Inglewood Nursing Homes Limited

Inglewood Nursing Home

Inspection report

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Ratings

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

Overall summary

Inglewood Nursing Home provides residential nursing care for people. People's nursing requirements varied with some requiring support for all their daily care and support needs. People had a range of complex health care needs which included stroke, diabetes, dementia and Parkinson's disease.

People recognised that the home had changed management and were happy and comfortable with this. They knew who the acting manager and deputy were and people spoke highly of the management telling us they found them, "Approachable," And, "There's a new manager and it feels very organised and helpful."

This service provides permanent and respite care funded privately or by the local authority.

The service is registered to provide care for up to 60 people. At the time of the inspection there were 46 people living at the service.

Summary of findings

This was an unannounced inspection which took place on 10 and 11 August 2015.

Inglewood Nursing Home did not have a registered manager. However, the acting manager was in the process of applying to register as manager with CQC. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was in a period of transition due to changes in management. There was an acting manager who had been working at the service for less than a month, and was in day to day charge of the running of the service. People and staff told us about the recent changes made to the service. People told us that they felt supported by the new management team and knew that there was always someone available to support them.

People were not involved in care planning and regular assessment of their care needs. People did not feel involved in decisions, for example daily choices around having a bath or shower.

The acting manager and deputy had identified areas of documentation that needed to be improved and a number of changes had recently been implemented with further changes planned. The acting manager was aware that changes needed time to become embedded and was introducing each change methodically to allow staff time to become used to each change.

Staff had a clear understanding of how to recognise and report safeguarding concerns.

Personal and environmental risk assessments had been completed and regularly reviewed. This included personal emergency evacuation plans for everyone living at the service.

People's health and care needs were reviewed monthly. Falls, accidents and incidents were analysed to identify any trends.

People were asked for their consent before care was provided and had their privacy and dignity respected.

People's nutritional needs were monitored and reviewed. People had a choice of meals provided and staff knew people's likes and dislikes.

Referrals were made appropriately to outside agencies when required. For example GP appointments and speech and language referrals.

A daily programme of activities were provided by designated activity co-ordinators.

There was an on-going recruitment programme to ensure that appropriate staffing levels were maintained and to ensure staff were safe to provide care to people. Staff received a period of induction with on-going support provided. There was a clear programme of staff training, regular supervision and appraisals. Staff felt their training needs were met and they had opportunity for further future development.

There was a robust system in place to ensure the organisation and management assessed and monitored the quality of service provided.

Feedback was gained from people this included questionnaires and regular meetings with reports available for people to access.

Notifications had been completed to inform CQC and other outside organisations when events occurred.

We found a breach of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what actions 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?

Good

The service was safe.

Staff had a good understanding about how to recognise and report safeguarding concerns.

Environmental and individual risks were identified and managed to help ensure people remained safe.

There was on-going recruitment and agency staff were being used to ensure staffing levels remained safe.

Peoples care and nursing needs were reviewed using a dependency tool to ensure appropriate staffing ratios were maintained.

Medicines policies and procedures were in place to ensure people received their medicines safely.

Is the service effective?

Good

The service was effective.

All staff felt they received effective training to ensure they had the knowledge and skills to meet the needs of people living at the service.

People were asked for their consent and involved people in decisions about their care. Management and staff had a good understanding of mental capacity assessments (MCA) and Deprivation of Liberty Safeguards (DoLS)

People were supported to eat and drink. Meal choices were provided and people were encouraged to maintain a balanced diet. People's weights were monitored and referrals made to outside professionals if required.

Is the service caring?

Good

The service was caring.

Staff displayed kindness and compassion when providing care.

People were given information and explanations appropriately when care or support was being provided.

People's dignity was respected and promoted.

End of life care was provided. People's choices about their end of life care needs were recorded and supported.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Documentation did not show that care was person centred.

Summary of findings

Documentation was not always appropriately completed. People's choice and involvement in decisions was not clear from care planning, assessments and daily records.

