The Royal Masonic Benevolent Institution

James Terry Court

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?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

We visited James Terry Court on 30 September and 1 October 2015.

The inspection was unannounced. The last inspection took place on 7 June 2013 when it was found the service was meeting the regulations we inspected.

The service provides residential care and nursing care for up to 76 older people with a range of needs associated with old age including people living with dementia. The home is divided into a residential unit, a nursing unit and a dementia support unit. At the time of the inspection the service was caring for 74 people and two people were due to fill the remaining beds.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

Care records were not always fit for purpose. We found parts of the record were not always put back in the right place; additional records were inserted in an ad hoc manner; some parts were incomplete; some records had not been reviewed; and, entries not dated. You can see the action we told the provider to take at the end of the full version of the report.

People at the service felt safe. Staff had completed knew how to recognise and report abuse and how to escalate concerns. They had completed safeguarding of adults training. People's needs were assessed and risk assessments recorded. There were sufficient numbers of staff to meet people's needs and safe recruitment procedures were followed. The service provided a safe and comfortable environment for people, staff and visitors. People were cared for in a clean, hygienic environment. Medicines were safely administered.

Staff had the skills, knowledge and experience to deliver safe and effective care, support and treatment. The provider ensured staff were trained and supported with regular supervision sessions and appraisals. Mental capacity assessments were completed to establish people's capacity to make decisions although these were could be improved and in some records were missing. Where it was necessary to deprive people of their liberty to deliver care and support the service had applied for authorisations under the Deprivation of Liberty Safeguards (DoLS). Staff demonstrated an understanding of mental capacity and DoLS and had completed relevant training. People were supported to have a healthy diet and to maintain good health. Individual needs had been met by the adaptation, design and decoration of the service.

People and visitors commented positively about relationships with staff and care was delivered in a patient, friendly and sensitive manner. People and their representatives were supported to express their views. Staff respected people's privacy and dignity.

Care plans were person centred and addressed a wide range of social and healthcare needs. People were encouraged to take part in activities to reduce the risks of social isolation and loneliness. A range of activities were available to people. The provider had systems to obtain feedback about the quality of the service they provided in order improve.

Staff spoke positively about the management team who had an open door policy if people, visitors of staff wanted to speak with them. Regular staff meetings were planned to exchange information and obtain feedback. The provider had a system of audits and surveys to monitor and assess the quality of service they provided.

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 safe. Staff were trained in and understood safeguarding procedures. People's needs and risks were assessed. There were sufficient numbers of staff to meet people's needs and safe recruitment procedures were followed. The service provided a safe environment. Medicines were safely administered.

Good

Is the service effective?
The service was effective. Staff had the skills, knowledge and experience to deliver safe and effective care and support. People's capacity to make decisions were generally assessed. People were supported to have a healthy diet and to maintain good health. Individual needs were met by the adaptation, design and decoration of the service.

Good

Is the service caring?
The service was caring. People and relatives commented positively about staff. Staff were aware of people's needs and preferences. Staff respected people's privacy and dignity.

Good

Is the service responsive?
The service was responsive. Care plans were person centred. People were encouraged to take part in activities. The provider had systems to obtain feedback about the quality of the service they provided in order improve.

Good

Is the service well-led?
The service was not always well-led. Care records were not always fit for purpose. There were staff meetings to exchange information and obtain feedback. The provider had systems to monitor the quality of service provided.

Requires improvement

James Terry 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 30 September and 1 October 2015 and was unannounced.

The inspection team comprised two adult social care inspectors 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. Our expert had experience of care for older people living with dementia.

Before the inspection we reviewed information we held about the service, including statutory notifications and safeguarding alerts and reviewed their website. During our inspection we spoke with 15 people using the service, 11 members of staff (including the management team) and five relatives. We carried out general observations throughout the inspection. We looked at records about people's care and support which included 12 care files. We reviewed records about staff, policies and procedures, general risk assessments, accidents and incidents, complaints and service quality assurance audits. We inspected the interior and exterior of the building and equipment used by the service.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe. One person told us, "I feel quite safe." Another person said, "I've felt safe here. I've never lost any of my possessions." One person said, "I've been absolutely safe here." Another commented, "I've had no problems with safety." A relative told us, "She has been very safe. She is well looked after." Another relative said, "The staff take steps to ensure safety." A member of staff said, "People are safe."

The service had policies and procedures for safeguarding vulnerable adults that supported staff with clear directions and guidance about safeguarding procedures. It was clear from discussions we had with care staff they understood what abuse was and what they needed to do if they suspected abuse had taken place. Staff told us they would report any poor practice or abuse to the manager and were confident any such matters would be addressed appropriately. Staff records confirmed that staff had completed safeguarding training and received periodic refreshers thereafter.

