Care Quality Commission

Sanctuary Care Limited

Hawthorn Green Nursing Home

Inspection report

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Ratings

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

Overall summary

We carried out this unannounced inspection under Section 60 of the Health and Social Care Act 2008 on 14th and 15th July 2014 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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

At our previous inspection on 11 October 2013, we were concerned that the service did not always maintain and promote people's wellbeing by providing social and daytime activities. On 13 January 2014 we found that some improvements had been made.

Hawthorn Green Nursing Home provides residential and nursing care for up to 90 people. The home is organised into six units, three of which specialised in caring for

Summary of findings

people with dementia. There was a registered manager in the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

We received some mixed feedback from people and their relatives about the service in relation to the care provided and staffing arrangements. However, the majority of people and their relatives told us they were happy with the care provided at Hawthorn Green Nursing Home.

The safety of people was being compromised with regard to staff numbers and staff arrangements and the ability of staff to access help when they needed in one of the units. Two relatives had some concerns about staff numbers on one unit and the ability of staff being able to meet people's needs. This reflected the views of some staff who were concerned about increased risks to the safety and wellbeing of people on the unit.

People who used the service were supported to have adequate nutrition and hydration, however staff did not always provide adequate support to people during mealtimes.

The provider could not always demonstrate how information about people's needs, hobbies and interests was used to plan and provide personalised and effective care to people.

People's needs were assessed and their care was planned with them, with their relatives, staff, and external health professionals. The main risks to people in relation to their care were assessed and action taken to minimise risks to them.

Staff worked well with health and social care professionals to meet the healthcare needs of people and responded well to plan and deliver care to people with complex needs.

People and their relatives told us they felt safe from abuse. Staff knew how to recognise and respond to concerns about abuse. Staff handled medicines in line with their medication procedures so that people received their medicines safely.

Staff were knowledgeable about people's assessed care needs and followed their individual care plans to provide their care and support. Staff received training and support in relevant areas to help them to perform their roles. However their knowledge and skills needed further development to enhance the care and welfare of people who have dementia.

Staff were patient, kind and caring and treated people who used the service with dignity and respect.

People knew how to complain and the majority of complaints were addressed, although not always promptly and records did not always show the outcome and response to people's complaints.

The majority of staff we spoke with said they felt supported by management staff, however some staff felt managers could be more proactive in listening to and addressing their concerns.

Whilst a range of systems were in place to check the quality and safety of the service, these were inconsistently applied. Areas for improvement and development were not always identified following quality monitoring systems and feedback from people and relatives who use the service.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. 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?

Requires Improvement

The service was not always safe. The safety of people was being compromised with regard to staff numbers and staffing arrangements and the ability of staff to access help when they needed.

People who used the service and their relatives said they felt safe from abuse. Staff knew how to recognise and respond to abuse. Risks to people were assessed and actions taken to minimise risks. People received their medicines safely.

People who lacked mental capacity to make decisions about their care and welfare were protected as the provider involved other professionals to follow best interest processes in line with the Mental Capacity Act 2005.

Is the service effective?

Requires Improvement

The service was not always effective. Whilst people were supported to have adequate nutrition and hydration, staff did not always assist people to have their meals promptly and as they needed.

Staff knew people's care needs and followed guidelines to provide appropriate care and support. There was good contact with healthcare professionals to access and provide care and treatment to people who used the service.

Staff had training and support in relevant areas, however their knowledge and skills needed more development around working with people who have dementia.

Is the service caring?

Good

The service was caring. The majority of people who used the service and their relatives said staff were patient, kind and caring towards them. People were treated with dignity and respect.

People and their relatives were consulted about their assessments and involved in developing their care plans. People's views and the views of their relatives were listened to in 'residents' meetings.

Is the service responsive?

Requires Improvement

The service was not always responsive. The provider could not always demonstrate how information about people's needs, hobbies and interests was used to plan and provide personalised and effective care to people.

