

Anglia Retirement Homes Limited

St Mary's Court

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?

Requires improvement



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

This was an unannounced inspection carried out on 6, 7 and 8 January 2015. At the last inspection in July 2014 we found that not everybody was receiving the care they needed and professional advice and support was not always being sought for people. There were no systems in place to develop solutions to reduce risk and protect people or drive improvement to the quality of the service being delivered. An action plan was received from the provider in October 2014 telling us of the actions they had taken to meet legal requirements. At this inspection we found that improvements had been made. Further improvement was required to ensure consistency and sustainability.

St Mary's Court provides accommodation, personal care and nursing for up to 90 people. The service mainly provides care to people living with dementia; and/or people who need nursing and palliative care. There were a total of 71 people living in the service at the time of our inspection.

There are four units spread across three floors. Ash and Beech provided care for 23 and 10 people living with early onset dementia; Cedar provided nursing care for 30 people and Oak provided care for up to 27 older people living with advanced dementia.

The service has a registered manager. A registered manager is a person who has registered with the Care

Summary of findings

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.

A lack of records in some areas including some relevant individual risk assessments, monitoring tools and care plans meant that people may not always be supported consistently and in the correct way. Staff did not always know about or understand how to use or check that equipment was being used safely.

There were robust systems in place to recruit and select new staff and ensure they were suitable for the role. Staff were not always deployed effectively across the service to ensure that at key times of the day people's needs were responded to appropriately.

The provider had systems in place to manage safeguarding concerns and people's medicines. Staff understood their responsibilities to report any concerns they may have.

People's views about meals varied. Improvements were needed to ensure that people did not wait too long between each meal. Although snacks were available it

was not clear how these were promoted or how people unable to communicate had their intake monitored. Records were also inconsistent so it was not possible to know in some cases what people had.

Plans were in place for staff training and professional development in areas specific to people's healthcare needs including dementia. This enabled staff to meet their needs more effectively. However this was not yet fully implemented across the service. This led to some inconsistencies in staff practice. The management recognised needed to be improved and sustained.

The provider had recognised that the environment needed further development to meet the needs of people living with dementia and plans were in the initial stages to address this.

The provider had strengthened quality assurance and governance systems which enabled them to have a clear oversight of the service provided, work towards addressing the issues previously identified and drive improvement. However not all improvements had been fully implemented in some areas to show that they had taken effect and were being sustained.

We found a breach 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 this 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?

The service was not consistently safe.

Staff did not always know what equipment they should be using or how to check it was working safely.

Staff were not deployed effectively across the service to ensure people's needs were met.

Staff were recruited appropriately and employed after appropriate checks were completed.

The provider had systems in place to manage safeguarding concerns and people's medicines.

Requires improvement



Is the service effective?

The service was not consistently effective.

Further improvements were needed ensure training was effective and staff practice is up to date.

People had varied views about the provision of food and drink. Some gaps between meals were very long and although snacks were available it was not clear how these were promoted.

People were supported to access appropriate services for their ongoing healthcare needs.

Requires improvement



Is the service caring?

The service was not consistently caring.

People's views about the care they received varied. Most staff were caring and had developed positive relationships with people. However there were occasions when staff were not responsive to people's needs or did not promote their dignity.

Requires improvement



Is the service responsive?

The service was not consistently responsive.

People did not always receive care that was personalised and responsive to their individual needs.

Records relating to the individual care of people were not always up to date or reflective of their current needs

Comments and complaints were received positively and used to drive improvement.

Requires improvement



Summary of findings

Is the service well-led?

The service was improving but needed changes to be imbedded and sustained in order to provide a consistently well led service.

People, relatives and staff had varied views about the leadership of the service. The provider recognised the need to continue to promote a positive culture within the service with effective oversight to improve quality and safety.

Requires improvement



St Mary's Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6, 7 and 8 January 2015 and was unannounced. The inspection team consisted of two inspectors, a specialist professional advisor and an Expert-by-Experience. This is a person who has had personal experience of caring for older people and people living with dementia.