We saw risk assessments had been completed as part of people's care and support plans which identified a range of social and healthcare needs and risks. Risk assessments provided staff with information about the nature of each identified risk and how to manage it. For example, in the dementia unit we saw information about people's individual care risks. Care plans identified the impact of dementia or mental health on a person's wellbeing and how it should be managed. One plan stated, "Keep furniture around [name of person] to a minimum, not to be seated in a crowded area with lots of people around." Risk assessments were reviewed on a regular basis and in response to specific incidents. When we spoke with staff they were knowledgeable about people's needs and any associated risks. We noted in the majority of records the location of risk assessments within care plans was ad hoc, did not follow a logical order or tie in with other risk assessments and subsequent actions. Despite this, the staff we spoke with were aware of the information contained in the risk assessments.

Between each shift the staff handing over provided a briefing to staff starting the next shift. We observed a handover in the nursing unit. Information was provided about the health and care of each person on the ward including mention of what people had been doing and what mood they were in. One person was off the ward visiting the hairdresser and this was made clear to the shift that was about to start. The incoming shift was then assigned to their duties for that shift and there were discussions involving all members of staff about how tasks for the shift would be met. The handover was not rushed and ensured that relevant information was passed from one shift to another. Two members of staff told us that this handover reflected normal practice in the service.

We found the service kept records of accidents and incidents. Staff were encouraged to complete these records even for minor injuries and incidents. The records were then submitted to an external agency to identify any trends, lessons to be learned or improvements that might be required.

The service provided a safe environment for people, staff and visitors. The premises were purpose built to provide residential and nursing care and we found buildings, fittings and outside areas were well maintained. Equipment used by the service to provide care and treatment was also well maintained. We spoke to the member of staff responsible for maintenance who told us equipment was serviced every six months by an external company. There was a simple system in place to notify any maintenance concerns that was open to people using the service, relatives and visitors and members of staff. We looked the maintenance book which showed maintenance required and actions taken by maintenance staff. There was also a rolling programme of redecoration and refurbishment as the service had been operating for over three years.

There were sufficient numbers of staff to meet people's needs. One person using the service said, "The staff numbers are okay, I can get help when I need it." Another said, "I've never had a problem, there are enough staff." A relative told us, "On the whole there are plenty of staff about." One relative said, "I feel the staff don't have time to stop for a chat." Overall, the feedback was positive about staffing levels. During our observations we saw people did not have to wait for attention and responded promptly when people became confused, upset or needed assistance with personal care.

The service managed and recorded staff rotas on a computerised scheduling system. The system was colour coded for easy identification of staffing levels. The majority of shifts showed that staff levels exceeded the required

Good

Is the service safe?

number of staff and one member of staff was usually scheduled as supernumerary to help out wherever needed. Domestic, catering, maintenance and activities staff provided additional support enabling nurses and care workers to concentrate their efforts on providing care and treatment. Most staff absences were covered by other members of staff and bank staff. The service made use of agency staff who were familiar with service whenever additional staff cover was required. Like other nursing homes in the area the service struggled to attract and retain permanent nursing staff.

The service followed safe recruitment practices. In a random selection of four staff files each one contained a completed application form, a record of interview questions, two references and a Disclosure and Barring Service check. Staff did not start work until all the pre-employment checks had been completed and verified by head office. There were also systems in place to check and monitor staff with visa restrictions and nurses' PIN numbers that demonstrated their qualifications and continuing registration to practice.

Medicines were safely administered and people received their prescribed medicines at the right times. One person told us, "Medication is given on time." Another said, "I usually get my medication on time but sometimes it is a bit late." One person said, "I get my medication when I expect it." A visitor told us, "They are pretty good with her medication and they give us what we need when she comes to us."

Medicines and controlled drugs (drugs regulated by the Misuse of Drugs legislation) were securely stored in a controlled environment. Medicines were only administered by trained and competent staff from locked medicines cupboards in each person's room. Records of medicines given to people were made at the time they were given. We looked at the medicines administration records for 10 people and found that they were correctly completed. Records of medicines received and their disposal were also completed and accurate.

People were cared for in a clean, hygienic environment. People told us that the premises were kept clean and tidy. One person told us, "The room is always clean." Another person told us, The home is clean and my room is done daily. One person said, "This place is spotlessly clean." We did not notice any malodours and the rooms and communal areas we saw were clean and tidy.

Domestic staff were employed seven days a week between 7.00am and 5.00pm. There was a cleaning schedule for each floor and guidance for staff on what cleaning products to use and when. There was also a laundry room where people's clothing was cleaned and ironed for them.