The service worked well with other professionals to plan and provide urgent or complex care and treatment. People were able to raise complaints however records did not always show the outcome and response to complainants.

Summary of findings

Is the service well-led?

The service was not well-led in all areas. Whilst a range of systems were in place to check the quality and safety of the service, these were inconsistently applied. Areas for improvement and development were not always identified in all areas following quality monitoring systems and feedback from people and relatives who use the service.

The majority of staff we spoke with said they felt supported by management staff, however some staff felt managers could be more proactive in addressing their concerns. The management of the home ensured staff knew their roles and responsibilities and understood the goals and vision of the home.

Requires Improvement

Hawthorn Green Nursing Home

Detailed findings

Background to this inspection

Before our inspection we reviewed information we have about the provider, including notifications of abuse and incidents affecting the safety and wellbeing of people. We considered the provider's information return (PIR) as part of this inspection. The 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 other information submitted by provider about the organisation, such as any statutory notifications we had received.

We visited Hawthorn Green Nursing Home on14 and 15 July 2014 to carry out this inspection. We talked with 11 people who used the service and seven relatives. We spoke with eight care workers, three registered nurses including the clinical lead nurse, the registered manager, kitchen manager and domestic assistant. We spoke with four healthcare professionals including the team manager of a local community team who were in involved with and in regular contact with the service.

The inspection team consisted of an inspector, a specialist nurse advisor, a specialist dementia adviser and an expert by experience. An expert by experience is a person who had personal experience of caring for someone who used this type of service.

We reviewed records about people's care, including eight files of people who used the service and looked at how the home was managed. We used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help to understand the experience of people who could not talk with us. We used this method to observe care and support in communal areas and observed how people were being supported with their meals in two units during lunchtime.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Requires Improvement

Is the service safe?

Our findings

Staff numbers and staff arrangements were not always adequate to meet needs and ensure the welfare and safety of people who used the service. There were six units with 15 people in each unit. All except one provided nursing care. One of the units had changed its admissions criteria from nursing to residential care. We visited all the units whilst touring the home and spent more time in four of the units observing and talking with people who used the service, relatives and staff.

A relative reported a concern to the Care Quality Commission (CQC) about staffing on the residential unit prior to the inspection. They said the needs of some of the people were still high on the unit; that staff could meet basic needs but were overworked at times and some staff were not as well able to cope as others. Another relative on the unit said, "I think they could do with more staff. They are running around." Staffing on the unit had reduced from three to two care workers and a senior care worker had replaced a nurse. Across two units at night there remained one nurse and three care workers to care for 30 people.

We spoke with staff on the residential care unit. Staff said at least two of the people who used the service had behavioural needs and that other people's behaviours were unpredictable and could put them and others at risk. They felt that the current staffing arrangements were not adequate to

help with behaviour management and help with hoisting people. They said people's needs were under assessed and there were occasions when staff absences were not covered. Staff said they needed one more care worker on the residential unit and better access to additional staff help when needed, particularly in the mornings for personal care and when presented with challenging behaviour to not put people and staff at risk.

A senior staff member told us if staff could not manage the behavioural challenges of a person they would inform the person's care coordinator to reassess their needs. They said people were sometimes agitated on the unit and calm on other days.

However later that day, we witnessed an unprovoked aggressive outburst by one person on the unit, who hit a care worker in the face. The care worker told us this was an example of what could happen at any time. The manager told us there were five senior staff, including the manager, who could be called in to assist the unit if help was needed. The seniors were working on the day of the inspection. One care worker however said that sometimes calling for help was difficult and described a recent incident as an example. They said on that occasion staff intervened to protect one person, whose behaviour put them at risk of harm. Staff said this triggered disturbance and challenging behaviours from others in the unit, leaving one care worker to cope with their increased needs. The third staff member was not on the unit at the time. They said one of the care workers went to seek help, leaving people and the other care worker behind at greater risk.