Prior to our inspection we requested a Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service including notifications of incidents that the provider

had sent to us since the last inspection. We also looked at safeguarding concerns reported to us. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect. We also looked at information we had received from other professionals including commissioners of care from the local authority and clinical commissioning groups.

As many of the people who live in the service had dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not express their views and experiences with us.

We spoke with ten people, five visitors and one healthcare professional. We also spoke with eleven care and nursing staff, three activity co-ordinators, three unit managers, the registered manager and the nominated person for the provider. We looked at 12 people's care records, 20 people's medication records, 18 staff records; staffing rota's and records relating to how the safety and quality of the service was being monitored.

Is the service safe?

Our findings

Risks to individuals were not always managed consistently to ensure people's safety. People's moving and handling risk assessments and care plans did not always specify the control measures in place such as the type of hoist, type and size of hoisting sling and number of carers required in relation to each person's daily activities. For example we saw two members of care staff were using a hoist and a toilet sling to transfer a person from a wheelchair to an armchair. They told us that the person's own hoisting sling could not be located and they were using somebody else's for the task. People can experience discomfort or a fall if the wrong size sling is used. Toilet slings do not provide adequate support for all users or for moving and handling. Additionally because of their purpose they should not be shared as they are a potential source of cross infection.

Where people were identified as high or very high risk of skin damage they were provided with pressure relieving mattresses but the risk assessments did not inform staff of the type of mattress and correct setting each person required for safe preventative measures. Staff told us that checks were made informally to ensure the pressure relieving mattresses were working as they should be but they could not tell us how the correct settings were calculated when utilising this equipment. This therefore posed a risk to people and preventative measures could be compromised.

Bed rails were fitted appropriately and had appropriate protective coverings and risk assessments had been carried out. However for people living with dementia, their capacity and understanding of the purpose for bed rails had not been considered in their risk assessments. This meant that the decision for use may not have been appropriately discussed with the person. Staff had not recognised the potential impact on people or explored alternative and more suitable options.

We saw a large chair placed in the open doorway of a person's bedroom. This had been put there to stop other people from entering the room. Alternative strategies had not been considered with the person to reduce their anxieties and enable the chair to be removed in line with health and fire safety.

The registered manager said they would address these areas immediately to ensure people were safe.

Risks to people's health and wellbeing such as eating and drinking and falls were identified and appropriate assessments and management plans were in place to inform staff on the measures in place to reduce and monitor those risks. When people's risk increased appropriate actions were taken for example a person who had recurrent falls was referred to the GP for a review of their medication, which was believed to be the cause. Other action had been taken in the meantime to keep them safe.

There were enough staff to meet people's needs but we found that the delegation and organisation of their duties did not always mean people received the support they needed consistently in a timely way. People who were more independent told us that they felt there were sufficient staffing numbers. One person said, "For me it's OK, there is enough staff to help me when I need it." Others told us they had to wait for assistance with personal care needs and

waiting caused them discomfort at times. Some felt that staff were not responsive, particularly at night. One person told us, "There are issues in the morning between 7.30 and 8.30 as staff seem to be involved in handover, it is pointless asking for help at this time." Two people told us that one staff member started work at 6.00am especially to assist them to get up as this was their preference; however there were no additional resources in place to extend this arrangement to cover the staff member on their days off. We saw that staff were busy and in most cases responded promptly to people's needs, however there were some times when people had to wait unnecessarily whilst staff members talked together or sat away from people doing paperwork.

The registered manager told us they were actively recruiting new staff but in the interim relied on agency staff for cover. They also said that they were looking to employ new staff on flexible hours to provide additional cover at key times of the day to meet people's needs. Staffing levels were determined according to people's need and although a tool was used to calculate staffing hours the registered manager said they provided above the recommended calculation. Staffing levels had increased by one staff member on two units since our last inspection. The provider had a robust recruitment system in place to ensure new staffs employed were suitable for the role.