A daily programme of individual activities was provided.

A complaints procedure was in place. Complaints had been responded to appropriately.

Is the service well-led?

Good

The service was well-led.

The acting manager was in the process of registering as manager with CQC.

The aims and values of the service were facilitated by clear leadership on all levels.

Their was a robust programme in place to continually assess and monitor the quality of service provided.

Policies and procedures were in place to support staff.

Notifications had been completed when required.

Inglewood Nursing Home

Detailed findings

Background to this inspection

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

This inspection which took place on 10 and 11 August 2015 and was unannounced.

The inspection team consisted of an 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 we looked at information provided by the local authority. We reviewed records held by the CQC including notifications. A notification is information about important events which the provider is required by law to tell us about. We also looked at information we hold about the service including previous reports, safeguarding notifications and investigations, and any other information that has been shared with us.

A Provider Information Return (PIR) had not yet been requested. 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 spoke to people living in the service who were able to tell us about their experiences and what it was like to live at Inglewood Nursing Home.

We spoke with 11 people using the service, four relatives and visitors to the service and 15 staff. This included the acting and deputy managers, team leaders, health care assistants, kitchen staff, housekeeping, activities co-ordinators, administration, quality and training co-ordinator and other staff members involved in the day to day running of the service.

We carried out observations in communal areas, case tracked five people looking at all documentation relating to their care and looked at documentation specific to other people's health needs including medicine administration records (MAR), daily care records, risk assessments and associated daily records and charts. We read handover information, diary entries completed by staff, policies and procedures, accidents, incidents, quality assurance records, staff and resident meeting minutes, maintenance and emergency plans. Recruitment files were reviewed for three staff and records of staff training, supervision and appraisals.

Good

Is the service safe?

Our findings

People living at Inglewood Nursing Home told us they felt safe, their possessions were safe and they were free from harm. We were told, "I would speak to staff if I was worried or unhappy about anything." And, "You can speak to anyone if you have any problems; they keep you safe and look after you." Relatives told us, "I feel they are safe when I leave, staff are very good."

Staff demonstrated a good knowledge around how to recognise and report safeguarding concerns. The acting manager and deputy both knew the correct reporting procedure. Staff had access to a member of management on call at all times. A safeguarding policy was available for staff to access if needed. We saw that safeguarding alerts were responded to and referrals completed to outside agencies if appropriate. The safeguarding policy was policy of the month. This was displayed in staff areas and staff read these to update their knowledge around this subject.

People's level of care and nursing needs differed. Risks to individuals were identified and well managed. There were individual risk assessments in place which supported people to stay safe, whilst encouraging them to be independent. For example people who were able to manage their medicines or just required a minimal level of support where encouraged and supported to continue. Those who required full care and assistance were supported to ensure this took place. Other risk assessments included moving and handling, bed rails, nutrition, weight, pressure area risk and any other individual risks identified during the initial assessment or subsequent regular reviews of care. For example people managing their own medicines were reviewed regularly to ensure this was still appropriate. This meant these people received their medicines safely.

There were systems in place to ensure the safety and maintenance of equipment and services to the building with a full time maintenance employee responsible for the day to day maintenance and checks around the service. The provider had recently employed an external professional to carry out a full review of health and safety and any associated environmental risk assessments. The provider was waiting to receive a comprehensive report back; this had been implemented to ensure continued safety and improvement.

Personal emergency evacuation plans (PEEPS) were in place. This information was located in the main entrance lobby alongside plans of the building and fire safety and evacuation information. This meant peoples care needs and mobility had been considered in relation to their safe evacuation in the event of an emergency. Fire alarm and emergency lighting checks had taken place regularly to ensure people's continued safety.