We received some mixed feedback about staffing in the other units from people who used the service, relatives and staff. A nurse said they often did not have enough staff, whereas staff in the same unit said they could meet basic needs but could not always spend as much time as they would like to provide a more personalised service. A person who used the service said there was not enough staff whereas a relative told us that whilst they thought it would help staff if there were more of them, they thought there were enough staff overall and people were never neglected. We observed staff chatting and being attentive to the needs of some individuals as we walked around all the units. In one unit however we observed four individuals waiting an hour for support to have their meals. The manager advised that staff levels throughout the home were based on individual needs dependency assessments, which we saw in the files of all the people who used the service.

The lack of adequate staffing arrangements was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed that one person in a wheelchair was calling out a lot and wanted to go out in the garden. We discussed their needs with a member of staff, who said that the person's family usually took them out. However we received contradictory feedback from the person's relatives, who added that the staff were too busy to get the hoist and take their family member out.

People were not always able to access call bells in their room, making it difficult for them to call for help when they needed. The call bells for three people we observed were beyond their reach. In one person's room, a staff member said the person would ring the bell if they needed to call for

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Is the service safe?

assistance. We saw, however, that the bell was inaccessible to them. A senior staff member told us there was only one person who was able to use a call bell on the unit we visited and that staff checked all people's rooms regularly. The senior and member of staff themselves acknowledged the individual staff had not ensured the call bell was accessible on this occasion.

People who used the service whom we spoke with said they felt safe from abuse. All the relatives we spoke with also said they had no concerns about abuse and thought people were safe. One relative said, "I'm completely satisfied that mum is safe, and I've been coming here for four years." They said the home had information about what to do if they were worried about abuse. Relatives said they were told about the safeguarding procedure, in place to protect people and minimise the risk of abuse.

Since the last inspection Hawthorn Green Nursing Home reported eight allegations of abuse involving people who used the service and staff. The safeguarding concerns were reported to relevant bodies, such as the Care Quality Commission and the local authority safeguarding team. We noted that actions were recorded and taken after safeguarding processes were followed and in line with the outcome of local authority safeguarding investigations. For example, involving the psychiatric team to help with behaviour management and to keep people safe. All the care workers we spoke with received training and were aware of safeguarding issues, whistleblowing procedures and what actions to take.

One person who used the service said they were concerned about the safety of having one staff member rather than two to mobilise them. The number of staff assigned to help mobilise people was determined by their moving and handling risk assessments, contained in all the files we looked at. Each person's file contained core care plans which included assessments for a range of risks to individuals, for example, in relation to personal care and safety; risk of developing pressure ulcers and health and nutrition. Actions were put in place to reduce risks and risk levels were reviewed every month or when there were any changes. All accidents and incidents were recorded, investigated and monitored by the senior management team.

Staff sought people's consent to care and treatment. Where people lacked the mental capacity to make decisions about their care, staff arranged 'best interest' meetings to plan decisions. This involved other professionals to ensure appropriate processes were followed to safeguard and protect people's needs, rights and interests under the Mental Capacity Act 2005.

People received their medicines safely. Staff followed medication practices in line with the provider's policies and procedures in two units we reviewed. Medication sheets were signed to identify when medication was administered and by whom. There was a drug disposal bin for medicines to be returned to pharmacy and records kept. Each person had a blister pack of all their medication and all known allergies were being recorded.

We noted there were two expired medicines in one of the units and the supply of one medicine had been incorrectly written in the medication book. We brought these to the attention of the manager who said they would look into this, however overall however we found that medicines were well managed.

The residential dementia unit had undergone a number of environmental changes as agreed with the residents and their relatives and friends. People who used the service and their relatives said they liked the relaxed décor of the home. The dementia specialist on the inspection team, commented however that there was inadequate signage on the toilet doors, walls and other rooms. They advised that the environment could improve to better promote the independence of people who had dementia or to help orientate them.

A visitor told us about some damage to their relative's wall in their room not being attended to. A senior staff member told us delays had occurred with repairs as they did not have a maintenance worker for some weeks. The manager told us they had a temporary maintenance worker in place and a permanent maintenance person was in the process of being recruited. The provider had a twenty-four hour helpdesk to report any urgent repairs.