Is the service safe?

People told us that they felt safe. One person said, “I feel I’ve got very good friends here”, another said, “Yes, I am safe and very happy here”. Staff were aware of their responsibilities to safeguard and protect people from poor care and identify abuse. They understood the providers safeguarding policies and procedures and were able to give a good account of what they were; how they would raise an issue or escalate a concern if necessary. They said that they would be happy to raise issues with their unit manager, nurses and matron.

Staff demonstrated a good understanding of their responsibility to report concerns and stated they would whistle blow if the need arose. Staff said they would talk to their unit manager or matron but some were not aware of other ways to raise concerns. The provider strongly promoted whistle blowing and staff were encouraged to raise concerns directly or anonymously. Posters were displayed around the service informing staff of a confidential call line that they could ring if they had concerns or wanted to seek advice.

People said that they received their medicine on time. Some people chose to manage some of their own medicines, for example, one person told us that they

managed their own inhaler. Another person said their medicines were “Always on time” and that they were given pain relief when they needed it, they said “At night time they knock on the door and ask me if I want Paracetamol.”

Medicines were stored safely for the protection of people who used the service. There were arrangements in place to record when medicines were received into the service, when they were given to people and when they were disposed of. People’s medication administration records and associated records showed that they received their medicines as prescribed and in a safe way. Where people were prescribed medicines on a “when required” basis, for example for pain relief, we found there was not always sufficient guidance for staff on the circumstances these medicines were to be used. We observed medicines being given to some people at different times during the day; this was done with regard to people’s dignity and personal choice and staff explained to people what they were doing. People were given their medicines by suitably trained and competent staff. Those authorised to handle medicines had received appropriate training and had been assessed as competent to do so. Weekly checks on the quality and accuracy of medication records were carried out and we saw that these had picked up some minor errors which had been investigated and resolved promptly.

Is the service effective?

Our findings

At our last inspection we found that professional advice had not always been sought for people when needed. At this inspection we found improvements had been made. People told us that they received the support they required to see their doctor and other health professionals. One person described how the service supported them by making appointments for them to go to the town to visit the dentist and said that they had seen both an optician and a chiropodist at the service. They also told us that the staff had called the doctor out recently to see them when they had recently been ill. A nurse from the mental health team, visiting people using the service told us that they had regular contact with the service and visited people on a regular basis to review their mental health needs and their medication. People's healthcare needs were monitored and any changes identified and acted on promptly. During our inspection a care worker recognised in one person the symptoms of having a low blood sugar and reported this immediately to the matron. This enabled prompt care, treatment and monitoring that prevented a hospital admission.

In most cases people felt that staff were sufficiently skilled and experienced to care for them. Action was being taken to improve staff knowledge for example, one person with a debilitating long term condition told us, "Some staff are very good, one or two are excellent but some staff have no understanding of my condition and how it affects me." Training was planned for staff and that this person had agreed to participate to give their perspective and help staff understand the difficulties experienced.

People accommodated on three of the four units were at various stages of their dementia ranging from early onset to advanced stages. Staff told us they had received training to help them understand the needs of people living with dementia. The registered manager told us that further dementia training for staff was planned to give staff further understanding in this area and enable them to meet people's needs more effectively. Staff advised that "There is always training going on" and some were being supported to complete national qualifications in health and social care.

The service's trainer told us that new starters and regular staff undertook mandatory training sessions together. Subjects were covered in two hour sessions. The trainer

told us that staff employed always have experience and do not require more in depth training. However one care staff member told us that they had no previous care experience and they felt the training sessions "Just touched the surface". They told us they would like more in depth training to help their professional development. This inspection identified that health and safety training was not always effective because staff did not always know the correct equipment to use or how to use it to ensure people's safety.

The provider had implemented a learning and development strategy in November 2014 and this was on going. A programme had been reviewed and developed to provide all staff with the training they needed for their role and to meet the needs of the people they supported and cared for and this would be continually reviewed to ensure it was appropriate.

