be used when a person needs to be deprived of their liberty in their own best interests. This can be due to a lack of insight into their condition or the risks involved in the event of the individual leaving the home alone. The training had been undertaken on line and the staff we spoke with demonstrated a limited understanding of MCA and DoLS. The acting manager's understanding was also quite basic and she told us her MCA and DoLS training was due for renewal in the near future.

There was appropriate paperwork relating to the one person who was currently subject to DoLS and one authorisation which had been applied for. There was a restrictions screening tool in each file and records of restrictive practices if these were in place. These outlined the issues and concerns, the equipment used, such as pressure mats to alert staff to a person moving about. There was also documentation of techniques, such as distraction, used to ensure restrictions were as minimal as possible. DoLS authorisations were to be applied for in respect of all people who used the service who required this in the future, in line with the local authority's agreed procedure.

We saw, within one of the care files, recording of a person's best interests, around the issue of appointeeship. There was evidence that the appropriate professional from the correct team had been involved, along with family members and the process was accurately recorded. In another file there were records of a best interests decision concerning the providing of personal care. This was also recorded appropriately.

Assessments were carried out by the acting manager or the owner of the service and evidence of the assessments were in the care files. Appropriate risk assessments were kept in the files for issues such as pressure areas, nutrition, moving and handling, falls and continence. We saw these were regularly reviewed and were up to date.

We did not see any written consent documents in the care plans we looked at. However, we did hear staff seeking verbal consent from people for all interventions they administered. They took trouble to ensure people were happy with the care being offered before doing anything.

People's health needs were recorded in their files and we saw evidence of professional involvement, for example GPs, podiatrists or opticians where appropriate. Relatives we spoke with told us they were kept informed of all events and incidents and that professionals were called when required.

Requires Improvement

Is the service caring?

Our findings

We asked people if the staff at the home were caring. All visitors said that the staff were very welcoming patient and friendly. A person who used the service said, "Yes very kind but, since I came here six months ago ten staff have left, really good girls, real blinders. It's very sad." Another person who used the service told us he had no one to converse or be friends with as most of the other people who used the service were living with dementia.

One relative said, "They have been very, very kind to X. At first they called me every morning and evening to let me know X was OK." They went on to comment, "It's just like being at home. I bring my knitting and sewing. When X had a chest infection a carer sat with him all night to ensure he was OK".

Another relative told us, "Sometimes you can sense staff are anxious. They really try very hard, they are very committed. They have too much to do in the kitchen to have the time to help the residents properly".

A visitor was moving their relative to another home on the day of the inspection. They said the main reason was staff turnover. They told us that ten staff had left since May last year and they felt the constant changing of staff had unsettled their relative. They said they felt their relative was unsafe as new staff did not recognise their needs. The high staff turnover was a concern reiterated by the majority of relatives we spoke with as they felt staff may not be familiar with their relatives' needs and preferences. This could result in the care delivery being less person centred than would be desirable, for the people who used the service.

We asked if people had been involved in care planning for their relatives. A visitor told us that, if a person's admission to the home was not an emergency, relatives would sit down with the acting manager to discuss medication, preferences, likes and dislikes. After this initial meeting no other preferences as far as they were aware had been logged in a care plan.

One relative told us that their loved one had arrived at the home straight from hospital. No meetings with the owner or acting manager had been arranged to discuss anything about her relative or their needs or personal information.

All the people who used the service and visitors we spoke with said that the staff were very caring.

As we arrived at the home we saw some people were eating their breakfasts, as they had only just got up. This demonstrated that people could choose when to get up and when to have their meals.

We noted that some people who used the service were poorly presented, three of the gentlemen had not been assisted to shave and other people were wearing clothes with food stains on them. We spoke with the manager about this and she told us that the men sometimes refused to have a shave. However, the men were still unshaven much later in the day, as staff had not gone back later to offer assistance with shaving again after the initial refusal.