Dependency assessments were completed to ensure appropriate staffing numbers to meet people's needs. The acting manager told us these could be reviewed and amended daily if people's care needs increased. For example, when people required end of life care or the number of staff required to support people safely increased. Daily meetings with nursing staff from both floors were used to identify any changes and staffing level requirements. There were also designated housekeeping, activity and kitchen staff. The staff rota indicated that agency nursing staff were regularly being used to ensure that adequate staffing levels were maintained. Staff told us that they appreciated that agency staff were being used until more permanent staff were recruited but that supporting an agency staff member did impact on their day as things took longer.

We asked people and relatives if they felt that there were enough staff available when needed. People consistently told us that there were plenty of staff. One told us, "There are absolutely plenty of them." And another said, "Always someone around when you need them."

A program of on- going recruitment was in progress, this included recruitment days to encourage applications from both nursing and care staff. Some new staff had been appointed and were in the process of commencing employment.

People were protected as far as possible by a robust recruitment system. We looked at staff recruitment files these included details of relevant checks which had been completed before staff began work. For example disclosure and barring service (DBS) checks, A DBS check is completed before staff begin work to help employers make safer recruitment decisions and prevent unsuitable staff from working within the care environment. Application forms included information on past employment and relevant references had been sought before staff were able to commence employment.

Good

Is the service safe?

Staff had access to policies including whistleblowing. A recent change in management meant that staff were still getting to know the acting manager and deputy manager. However, staff felt able to raise concerns and were aware that this policy was in place.

People in their rooms and communal areas had access to their call bells. We spoke to people regarding the time it took staff to respond when they used their call bell to alert staff that they needed assistance. People told us, "I am attended to promptly when I ring my call bell." And "I'll ring my bell even if I just need my blinds drawn and they don't mind." We observed that some people used their call bell more frequently than others. Staff responded promptly, when a second staff member was required to help them, for example for a person who needed to be hoisted this was sought and the task carried out in as timely a manner as possible.

People told us they received their medicines appropriately and supply did not run out. One person said, "Yes I do my own tablets and I just let them know a week in advance when I'm running low and I've always plenty then in stock." And, "I did have to tell them about one nurse who insisted on locking my medicine cabinet when I self-medicate, it did get sorted out though. I am happy with it all."

Medicine administration records (MAR) charts were stored on trolleys at the nurse's station on each floor. MAR charts had been signed by nurses after medicines were administered. A list of signatures was seen at the front of charts to ensure staff signatures could be identified. People had photographs in place to assist with identification. Self-medication risk assessment forms and protocols for administration of medicines were in place. This included guidance for 'as required' or PRN medicines. PRN medicines were prescribed by a person's GP to be taken as and when needed. For example pain relieving medicines. PRN guidance identified what the medicine was, why it was prescribed and when and how it should be administered. People had locked medicine cabinets in their rooms. These contained all their medicines. Temperatures were logged daily to ensure that medicines were stored appropriately. People who self-administered were able to store and access their own medicines. There were appropriate processes in place for the ordering, administration and storage of medicines. Medicines kept refrigerated and medicines due to be returned to the pharmacy. All medical equipment had been checked regularly to ensure they were in good working order. This included suctioning equipment, blood pressure machines and nebulizers.

Incidents and accidents were reported and the manager conducted a thorough investigation of each incident. For example falls and accidents were analysed to identify trends. The management and staff understood the importance of learning from incidents to facilitate continued improvement within the service. For example when people had falls or incidents had occurred care had been reviewed and changes made appropriately. This meant people's safety had been maintained and care needs reviewed to ensure the most appropriate care and support was provided.

Good

Is the service effective?

Our findings

People told us that staff were, "Competent and skilled at their roles." "Good, friendly and clever" And "Very good at their job" Relatives told us, "Even though some of them are very young they all seem very capable and know what they're doing." And, "Staff looked after them very well and in difficult circumstances caused by their medical condition."