Staff told us that although they felt well supported by their staff team and unit managers they did not receive regular recorded one to one meetings with their line manager to discuss their day to day practice. The new matron told us that improvements were being introduced to help support improvements and share knowledge and skills through on-going supervision.

Staff sought people's consent before they delivered any care and support. Care records showed that the principles of the Mental Capacity Act (MCA) 2005 Code of Practice had been used when assessing an individual's ability to make a decision on everyday matters such as receiving personal care, nutrition assistance and being moved using a hoist. Where people had someone to support them in relation to decisions this was recorded in their care plans. The records showed that not all assessments were up to date and evaluations did not indicate a thorough reassessment of a person's capacity to ensure there was no change as indicated in some records. Some people were given their medicines concealed in food and drink. We saw that the service had consulted the person's GP, health professionals and relatives about this in the past. However the decision had not been reviewed to ensure that it continued to be in their best interests.

Applications had been made to appropriate professionals for assessment for people who lacked capacity and needed constant supervision or restrictions to keep them safe. This met the requirements of the Deprivation of Liberty Safeguards (DoLS). However people living on Ash unit told

Is the service effective?

us that they were locked out of the dining room throughout the day and night except for mealtimes. A key pad lock was on the dining room door and only staff knew the code; people were going to the door and trying to open it. Staff did not fully understand the principles of DoLS or impact for people by restricting their movements within their home. We brought this matter to the attention of the provider and registered manager. They took action to remove the keypad lock and introduced other measures to reduce the risk to people meaning they were free to access the dining room at any time.

Meals and hot drinks were not appropriately spaced and flexible to meet people's needs. People told us that hot drinks were not regularly provided. One person said, "You do not get one first thing and rarely do you get offered one at night, you have to request it. My first hot drink of the day is at breakfast which is served between 8 and 10am." Another person told us that no hot drinks were served after 4.30pm; they said, "I suppose I can request one but I expect to have a hot drink in the evening." Staff told us that hot drinks were available at 7pm and then again later in the evening. They told us that the evening meal was served at 4.30pm and that there was no provision of hot food for people after this time. This meant there was a long gap, for some people, between the last hot meal of the day and breakfast the next morning. Lack of food and drink particularly during the night can quickly exacerbate some of the symptoms of dementia, making individuals feel agitated and more confused. We were told that the kitchenette on each unit was equipped with a fridge, toaster and microwave for the provision of soup and toast for people outside of mealtimes and that snack boxes were available which included biscuits and sweet cake bars. However we remained concerned about people's knowledge about extra food being available and especially the arrangements in place for those who were unable to communicate.

One person told us, "Staff pay a lot of attention to record keeping but my fluid intake records are not accurate because they only relate to what they give me and they do not take into account what I drink independently." A relative expressed concern that the fluid chart for their family member showed that drinks were not offered or taken regularly. Where there were entries they were for very small amounts. The relative said that their family member was always thirsty and that they had no trouble in assisting them to drink full cups of drink when they visited.

Documentation recording people's food and fluid was inconsistent, particularly on Cedar unit, the nursing unit. In some cases more than one chart was being used and staff were not consistently recording on one chart or another, some records omitted a name and/or date and some records had gaps of up to seven hours. This meant that the records did not always provide an accurate account of people's food and fluid intake which made it difficult for monitoring purposes and there was no system in place to regularly check at the end of each shift to ensure that adequate sustenance had been received.

This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

People gave mixed views about the food provided. One person said "The food varies, for me its fine, very nice and tasty and filling." Another person told us, "There is no variety. The menus are the same every week. I can't eat very much but I like good food. The food leaves a lot to be desired. There are not enough fresh vegetables. The portions are ok though." A relative told us that there was a good variety of food and relatives have been asked to 'taster days' where they get the opportunity to taste the food.