We observed staff assisting one person in a small lounge area, ensuring their dignity and privacy was respected. They demonstrated patience and compassion whilst assisting this person with their food. The same care was given to this person at the lunch time meal.

We observed staff delivering care throughout the day and saw some examples of care being given with kindness and compassion. We observed a staff member dealing sensitively with a person who was shouting loudly and appeared to be annoyed by another person who used the service. This person was moved to a suitable chair away from the person they perceived to be annoying them. The staff member engaged them in gentle conversation about the weather whilst moving them away and managed to calm them down.

Staff members were observed to be kind, patient and caring whilst delivering care. However, we did see for one person that their dignity and privacy was not maintained. We observed a member of staff take a person to the toilet and leave the toilet door open whilst they went to get continence products, affording them no dignity or privacy. The staff member returned, and then closed the door.

We found that the provider had not ensured that people's privacy and dignity was respected. This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The three people who used the service that we spoke with said they had not seen a care plan. However, within the care files we looked at there was evidence of involvement from family members and appropriate and timely referrals to relevant professionals.

Requires Improvement

Is the service caring?

We saw the information, in the form of the service user guide, given to people who may want to use the service, or their relatives. This included statements about the quality of service offered, which did not reflect what we saw on the day of the inspection. There was also information about open visiting and encouragement to relatives to remain involved in the care given to their loved ones. Other information included guidance around safeguarding issues and contact numbers for people with concerns.

Requires Improvement

Is the service responsive?

Our findings

A visitor told us, “The manager is very good at responding to health needs she calls us out straight away.” Another visitor said, “[My relative] rolled out of bed they rang me in the morning to say they were getting [my relative] checked out by the doctor. [My relative] was fine. Another time [my relative] had a chesty cough and they got the doctor in then”.

All the staff and visitors we spoke with said that when a health professional was need the acting manager responded straight away.

One of the people who used the service told us they had no one to converse or be friends with. They had various interests including painting and going to church but, though they had been offered support with these, had not pursued them. This person described their radio as their “best friend”.

Another person who used the service said they had asked for an easy chair and one had been provided. They said they would like a bigger room and we passed on the request to the acting manager. This person said they had been told on admission they would be taken out and activities would be available throughout the day. They had been in the home for six months and this had not happened.

We saw that people could get up and go to bed when they chose and could eat where they liked. We observed people who had stayed in bed late having a late breakfast. Visitors told us people could take their meals in their rooms if they wished to.

We looked at three care files which evidenced discussions with people who used the service and their relatives about preferences, likes and dislikes. We saw good documentation of referrals to other services and communication between services and with relatives. Assessments were evident in each file and reviews of care plans and risk assessments were carried out regularly and files updated with changes recorded. Relatives we spoke with said they had not been asked to contribute to any reviews.

We were shown the most recent newsletter issued by the home. This included information about the staff team, new residents, birthdays and events which had taken place, including a cake morning, barbecue, summer games and a trip to the Blackpool illuminations.

We saw that a residents and relatives questionnaire had been sent out in October 2014. These had been completed by three people and the comments included in them were positive.

We were shown a weekly activities programme with activities such as floor games, films, board games, pub quiz, arts and crafts, DVD, morning cake decoration, bingo, pamper sessions and Wii games. We showed this programme to the people who used the service we spoke with and three of the visitors. All said apart from DVD and the hairdresser none of the activities took place on a regular basis or at all. The only activity we observed on the day of the visit was the acting manager playing ludo with three of the people who used the service in the lounge.

We looked at the home’s complaints policy which was up to date. We saw the complaints log which documented responses to complaints. One response letter described the person who used the service as being “violent” which was insensitive and inappropriate language. There was no evidence of whether any attempt had been made to understand the reasons for the person’s behaviour and to try to address this in a positive way. Two other complaints documented that a letter of apology was sent out. We asked numerous times to see copies of these letters but they were not produced.