Nurses, carers and domestic staff wore uniforms. We were told by staff that uniforms were provided. Staff were required to change in and out of uniform at work. Staff were also provided with single use items of personal protective equipment such as gloves and aprons.

We looked at documentation and found that the service was following the Department of Health Codes of Practice for the prevention and control of infection in care homes. The service had a range of relevant policies in place and used the Department of Health audit tool. The service had an infection control champion who was responsible for auditing the service and promoting good practice. There were appropriate risk assessments and COSSH assessments in place.

Good

Is the service effective?

Our findings

People were supported by staff who had the knowledge and skills they needed to carry out their role. People felt comfortable with the support staff provided. One person in the nursing unit said, "I think it's very good, the staff are very caring." A visiting relative in the dementia support unit said, "They seem to be dementia trained." In the residential area one person told us, "The staff are really caring and attentive. I don't need a lot of help but they are always there if I need them." Another person said, "The people on night duty are very good." One person said, "The carers know what they should be doing."

Staff were required to complete regular training relevant to their roles. This included areas such as first aid, safeguarding, moving and handling, infection control and medicines administration. Staff received dementia training ('Tomorrow is Another Day' produced by the Alzheimer's Society). Nursing staff completed the same training as other staff and additional training specific to their clinical role such as phlebotomy, catheter care and wound care management. Staff told us that they were 'always' training. Staff also told us that they were supported with regular supervision sessions and appraisals. Staff training records were maintained centrally and recorded both training that had taken place and scheduled training dates. Records confirmed that staff received training and supervision on a regular basis.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We spoke with staff who told us they had completed relevant training and showed they understood the basic requirements. However, we found care records did not always comprehensively record consent to care and treatment, mental capacity assessments and best interests meetings. Where there was an absence of mental capacity assessments there was no way of being sure that those people were providing informed consent to care and treatment or where people were having decisions made on their behalf that they were not capable of making some decisions themselves. Where there were mental capacity assessments they tended to be general and not decision or time specific. Where people had been identified as having their liberty restricted in order to provide safe care and treatment appropriate DoLS authorisations had been obtained. The new manager told us the issues we identified around mental capacity had been identified by the service in an internal audit and they have been reviewed and addressed.

People had sufficient food to eat and liquids to drink. One person told us, "I enjoy some of the food and I can have something different." Another person said, "I've got no complaints about the food. I get enough to drink during the day. There is water in my room which is changed daily." One person told us, "The food is quite good. There's always a choice of meals." A visiting relative said, "[She is not eating too well but mostly she eats the food. They do encourage her to eat."

We found staff had a good knowledge of people's dietary needs and preferences. One staff member explained that one person required a soft diet and described the types of food they would offer. A list was available of daily meal choices and information about any special diets. Where there concerns about people's weight were identified we saw care plans showed risk assessments had been completed and appropriate support sought from healthcare professionals. Where necessary dietary supplements had been provided. This showed people had their nutritional needs assessed and reviewed on a regular basis.

We observed lunch being provided in the dining room. People came when they were ready over the course of a 15 minute period and were served by catering staff. The catering staff greeted people and brought food to the table. Vegetables were served separately so that people could help themselves. Two people were attended by care workers who helped them to eat their meals. There were

Good

Is the service effective?

plenty of drinks available. We spoke to the chef who told us that there were three main courses available and desserts. Alternative meals were available if requested. We saw that the food served was hot and people seemed to be enjoying their meals. We also observed meals being served in the dining rooms within the units and in bedrooms. Meal temperatures were brought to the units in heated trolleys and food temperatures were checked before being served.

People were supported with their healthcare needs. Appropriate professionals were involved when necessary and staff generally maintained records for any about advice given or action required. Records showed that staff recognised when people became unwell and that appropriate action was taken such as requesting a visit from the GP or making a referral to other healthcare professionals such as an optician, dentist, chiropodist and district nurses. Care records showed people had input from the local falls team, memory clinic and speech and language therapy team.

We spoke with people using the service about their experiences of being supported with their healthcare needs. One person told us, "I can see the dentist or chiropodist if I need to." Another person said, "I get all the attention from chiropodists and the others. They send someone with you when you go for an appointment." One person said, "The Home arranged for a chiropodist and she came today. A dentist also visits." Another told us, "I see the hairdresser, chiropodist, optician and dentist." A relative told us, "The doctor visits weekly. If he is unwell he is put on a list." Another visitor said, "They sent someone with Mum went she went for a hospital appointment."