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Is the service effective?

Our findings

We found that permanent staff overall were knowledgeable about people's needs and how to meet them. Staff said they were familiar with people's needs by reading their care plans and providing care to people over a long period. One staff member we spoke with had been working in the home for 14 years. However in one unit a nurse gave us feedback that a lot of agency staff were used on that unit when cover was needed to fill shifts. They said, "The agency staff are not very good as they have poor skills and knowledge base." All staff were subject to the same training, support and supervision processes, including agency staff.

Staff acted in line with people's individual care plans to meet their needs, for example, to ensure those at risk of pressure ulcers were prevented from developing them. Staff documented their actions in wound assessments, body mapping and turning records in line with their care monitoring and recording procedures. No one in the home was receiving treatment for pressure ulcers at the time however referrals had been made to the Tissue Viability Nurse for further advice as needed in people's files.

The provider used methods to assess and monitor people's ongoing needs, using tools such as the malnutrition universal screening tool, weight and body mass index monitoring, physical dependency and moving and handing assessments. The care provided to people was clearly linked to the assessment tools used.

Staff said they received induction, regular training and supervision meetings with their managers every two to three months. Staff told us most of their training was computer based rather than practical and face-to-face with the trainers. One member of staff commented that computer courses were not as useful and that not all the training was relevant. We noted that training was a regular item of discussion in staff team and one to one meetings.

We saw that staff files included evidence of training on a range of relevant courses, including, positive behaviour management, dementia in care, fire safety, moving & handling, and National Vocational Qualifications (NVQs), health & safety courses and the Mental Capacity Act 2005. Staff files contained qualification certificates in health and social care. This indicated people were cared for by people who were trained and had a relevant care qualification. The domestic worker told us they had received a practical session in infection control. Kitchen staff said they had annual training and development.

We spoke with an external professional who had regular contact with the service who shared the view that staff needed more training and support to educate them and work more effectively with people who had dementia. This was a view that was shared by our specialist dementia advisor who assisted with the inspection. The professional also added that they had been working with staff to help develop their knowledge and skills in this area. The provider had sought additional training via the community mental health team.

We observed mealtimes in two of the units using the Short Observational Framework for Inspection, (SOFI). Whilst people were supported to have adequate nutrition and hydration, staff did not provide adequate support to a number of people at lunchtime in one of the units we observed.

In the dining area of this unit, for example, we saw that one person was not served a meal when other people were served theirs. Staff told us they always served the person last because they took so long to eat. There were four people in the main sitting area of the same unit, who were all confined to wheelchairs and had complex physical needs. One care worker assisted all four people to have their meals. We observed that this took up to an hour for them to get around to all the people.

We saw one person sat at the table for more than an hour, who was not engaging with anyone and not offered a drink by staff. In contrast to the other unit we observed there were no napkins for people to use during this lunch period.

Four people in the other unit we observed told us the meal they had was "very nice". The lunch time atmosphere was friendly, relaxed and sociable, including visiting relatives. Staff promptly served people's meals and helped those who needed assistance with their meals, giving choices of food and drink. We observed three people have lunch in their room independently. We saw a care worker assisting another person with their meal.

There was a choice of meals available in a set menu that included people's choices. Meals were discussed with people in regular meetings. We saw that culturally

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Is the service effective?

appropriate meals had been requested, including West African, Caribbean, Chinese and Asian as alternatives to the main menu. The chef said they attempted to meet special requests where possible and there was evidence of this.

A white board in the kitchen listed the dietary requirements of all the people, which included kosher, halal, puree, diabetic, gluten and salt free meals. The Provider Information Return (PIR) reported that 47 people had been assessed as being at risk of malnutrition and dehydration. Staff monitored the weight of individuals and ongoing concerns were referred to the doctors. We saw records of the input from visiting dieticians to the home. There was evidence that staff followed recorded guidelines as required.