People chose their meal the day before and pictures were included with the written menu to enable people to make a choice. Staff told us that people were able to change their mind about what they had chosen to eat on the day. However, when asked what the alternative would be if someone didn't want the available options, staff told us, "Toast."

On the first day of our inspection the mealtime on Oak unit was not well organised and three people became very anxious and distressed. The dining area was confined. There was constant interruption; staff were unable to sit appropriately with the people they were assisting to eat and people were not provided with a pleasant and enjoyable experience. We observed very poor practice by an agency staff member and when we brought this to the attention of the deputy manager the agency staff was immediately removed from their duties. On our second day we saw a complete contrast and this was because the deputy manager had addressed the issues by arranging two sittings for lunchtime. People received the correct level of support they needed to eat and drink, at their own pace,

Is the service effective?

with dignity, and people's anxiety levels reduced. This change in practice also enabled staff to have the time to interact more with people eating independently and encouraging them to eat more.

The provider had recognised they needed to improve the environment for people and they were seeking professional guidance on this. The environment on each unit was not suited to meet the needs of people living with dementia. Corridors were bland with no distinguishable features to enable people to recognise toilets and bathrooms. Handrails around the units were painted the same colour as the walls and did not provide any differentiation to be seen clearly by those people with dementia and sight problems. There was also no signage for people to find their way around which can contribute to people becoming

confused and disorientated. People were observed walking around confused and not knowing where they were. Some people's bedrooms did not have a name on their door; some had a memory box outside containing personal items to stimulate their memory, other boxes were empty. Staff told us that they felt that more needed to be done to make the environment more conducive to the needs of people living with dementia by providing more space and interesting areas for people to go.

Recommendation – We recommend that the service seek advice and guidance from a reputable source to ensure that arrangements for the provision of food and drink reflect best practice for the needs of people living with dementia.

Is the service caring?

Our findings

People had varying views about how staff caring in the way they provided their care. One person said, “If I can’t do something, they help me.” Another person described how a member of the night staff had embroidered their initials on their towels in the colour of their favourite football team. Another told us how staff styled their hair and applied their makeup each morning and another told us how staff shopped for them. Other comments included, “I can’t praise the staff enough” and “I can’t thank enough the staff and the management. They look after me very well” and “Hand on my heart all staff are great.”

Some people told us that they experienced difficulty in building positive relationships with agency staff because they were not familiar to their needs and preferences. Others told us that they experienced difficulties in communicating their needs to some staff, whose first language was not English.

Throughout our inspection we saw examples of people treated with respect and in a caring and kind way, however this was not always consistent. We saw staff offering comfort and support to people by touching them gently on the hand or putting an arm around their shoulders, we saw others sharing a joke and laughing with people. Managers told us about a new course that staff had recently attended called ‘Heart of Care’, which was about seeing people as individuals and placing them at the centre of their care; however this was not being put into practice by all staff. One person told us that they often received comments such as “You are not the only one here” and “You are one of 30 people to deal with.” We saw some staff being dismissive to people’s needs and speaking to them disrespectfully. We heard a member of staff say quite brusquely to one person, “Open your mouth” when they were assisting them to eat and when somebody said they wanted to go to bed they were told by a member of staff that they could not go.

We found on Cedar unit that people were referred to as a room number by some staff and their names had not been placed on their bedroom doors. We also saw notices stuck on some bedroom walls with instructions for staff relating to the individuals personal care needs which did not respect their privacy. Staff were aware of the need to maintain privacy and dignity for people when providing personal care but we saw that staff practice varied. For

example we saw moving and handling to support a person in a very considered and respectful manner, but in another case staff did not give the same consideration which compromised the person’s dignity.

People were supported in having varying degrees of independence. Some people were able to make independent choices and decisions to involve themselves in the local community by meeting others and socialising during the day. One person described how they managed their own accounts. Others were able to choose to use the garden and when to have a cigarette. One person told us, “I basically look after myself. I wash and clean myself. I’m basically what you call independent.”