Staff received appropriate training and told us that the training they received was very good and gave them further opportunities for professional development. One staff member had recently taken over a new full time role of quality and training supervisor. They had been supported through this change and were now involved in ensuring staff training and development needs were identified and provided. This included all training designated by the provider as essential, and further training opportunities for nurse and care staff for example training provided by the local hospice, supporting staff to improve their understanding around end of life care. Nurses felt that extra training was a positive move in light of the recent requirement changes for continued registration, where registered nurses need to be able to demonstrate continued development and training has been achieved. Care staff felt that they had all their training needs met. One told us, "There is always training going on, today its first aid. I feel I have the training I need to carry out my role." Team leaders and care staff had attended role specific training. For example further infection control training for the infection control lead. Designated team leaders worked each shift and used allocation sheets to divide staff into teams covering each floor. This ensured that people's strengths were identified and an appropriate skill mix shared out across the service to ensure peoples care needs were met and facilitate on going learning and improvement.

When agency staff were used the deputy manager told us that they requested staff who had appropriate training and experience of working in a nursing home environment. When new agency staff worked at the service, they were shown around the building and given information about people and their care needs. Regular agency staff were used when available to ensure continuity of care for people.

New staff told us that they had a period of induction and were supported throughout this time by management and other care staff. Staff felt that training provided was effective and people living at the service told us staff were knowledgeable about their care needs. We spoke with an agency nurse during their first shift working at Inglewood, they told us they had previously worked at another of the provider's nursing homes and felt supported and had received all the information they felt they needed to provide care during their shift.

The acting manager told us they had recently started using the new Care Certificate Standards induction for new care staff. The Care Certificate sets out the learning outcomes, competences and standards of care that are expected from care workers to ensure they are caring, compassionate and provide quality care. This included self-evaluation and assessment completed by staff. This gave staff leadership and ownership of their roles responsibilities and development.

Staff and management had a good understanding of the Mental Capacity Act 2005 (MCA). This legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. People's mental health was reviewed regularly as part of their overall care reviews. This ensured that any changes were identified and appropriate action could be taken. MCA assessments were completed and reviewed regularly. The acting manager told us, "If there is even a question mark about people's mental health needs we take the appropriate action." The service was meeting the requirements of Deprivation of Liberty Safeguards (DoLS). These safeguards are in place to ensure any restrictions to people's freedom and liberty have been authorised by the local authority. The acting manager and deputy manager understood how and when referrals may be required should there be any concerns regarding people's capacity. We saw that applications were in progress and a number had already been referred appropriately to the local authority and were pending a decision.

People had "Do not attempt resuscitation (DNAR) forms in place. We saw that these had been discussed with the individual or Lasting power of attorney (LPA) as appropriate. This information was included in people's care documentation. Which showed that decisions had been discussed appropriately with people or those making decisions on their behalf.

Good

Is the service effective?

People and relatives felt that staff asked for consent before providing any care. Staff were aware when people had a LPA and who was involved in decision making. We spoke to a relative who was a LPA and they told us, "I am kept fully informed of any changes and decisions that affect us, you can give feedback and staff listen. Staff are meticulous I am so glad we chose Inglewood."

Staff described how they would ask for people's permission before giving support, and what they would do if someone declined the support offered. We observed staff involving people in decisions and speaking to people to ensure they were involved in how they received care and spent their day.

Referrals had been made to other health professionals when required. This included GPs, chiropody, speech and language therapy and mental health professionals. Staff supported people to arrange appointments. For example a relative asked us whether an appointment had been made to assess their relative's eye sight. We discussed this with the management and were told this had been arranged. Another relative told us, "We had a doctor called for a chest infection, it was even a weekend." People felt that medical attention would be sought in a timely fashion. "I go to the hospital as I have an eye problem and they do me a packed lunch if I'm going to be there sometime, so I don't go hungry."

We saw that during the inspection visiting mental health professionals and a GP attended the service. People's health needs were being met, and people were supported to attend appointments. All appointments and visits were documented in people's care files so staff were aware when appointments had been arranged or taken place. This information was also included during staff handover.