There was good contact with healthcare professionals to access and provide care and treatment to people who used the service. There were bi-weekly visits from the GP Practice, referrals to and involvement from the tissue viability nurses, dieticians, dental services, occupational therapists and other health professionals. Hawthorn Green Nursing Home retained responsibility for coordinating care when there was a need for a multi-professional approach. There were records in all the files we looked at of care reviews and professional visits.

Good

Is the service caring?

Our findings

We observed staff interacted with people in a friendly and caring manner. Staff spoke with people and explained what they were doing to assist them with their needs. Staff gave people choices about how they wanted to be supported and explained to them what was available. Overall people who spoke with us said they thought staff were kind and caring. This was particularly well demonstrated by staff, who were patient and calm in their response to an individual displaying aggressive behaviour that challenged staff and others.

The views we received from people reflected the comment of one person who said, “They [the staff] are lovely. Very nice and kind.” One relative said, “Staff are always friendly and helpful.” We observed a good interaction between a member of staff who was reading to a person who used the service. Another person said they were “quite happy [with the service]”. When we asked a person if staff treated them with respect they said, “Yes.”

We found that staff supported and interacted with people in a way that showed them dignity and respect. We saw staff knocked on people’s bedroom doors and waited for permission before entering. When we asked staff how they would ensure people's privacy they told us they closed the doors or pulled the curtains when supporting them with personal care.

People and their relatives were consulted during their assessments and involved in developing their plans of care to reflect their wishes. They were encouraged to share their views, participate and volunteer with the home’s activities, as seen in records of their bi-monthly meetings.

People’s individual diverse needs were assessed and met, where possible, for example, in relation to people’s meals and cultural preferences. However people’s files did not always make clear how individual diverse needs were being met in other areas. For example, where ‘faith’ identified a religion in one person’s care plan, there was no action or support plan identified in any documents to state how this need would be met, such as by a visiting minister, staff or relative to assist the person.

Hawthorn Green Nursing Home had designated a room for relatives who wished to stay overnight and be close to their family member. People had access to hairdressing services in a room designated for this purpose, helping to respect and promote the dignity of people. Staff paid attention to people’s personal appearance and we saw that some of the women who used the service had their nails painted. However, we also observed that one person appeared to be unkempt in one unit and needed some attention to preserve their dignity. We advised the manager about this who said they would look into this and discuss the issue with staff providing their care.

Prior to this inspection we received information of concern that staff were not able to identify people whose needs or conditions were changing. They said there were inconsistencies in caring for people who were at the end of their life and processes were not always being followed. They felt the choices of people or their relatives were not always being achieved and there were training needs about this for staff.

We spoke with a senior clinical staff member about this concern. They told us the provider was currently working towards achieving the national programme in The Gold Standards Framework in Care Homes (GSFCH). GSFCH was recommended as an example of best practice and set standards and guidelines about end of life care.

The staff member said a monthly meeting had been set up recently with doctors and professionals who were involved in managing end of life care with people. The clinical lead nurse was attending the meeting that day with a doctor and a palliative care professional. The focus was to ensure people’s choices were respected, to assess people’s care needs and improve the planning and provision of end of life care. GSFCH champions attended monthly training and development at a local hospice. There was a designated end of life facilitator who provided support to the home. We saw documentation in people’s files which recorded people’s end of life and do not resuscitate wishes.

Hawthorn Green Nursing Home involved independent advocacy services, such as MIND, to advise, support and enable people to make informed choices and be fully involved in decisions affecting them.

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Is the service responsive?

Our findings

The provider could not demonstrate that information about people was always used to plan and provide effective personalised care for people who had dementia. Where people had dementia, for example, there was little information in their files to show how the dementia affected the person, what triggered their agitation and what calmed them. This meant staff did not always have useful and significant information about how to defuse behaviour in individuals whose behaviour appeared challenging to others.

All the individual files we looked at had documentation including care plans, which outlined people's needs, relevant background and social history related to them. "My life story" forms in people's files were detailed including people's lifestyle, faith, diet, family, likes and dislikes.