People’s involvement in their own care planning and making decisions about their care and support was inconsistent. One person told us that they had been involved in discussions about their care plan; they had seen it, agreed to it and signed it. Another person said that they were involved in making decisions about their care and support but when asked if they had seen their care plan they said, “Not that I’m aware of.” Another person said that they had not seen their care plan since their admission.

Where people were not able to express their views and participate in the planning of their care steps had been taken by management to involve their relatives or representatives to ensure their preferences and specific individual needs were taken into account. One visitor told us that since they had discussed the specific care and support their family member required, they were satisfied that they were now receiving the appropriate care and support that ensured their comfort and safety.

A relative told us that “Most staff are very cheery and try very hard to make the end of people’s lives as comfortable as possible.” Staff described how they ensured people at the end of their life were supported to have a comfortable, dignified and pain free death. There were no advanced care plans or directives in place and some care plans were better than others in relation to planning for end of life care. We were told that staff were currently working through these to make them more relevant, detailed and specific to people’s needs. Some people had Do Not Attempt Resuscitation (DNAR) orders in place and these were completed appropriately, signed and in date.

Is the service responsive?

Our findings

Where there were opportunities to support people to maintain independence we found this was not being delivered consistently. For example two people had specific exercise instructions left in their room by a physiotherapist to be carried out by staff. They told us that they very rarely received assistance by staff to carry out the exercises which were important to them to prevent joint stiffness and pain. We also found some people had not had the residual effects of their stroke, and how this affected them in their daily lives, assessed and planned for.

There were inconsistencies across the service in the quality of the information included in people's care plans. Not all care plans provided sufficient detail to give staff the information they needed to provide personalised care and support that was consistent and responsive to people's needs. Where sufficient detail was provided this was not always delivered. For example one person's care plan detailed how they required tubular bandages to protect their arms and to have repositioning every two hours during the day and four hourly during the night. The tubular bandages had not been applied and there were no records available to show repositioning was being carried out. When we asked staff about this they were not aware of the contents of the care plan.

For people living with dementia, triggers and diversion strategies were not always identified and planned for sufficiently to guide staff on how they could reduce people's anxieties effectively and consistently. Care plans lacked detail on the type and level of support they required to maintain independence and did not reflect people's strengths and aspirations, past lives, hobbies, pastimes or social histories which would help staff to understand the person they were supporting.

Daily records did not give any indication of how the person's day was spent nor did they give any reference to their wellbeing. Where there were notes that showed the person had not had a good day there was no information as to why or how staff supported them at this time. This lack of records did not show if staff were providing personalised care which promoted people's independence and met their needs.

This is a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

The service offered many activities for people to take part in, and employed staff to facilitate this. These included trips out to various places of interest in the community. One person told us, "I go to ten pin bowling and swimming. Once in a while they take us shopping." Another person said that they "Enjoyed going out with one of the girls." Some people were able to plan their own entertainment and made some arrangements to socialise outside the service during the day. One person said that staff, "Give me a wake-up call at 7.30. It gives me the time to take a bus at ten to nine."

People were observed going for a walk in the garden when they chose and having a cigarette when they wanted. People were supported to maintain contact with friends and family through various methods such as email, internet links, phones and mobiles.

One activity coordinator described other activities on offer to people such as exercise, art therapy, quizzes, music, live entertainment and singing. In one unit, a reminiscence activity with photographs was seen in the morning which involved a small group of people. Music was played for people to enjoy according to people's request. Another person was reading the paper.

Despite this positive interaction this experience was not consistent for people across the service. People who were able to spend time in communal areas had more social interaction with staff than those who spent the majority of their time being cared for in their bedrooms. The activity staff told us that they tried to provide as much one to one time with individuals as they could but this was not always possible. Throughout our inspection we saw no activities taking place on Cedar unit (the nursing unit) and we did not see staff actively involved in spending time with people.