For people who were able to or who chose to use the dining room at mealtimes, this was a very sociable and pleasant experience. Tables were nicely arranged with flowers, glasses and water. With condiments and napkins provided. One person chose to have sherry with their lunch, and a varied choice of drinks and meals were provided. One person had requested cheesy chips and these had been made for them, others enjoyed one of the two main meal choices and these were nicely presented. We received very positive comments from people during and after their meal. Including, "Food, is very nice." And "If you don't like something they can get you something else, it's no bother." There were small numbers of people at each dining table and it was a positive social time with lots of chatting about different topics which were unrelated to being in a care home. We also observed a member of staff engaging within these conversations. People who needed one to one support with their meal received assistance by a consistent member of staff who sat close by offering food in an unhurried and calm manner, giving good eye contact and encouraging the individual to be as independent as possible whilst supporting when necessary.

During meal service staff gave people their meals referring to the person by name and reminding them of their meal choice. And asking people if they had eaten enough, reminding people to ask if they wanted anymore to eat or further drinks. Staff were seen to gently dab napkins around people's mouths if required but always asked if it was ok to do so beforehand. The meal time was rounded up with the offer of teas and coffees. After lunch was finished people were asked where they wanted to go.

People who stayed in their rooms or were too unwell and remained in bed had meals provided in their rooms. We saw that staff provided assistance in a timely manner. People who remained in bed were sat up and supported appropriately. Staff sat next to people's beds, and we saw that good communication took place and meal times did not appear to be rushed. We spoke to one relative who told us their relative had specific dietary requirements due to their medical condition. They told us. "Meals are good quality, it has to be of a specific consistency and this is always done. If we need an alternative this is provided."

People's nutritional needs and preferences were met. We spoke to the cook who told us they were aware of people's dietary requirements due to health related conditions, for example diabetes and anyone with swallowing difficulties or allergies. Information was clearly recorded regarding allergens for all ingredients and food items used in the meal provision. We saw that a wide variety of choices were being catered for. Meal choices were taken during the morning and this information given to the kitchen staff. If someone changed their mind this could be incorporated. The cook told us, "If someone wants something, as long as I have the ingredients to make it they can have it." Meals were also available for staff if requested. People felt able to give feedback about meals. One person said they had told staff that "Their vegetables were over cooked for their liking" but they appreciated this was their personal choice.

Good

Is the service effective?

People's weights were monitored regularly to ensure that health related conditions for example pressure area care were monitored and reviewed appropriately. If staff identified that someone was not eating or drinking sufficiently or just appeared, "Off their food." We were told this would be reported to the nurse on duty and food and fluid daily charts introduced to monitor this. No one at the service required daily monitoring at the time of the inspection.

Good

Is the service caring?

Our findings

People gave very positive feedback regarding the caring nature of staff. Telling us, "The staff are very good, nothings too much trouble." And, "They are all very very kind people." Relatives said, "The care is very good the place has a nice feeling about it. It's not pristine or modern and clinical but homely. The staff are incredible and always talk to you, all of them and they all seem happy."

We saw many examples of positive interaction between staff and people living at Inglewood Nursing Home. We observed that when people required assistance this was provided with kindness and compassion. People were referred to by their preferred names and explanations were given when assisting people. For example, one person was being lifted with a hoist from bed to wheelchair and this was done sensitively with explanations of what was happening, what would happen next and constant checking and reassurance by staff that the person was alright. When the transfer was completed the person was made comfortable and asked if the wanted their slippers on and hair brushed before going for dinner. Another person who rang the bell to let staff know they were uncomfortable in bed was repositioned by two care staff, who took the opportunity to ask whether the person required any other personal care. This was done calmly and discretely with constant reassurance. Staff were heard to ask, "Can we just make you more comfortable, do you mind if I take your glasses off." Staff then checked the person felt comfortable before leaving the room. Staff ensured that any furniture moved was placed back within reach to ensure people had access to their telephones, call bell and drinks. One person told us, "They can't do enough for us here." And a relative said, "I think they are well cared for and I can't think of anywhere else better for them to be."