Whilst the files had relevant background history, we did not always find evidence of how this information was used to plan and provide personalised care. For example, the provider could not show that the welfare and wellbeing of people was always promoted by taking into account people's hobbies and individual interests in the planning and delivery of their daily activities.

This was a breach of Regulation 9(1)(a)(b)(i)(ii) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Activities were led by one full-time activities coordinator and their part-time assistant. There was an activities timetable and we observed sensory items and dolls in some of the communal rooms. On one unit staff told us the main activities that people who used the service engaged in was listening to music, puzzles, colouring, drawing and watching TV. We saw a positive interaction between a care worker and a person who used the service with the care worker reading to a person. In another unit, outside of the activities room we observed eight people in wheelchairs sat in a semi-circle with taped music playing. None of the people appeared to be engaged in an activity and no one appeared to be with them. A member of staff later began to clap along to the music and encourage people to join in.

We spoke with professionals from the local community mental health team who were regularly involved with the service and asked them for their feedback. They included the team manager, an occupational therapist and community psychiatric nurses. We received the feedback, "[The professionals] felt planned activities for people was a big problem. There is one full and one part-time activities coordinator for the home with little reference to individual activities in care plans." Some relatives we spoke with also expressed concerns about the lack of sufficient and meaningful activities. We noted in one recently held 'residents' meeting that activities were discussed and people who used the service and their relatives were encouraged to participate and volunteer within the home's activities and contribute any skill they had.

We spoke with an external professional, who said they advised staff about how to work with people who had dementia and the activities they could use. They said whilst the activities coordinator was very good, the activities and quality of staff engagement with people was not always effective as it depended on the skills of individual staff. They said that this was work in progress. The professional's view reflected the perspective of some of the relatives, whose discussions were recorded in their meetings. We had a similar comment about a lack of individual activities reported to us by a relative prior to the inspection.

The activities coordinator had started to complete an assessment tool called the Pool Activity LeveL (PALs) assessment for people who used the service. This was to identify what kind of activities would be appropriate for each person. It was also to determine people's levels of ability and support they needed in all aspects of their daily living. They had planned for staff to integrate this tool with people's individual plans. However the continuation of this work was unclear as the activities coordinator was soon to be leaving.

All people who used the service had their needs assessed prior to their admission. The provider used tools, such as a physical dependency assessment and a malnutrition screening form to assess and monitor people's needs. This information was used to develop individual care plans. Once a person was admitted, a named nurse or team leader took responsibility for coordinating all aspects of their care.

Care was planned with people who used the service, their relatives and external health professionals. Staff provided care in line with people's assessments and their plans of care. For example, people at risk of developing pressure ulcers were provided with pressure relieving mattresses to

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Is the service responsive?

protect them and were regularly re-positioned to prevent them from developing pressure sores. We saw referrals made to the tissue viability nurse for advice and no-one was currently receiving treatment for pressure ulcers. The manager told us they had prompt access to out of hours GP services and emergency services when needed. This reflected the feedback we received from a consultant psychiatrist, who felt there was good response from staff to seek medical assistance where required.

Most of the relatives we spoke with told us they knew about the complaints policy and had no complaints. The complaints policy was displayed on the noticeboards and "resident's guide book" and people told us they were able to raise their concerns with staff.

We were made aware of some complaints about the service during the inspection. One relative said they were concerned about the way staff communicated with them. They said, "Communication is not good." They described a recent incident where staff omitted to communicate with them about an important matter concerning the health of a person. This was discovered after their visit by another relative. A community team professional gave us information that they had a recent complaint from one person that the constant music in the lounge area could be irritating and we informed the manager about this.

Concerns and complaints raised were regularly discussed in staff, resident's and relatives meetings. Whilst the records showed the majority of issues were addressed, the outcome to some of the complaints and response to complainants were not always recorded. During the inspection one relative told us they had raised a complaint but had not received a response after three weeks, indicating that some complaints were not always handled in a satisfactory way. A recent quality health and safety audit report showed that complaints monitoring and closing of complaints was an area that needed improvement. We noted that a high percentage of people from the service's last survey were however satisfied how their complaints were handled including the communication from the service.