There were no dementia related aids freely available or accessible or being used by people which would generally aid stimulation or provide comfort and reminiscence and this left people without many opportunities to independently entertain themselves. Films were put on for people to watch. It was not clear who chose the films on offer for example; some people on Oak unit were watching a Laurel and Hardy film. When asked if they liked Laurel and Hardy, one person said, "Not really."

People said that they were encouraged to express their concerns and that they felt that they were listened to. When asked if they were encouraged to raise concerns, one

Is the service responsive?

person said, “I should think so. It’s never really arisen.” Another person said, “I just come straight out with it” and another told us, “Nothing has gone wrong for me. They’ve always looked after me.”

The complaints procedure was displayed in reception and people could make use of a suggestion box and ‘Have your say’ cards. Results and feedback from a survey were displayed around the service in a clear and accessible way so people could see what action was being taken as a result of their comments and feedback. Monthly residents’ forum meetings had commenced where people were

invited to make suggestions. One person was concerned that they may have to move from their current room to another on a different floor and was in discussion with staff members about this.

Recommendation – We recommend that the service seek advice and guidance from a reputable source to develop ways of ensuring a range of meaningful activities for those who are unable to do this independently.

Is the service well-led?

Our findings

When we inspected the service in July 2014 we were concerned about the lack of robust and effective systems in place to assess and monitor the quality and safety of the service. We asked the provider to send us an action plan to tell us how they would make improvements. At this inspection we found that quality assurance and governance systems had been significantly strengthened to ensure review and scrutiny of data and responsibility for actions. This enabled the provider to have a clear oversight of the service provided, work towards addressing the issues previously identified and drive improvement.

Although we recognise that the provider had identified improvements needed they had not yet been fully implemented in some areas and they needed time to show that they had taken effect consistently and were being sustained. For example staff learning and development strategy and supervision processes had not yet been fully established. We also saw inconsistency in staff practice which meant people using the service had different varying experience of the service

The provider had put in place projects to promote best practice such as recognition rewards for staff from nominations which they felt would help to develop a more engaged and involved staff team. This was part of work to promote a positive culture that was open and inclusive. Various methods had been set up to capture people's views, comments and suggestions such as a Resident Experience Group and an externally supported resident survey. Information from these forums was incorporated into the service improvement plan and actions taken in

response were displayed in a clear and accessible way around the service via 'You said We did' posters. One person said that they felt the service was well managed and that they were kept informed about any changes to the service both verbally and in writing. Another person told us that they had completed a survey and that they had received feedback from these.

People, relatives and staff had varying views about the leadership of the service. Some told us that things had greatly improved and they felt very engaged in their family members care. Newsletters were in the main reception area of the service as was information relating to raising concerns and making complaints. Some relatives told us that they knew and communicated with staff and unit managers but had had very little to do with the registered manager. They felt this was to do with the size of the service and the number of people using it. Staff were aware of their roles and responsibilities and felt well supported by their team and unit manager. Staff across the service told us that they rarely had contact with the registered manager and felt that each floor operated relatively independently with each having their own culture and routines. We were made aware that in one area there were negative comments about the leadership but staff did not feel confident to feed this back to the registered manager. We shared this with the nominated individual who represents the provider. They told us they would take action to ensure that the work to develop the positive culture in the service encouraged staff to share their views and concerns both in person or if needed anonymously via systems they had set up. The nominated individual was present at the service weekly and therefore was developing an oversight of the service and its leadership moving forward.

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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>People who use services and others were not protected against the risks of unsafe or inappropriate care arising from a lack of proper information about them. Accurate records were not maintained in respect of each service user and did not include appropriate information and documents in relation to the care and support provided to each of them.</p> <p>This was in breach of Regulation 20 (1)(a) of the Health and Social Care Act 2008 (Regulated Activities) 2010, which corresponds to Regulation 17(2)(d) In good governance of the Health and Social Care Act 2008 (Regulated Activities) 2014.</p>