Staff were observed knocking on doors before entering people's rooms and waiting to be invited in. Doors and curtains were also closed whilst personal care was taking place. Housekeeping staff were heard to engage in conversations with people whilst cleaning their rooms, people told us they enjoyed this interaction and staff were, "Always chatty and pleasant." Staff were seen to support each other. When assistance from a second staff member was required for example to assist with helping someone to move, we saw that staff responded to requests promptly.

People were encouraged to maintain relationships with family and friends. Some people were taken out regularly by family and visitors. This was encouraged and supported by staff and the provider. Relatives were seen to visit throughout the day and told us they were always welcome at any time to pop in if they wished and felt welcomed and involved by staff. People were kept informed when they had appointments and information regarding future activities and events was available. This included a diary of events, a monthly leaflet which informed people of up and coming daily activities and other information about Inglewood Nursing Home.

End of life care was provided to people. Staff told us they received specific end of life training, provided in liaison with the local hospice. Peoples end of life wishes and preferences were included in care planning. DNAR forms were in place and staff aware of people's wishes. We spoke to activity coordinators who told us that they had attended end of life training. This had helped them to feel comfortable providing support to people and their families. Staff told us they tried to take time to sit with people so they were aware they were not alone to chat or read to them when appropriate.

We saw that people who were receiving end of life care had been placed in rooms close to the nurse's station with the agreement of the individual or their next of kin if appropriate. Staff checked on them frequently throughout the day. Relatives and friends were encouraged to visit at any time of day or night to allow them to spend quality time with people. It was clear in documentation who were next of kin and who wished to be contacted in the event the person's health deteriorated. Staff told us that when peoples passed away the whole team felt the impact. Staff told us that they attended funerals when possible and families often popped in after people had died to thank them for the care provided. We saw a number of cards received by the service expressing people's gratitude for the care and support received after their loved one had died

Requires improvement

Is the service responsive?

Our findings

The service used a computer system and paper records to record people's care plans and assessments. The nursing staff and management had access to the computer records and documented any changes and reviews which took place. Care staff did not have access to the computer records; information about people's care needs was also printed and stored in files at the nurse's station however, care staff told us they did not always have access to this. Some information was kept in people's rooms, this included information for care staff relevant to the individual's daily care, mobility and to record personal care provided.

The acting manager and deputy manager had identified areas of documentation that needed to be improved and a number of changes had recently been implemented with further changes planned. This included more information in people's room files to inform staff and information about people's choice and involvement and improvements to MAR charts as these were untidy.

We saw new documentation which had been devised but not yet introduced. The acting manager was aware that changes needed time to become embedded and was introducing each change methodically to allow staff time to become used to each change.

Care documentation was securely stored on a computer system accessed by password only. This was used by nursing staff to record care planning and risk assessments. Paper files were in a locked area on both floors. Information stored in people's rooms included information for care staff regarding moving and handling, and included daily records and checks completed by staff. These were checked and signed by senior staff to ensure that daily personal care and support had been provided.

Documentation was not always appropriately completed. There was minimal evidence in people's care plans of their views on how they would like to receive their care and support. Preferences and choices were not well recorded. Due to staff rotation which had recently taken place, staff were not always familiar with peoples care needs.

People's choice and involvement in decisions was not clear from care planning, assessments and daily records. Information regarding people's choices in relation to baths and showers had not been clearly recorded. People told us, "I have a good wash every day and I have a shower once a week but it's all quite an effort." When people received assistance with washing it was not clear whether they had been offered a choice that day or declined a bath or shower. One person told us that they did not know if they could request a shower or bath. That day staff had asked this person how they had been washed previously and had followed the same pattern of care without offering an alternative. Documentation for this person did not specify whether information regarding preferences for bathing or showering had been discussed during the pre-admission assessment. We did not find any documentation to show that this had been discussed since admission.