Whilst staff kept records about the care they provided, professionals we spoke with from the community team said that record keeping was generally poor and sometimes contradictory to verbal feedback about people. We found that the standard of records made by staff of the care they provided and of their observations was variable and not always clearly linked back to individual assessments of need or care plans and that feedback between staff and relatives was not always consistent.

Requires Improvement

Is the service well-led?

Our findings

There were clear lines of accountability in the management structure at the service. The management team included the deputy manager and clinical staff. The lead clinical nurse managed the nurses who in turn supported the care workers.

The monthly head of department management meetings included the senior managers of the service. Their records showed discussions took place about staff training, activities for people, housekeeping issues, clinical issues and actions following recent audits of the service.

The provider had quality governance procedures in place to ensure the service was well-led by a system of internal quality audits. Examples included monthly medication and care plan audits; quarterly infection control and quality audits and health and safety audits.

Audits were completed by staff within the service, by other internal teams and external organisations. The regional manager conducted monthly compliance visits to identify quality goals and to capture the experience of people. Every six months the provider conducted an Essential Standards of Quality and Safety audit. We saw action plans resulting from these audits and the actions undertaken by the responsible staff.

There was some evidence of improvement plans within the organisation. A business contingency plan was identified as an area for development and meetings were planned to discuss this. Moving and handling safety procedures were being reviewed to look at how people were moved from their beds following a complaint by a person.

These monitoring and control systems and actions showed the provider recognised the importance of regularly checking the quality and safety of the service. However, whilst quality assurance systems were in place, these were inconsistently applied. For example, we found the quality monitoring systems had not identified or addressed issues regarding the pressures and concerns staff experienced on one of the units and comments, suggestions and the outcome and response to all complaints where these were not reported.

The provider was unable to show any action or development plans regarding how they would improve the service for people or their relatives. For example, whilst annual satisfaction surveys were conducted, there were no actions identified or analysis of areas shown for improvement and development following the last survey in 2013 where people showed areas of discontent. An analysis of the latest results had not yet been produced as the survey returns were still awaited.

The service held regular meetings with people who used the service and their relatives in order to involve them in the delivery of their services. Meetings took place every three months and these were well attended. However records did not always show the actions taken and response to people and their relatives who expressed their views in the meetings.

The majority of staff we spoke with said they felt supported by management staff, however some staff we spoke with felt managers could be more proactive in listening to and addressing their concerns. Visitors talked positively about the management of the service. The manager said they had an 'open door' policy and people and staff could talk with them at any time.

The manager said staff were supported through training and supervision. Staff told us that it was through their training, one to one support, team meetings and handover meetings that they were made aware of the policies, procedures and their responsibilities.

There were regular staff meetings to ensure the staff understood the goals and vision of the home. Records showed that discussions focused on a range of areas with staff, such as care planning, incidents, training, health and safety, policies, procedures and quality assurance systems.

Staff informed us that information was shared in staff meetings and daily handover meetings. Two staff members told us the staff meetings were sometimes inaccessible to them as they were often announced at short notice. To evidence this they showed us a letter of a team meeting and we saw the letter was dated the same day as the day of the meeting. They said they had a care worker representative whose role was to communicate issues on their behalf. However they felt the communication flow between staff, the staff representative and the management team was not always effective. They felt this meant management could miss out on important matters affecting them and of the staff team not having essential

Requires Improvement

Is the service well-led?

information. The manager said that minutes of staff meetings were recorded which staff could consult and staff could approach them directly any time to discuss their views or concerns.

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 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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The safety of people was being compromised due to staffing numbers and staff arrangements and staff being unable to access additional help when they needed.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The provider could not always demonstrate how information about people's needs, hobbies and interests was used to plan and provide personalised and effective care to people.**