One relative told us they had previously raised concerns with the management which they felt had not been addressed. They told us they felt the provider had consistently avoided contact with them and would not discuss the concerns. They told us they had purchased equipment for their relative on advice from the home management staff, which was then deemed unsuitable for the premises. They were very unhappy with what they felt was an unsatisfactory response to their concern.

We saw that a monthly complaints audit was undertaken. However, we felt this was not effective as we spoke with one person who said the owners had consistently refused to discuss a complaint raised by them, resulting in them moving their relative to another home. Other visitors reiterated that when they raised concerns with the owners

Requires Improvement

Is the service responsive?

they were met with a defensive wall. One person told us they had raised a concern and the owner had "washed her hands" of it and told them they would have to sort it out themselves. Another relative said that, following an incident with their loved one, they had not received a satisfactory explanation from anyone, despite asking for this.

We found the provider had failed to respond appropriately to complaints and concerns received.

This was in breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

There was an acting manager at the home who was in the process of registering with the Care Quality Commission. She told us she was well supported by the owners. All the people who used the service knew the acting manager by name and said she was very approachable, but felt the provider was not.

We observed the acting manager interacting politely with people who used the service and people responded to her well. The acting manager knew the names of all the people who used the service and their relatives and was able to speak in some detail about them.

We were told by all the relatives we spoke with that communication about health matters was good. They were contacted by the home in a timely manner if their relative was unwell or had a fall and professionals, such as GPs, were brought in promptly when required.

We spoke with a number of staff members, some of whom were present at the inspection and others who we contacted afterward. The general feeling was that, although the acting manager was approachable, staff were not listened to by the owners of the home. They told us the owners had the last word about everything. One visitor we spoke with said, "(The owner) will not discuss concerns and staff are terrified of her". Another said they felt staff had been warned not to speak to relatives about concerns.

Staff meetings were held on a regular basis and we were shown the minutes of the most recent meeting. The meeting appeared to have been a list of directions from the owner and the manager, with little opportunity for staff to participate and voice their opinions. We were told residents' meetings were held on a six monthly basis but no minutes were produced for these.

We saw a number of audits undertaken by the home. These included a monthly overview which looked at accidents and incidents, complaints, training and safety. Separate audits included an annual medication audit, annual health and safety audits, monthly spot checks of the home and monthly care plan audits. These were complete and up to date at the time of the visit. We saw an annual development plan and planned programme of improvements which included completion dates.

A monthly audit of accidents was completed and actions were recorded. However, there was no analysis of accidents and incidents to look at any trends or patterns and lessons learned. We spoke with the manager about this who told us she planned to address this in the near future.

Some actions from audits were followed up, for example, there was an observation chart audit where missing documentation had been identified. A staff meeting had been arranged to address this. The room by room audit had identified some actions required and the date of completion was documented. However, the addressing of issues was not consistent. We saw a kitchen audit from which it was noted that fridge temperatures had not been taken for some time. These were still not being completed by the home on the day of our visit. Food which was open in the fridge had no date of when it had been opened. On the audit where dates of food opening were asked for the notes stated there were no "high risk" foods. All foods should have been labelled with the date of opening to ensure the safety and well-being of people who used the service. The medication audit, carried out in December 2014, had identified that photos were missing from some of the MAR sheets. This had not been rectified on the day of the inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: People who use the service and others were not protected against the risks associated with unsafe or unsuitable premises by means of appropriate measures in relation to the security of the premises.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People who use services and others were not protected against identifiable risks of infection by means of the maintenance of appropriate standards of cleanliness and hygiene in relation to premises occupied for the purposes of carrying on the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met: People were not getting a choice of suitable and nutritious food in sufficient quantities to meet their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints How the regulation was not being met: The provider had failed to respond appropriately to complaints and concerns received.

How the regulation was not being met:

Suitable arrangements were not made to ensure the dignity and privacy of service users.