People told us they had not been involved in any formal assessment or planning of care needs. Staff spoke with them during the day about what they wanted or needed, but people had not seen or read any care documentation. We were told, "I've been here two weeks and there's no care plan to date that I am aware of, although it could be with the nurses. I've no idea what they have outlined for me." For people who had next of kin involved in their care, we asked them if they had been involved in any meetings or discussions about care plans. They told us "I can speak to staff whenever I come in but now that my relative has been here a couple of months now and they are settled perhaps it's time to let them know more information about them."

Relatives spoke highly of staff and told us that when people become unwell or in need of a visit by the GP for example, that they had been informed promptly by telephone or spoken to by staff when they visited, but had not seen any care documentation or remembered being consulted about care plans or risk assessments in place.

We found in one person's room that personal information regarding behaviours that may challenge was being recorded by staff on a sheet of A4 paper. This document had been placed onto the front of the room folder and was left on the person's bed, visible to anyone who entered the room. Nursing staff were unsure why this information was being recorded. We discussed this with the acting manager who removed this paperwork immediately. The acting manager ascertained that the information had been recorded at the request of a visiting mental health professional. However, this had not been done using specific documentation or stored confidentially at the nurse's station. Immediate action was taken by the acting

Requires improvement

Is the service responsive?

manager to inform staff that this information had not been appropriately recorded or stored to ensure this person confidentiality and privacy regarding their health and behaviours had been maintained. The acting manager assured us that this would be discussed further with staff to ensure that this was not repeated.

There was not an accurate, complete contemporaneous record in respect of each service user.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans were reviewed monthly and a care plan audit completed. Wound care folders and wound dressings were in files at the nurse's station. These informed RNs of who had wounds and required dressings. Body maps were completed when injuries occurred; these were seen in people's care documentation.

People had the opportunity to share their views and give feedback during regular resident and relatives meetings. We saw minutes from meetings detailed discussions and actions taken. These included discussions around the changes to management and environmental things for example the decoration of the main lounge where people had the opportunity to be involved in the choice of wallpaper.

A complaints policy and procedure was in place and made available to people as part of their organisations brochures and information located in bedrooms. People told us that they would be happy to raise concerns and would speak to staff or management if they needed to. We looked at complaints and saw that these had been responded to in accordance with the organisations policy and procedure and a copy of all documentation recorded to ensure a clear audit trail of investigation, actions taken and learning from events to improve and develop the service. The acting manager understood the importance of ensuring even informal concerns were documented to ensure all actions taken by the service were clear and robust.

There was a designated team of activity co-ordinators providing daily programme of activities for people living in the service. This included games, crafts, gardening, computer lessons, coffee mornings, visiting entertainers and activity providers and trips out for those able to attend. Activities had been arranged to support people's interests and hobbies, for example a Wild West Day and a picnic in the park. People were kept informed of recent and planned events and activities in a monthly newsletter diary of events.

Activities were recorded including information about who had attended and discussions with people regarding feedback about what people wanted to have organised for the future. There was a programme of improvements to activity provision which had commenced. The activity co-ordinator told us that the organisation had encouraged and supported the activities team to attend training including dementia and end of life to facilitate them in providing appropriate activities for people. Activity staff told us that training received had helped support them to provide appropriate activities tailored to the individual. The service participates in the National Association for Providers of Activities for older people (NAPA) awards. NAPA is a registered charity and membership organisation for people interested in increasing activity opportunities for older people in care settings. People who were unable to attend group activities due to their health related conditions or who did not wish to attend group activities were visited by a member of the team on a one to one basis when possible to prevent social isolation.

Good

Is the service well-led?

Our findings

There was no registered manager at the time of the inspection. The previous manager had left and removed their registration shortly before the inspection. The acting manager and deputy were both newly appointed to this service, however, the acting manager had experience of working for the provider and been seconded from another home within the organisation. The acting manager's application to register as manager with CQC was in progress.

The acting manager worked full time and was in day to day charge, supported by the deputy manager. People had been informed that the management was in a process of transition. People and visitors told us they knew that the management had recently changed and they felt they had been kept informed.

The acting manager told us the focus of the service was to ensure people received person centred care which supported them to maintain independence and dignity at all times. They strove to ensure the service was open and transparent and welcomed comments and suggestions from people and staff to take the service forward and make continued improvements. They were well aware of the culture of the service and the attitudes and values of staff, including the issues relating to the new management transition. Staff were able to tell us about the new ways of working and that the changes were positive. All staff and management told us they dealt with any concerns in an open and objective way. There was a good professional working relationship between the acting manager and the deputy manager. This gave consistency to the way the service was managed on a day to day basis.

To ensure good communication between management and staff a daily meeting took place attended by the nurses and management. This was used to share any relevant information about people's health and any changes staff needed to be aware of. Nursing staff then cascaded the information to the care staff on duty.

The acting manager had only been at the service a few weeks, but had already looked at ways to improve the service, this included improvements to documentation. Dividing teams to ensure a skill mix across the service. Introducing new designated roles, policy of the month and a review of training needs and support for staff.

The acting manager told us this was to improve standards and meet regulations. Staff were supported with the introduction of further training to that which was previously deemed 'essential' for example further end of life training. Staff roles were clear to ensure staff were aware of the organisations expectations of them whilst working at the service.

There was a robust programme of quality assurance. The provider had a clear overview of the service due to regular audits and visits to the service by the operations manager. This included administration audits, talking to people and staff, documentation checks, observing staff interaction, and documenting any concerns identified in a monthly report. In the short time they had been working at the service, the acting manager had identified some areas of improvement with regards to documentation and any areas identified for improvement were discussed in meetings with management and improvements taken forward to continually improve the service and care provided.

An annual resident and relative's quality survey and results was produced, the most recent dated December 2014. This incorporated day to day experiences of people and the environment. Including feedback from people living at Inglewood, staff and relatives. This was displayed in the main entrance area. This included an action plan given to the manager to agree any improvements identified in the survey. We saw that these had been responded to and actioned appropriately.

Audits were completed throughout the service to assess and monitor the quality of care provided and to ensure appropriate maintenance and equipment. These included six monthly health and safety audits, monthly infection control, maintenance, medicines, care plan and wound care audits. The pharmacy used by the service had also completed a medicines audit in July 2015. Actions identified had been responded to and actioned. For example thermometers had been purchased for each room in which medicines were stored, All areas of the building, including communal and peoples rooms were checked to ensure they were suitably maintained and decorated. Equipment was checked and any maintenance work required was documented and signed when completed. This showed that issues were responded to in a timely manner.

Good

Is the service well-led?

It was clear that the provider had invested in the service to improve the environment. The communal areas had been recently redecorated with new furniture purchased. Improvements had been made to staff areas and further improvements were in progress.

We saw the organisations schedule of meetings. This showed regular management, staff, relative and resident meetings, including meetings with night staff, housekeeping, kitchen and maintenance staff took place and were scheduled. All meetings had minutes produced and were available for staff to access if required. Actions were seen to be responded to for example requests for alternative activities and trips responded to.

Policies and procedures were available for staff on both floors, with copies also online. The acting manager told us the organisational policies were updated regularly by the head office and any amendments or changes sent through to them. They then ensured staff were aware of these changes. This information was being included in meetings if appropriate or by the new 'policy of the month' when staff had the opportunity to read and discuss individual policies. Staff were aware of the whistleblowing policy and told us that they felt they could raise concerns with any of the management.

The acting manager and deputy carried out a daily walk around of the building, chatting to people, staff and visitors. The acting manager was introducing themselves to people to ensure they had the opportunity to meet the new manager and discuss any issues or concerns. We observed visitors talking to the acting manager and they told us they felt able to speak to any of the staff as, "Everyone is open and helpful."

All of the registration requirements were met and the acting manager and deputy ensured that notifications were sent to us when required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Maintain securely an accurate, complete, contemporaneous record of care for each service user. Regulation 17(2)(c)