People's individual needs were met by the adaption, design and decoration of the service. The building was purpose built to provide residential and nursing care for older people including a unit specifically for people living with dementia. Corridors were wide and kept free of obstacles. Some corridors and communal areas provided handrails ran to provide people with extra support. There was good lighting throughout the building to compensate for the natural deterioration in older people's eyesight and to alleviate the confusion of processing what can be seen for people living with dementia. There were numerous quiet areas of seating scattered around the building. The building had gardens and covered courtyards, including a roof garden, for people and their relatives. The dementia support unit had a secure garden attached to the unit. A reminiscence corner shop had been created. Each unit had a lounge and dining area. The nursing unit provided a homely atmosphere without impinging on clinical processes. People's rooms were bright, well-lit and personalised to the extent people preferred. Bathrooms and toilets were large enough for staff to provide assistance. Appropriate equipment was provided to enable staff to meet people's needs such as fixed and mobile hoists, baths and showers. There were lifts available for people to access the different levels of he building.

Good

Is the service caring?

Our findings

We spoke with people and visitors about their experiences of the care and support at James Terry Court. One person told us, "The staff are lovely. All the staff are very caring. We are well looked after here" Another person said, "They are all so kind; there's a very friendly atmosphere here." One person said, "Staff are kind and sensitive, no complaints." One person told us, "There are no problems with the staff. They are kind." Another person told us, "I don't ring the bell very often but they do respond quite quickly." A visitor said, "You can't fault the care." Another visitor told us, "Staff are kind and sensitive, no complaints."

Care was observed to be delivered by staff in a patient, friendly and sensitive manner. Staff supported people to move around the home, including assisting people to sit and stand with appropriate equipment. People were given time to respond and were not rushed. We saw numerous friendly conversations and interactions between people and staff during the inspection. For example, one person in the nursing unit required two members of staff to hoist her from a chair so she could visit the hairdresser. As they approached they reminded her that it was time for her to visit the hairdresser. They chatted to her as they prepared the hoist, gave her simple directions throughout and told her what was about to happen so she was prepared. When she had been transferred into a wheelchair one care worker carefully straightened her clothing at the back which had gathered and would have been uncomfortable if not addressed. The transfer was completed with the minimum of fuss.

In the dementia support unit we observed one person sitting in a chair, who was clearly confused and upset. Two members of staff talked to her as they approached, knelt in front of her, held her hand and provided words of comfort. Over a period of five minutes the person calmed down and eventually smiled and accompanied staff to the lounge area. We observed two people who frequently questioned staff about what was happening and staff promptly responding and providing reassurance. Before a member of staff left for their lunch break they explained to a person what they were doing and introduced a second member of staff to limit any confusion. During an activity we saw staff engaging positively with people by chatting and encouraging individuals to join in. We saw staff interacting with individuals throughout the inspection. In one example, staff spent time with an individual who was engrossed as they showed black and white photographs and chatted about them. One member of staff explained how they encouraged sensory stimulation by holding a person's hand and offering different textured fabrics. We observed this brought comfort to the person when they became unsettled. Although these observations and findings were in the dementia support unit this was a pattern reflected in the actions of staff in the residential and nursing units.

People who could tell us about their experiences said they had some involvement in planning their care, support and treatment although we found examples of people who did not. Some relatives of people unable to express their views told us they were involved in reviews of care. Generally, care records showed people's involvement, or the involvement of appropriate representatives but some care plans did not. Some care plans showed involvement in certain areas but not others. We found this issue had already been identified in a recent internal audit and the new manager was taking steps to ensure people were fully involved in planning their care and treatment.

We found staff respected people's privacy and dignity. One person told us, "They do give me my privacy." Another person said, ""If they deal with me personally, they shut the door and draw the curtains." One person said, "They are very respectful, they knock on my door and draw curtains." Another person told us, "The staff are very sensitive towards me and my privacy." A relative told us, "His dignity has been preserved." We found that in addition to the main lounges that were available there were smaller 'quiet' areas, often with bookshelves with books and magazines, where people could sit quietly away from others. One person said, "I need to have some time to myself every now and again so I come and sit here. Its very relaxing and I can just sit and think." The service also provided a library room on the ground floor.

Good

Is the service responsive?

Our findings

We spoke with people and their relatives about personalised care. One person told us, "I do get the care I need." Another person said, I've never complained about anything. There is enough to interest me here. I join in everything, like games. We get out occasionally in the mini-bus." One person said, "You get a choice about who looks after you and I don't mind who does. I prefer my own company, so I don't go to the activities. There are trips out." Another person told us, "I do get what care I need. We have entertainment and there is enough to occupy me with my hobby. There could be more interesting trips out. I'd like a game of bridge but there is no one here who can play." A relative said, "She does get person centred care here, it suits her."

The manager or deputy assessed people's needs before they moved into the service. This pre-admission assessment contributed to the development of a person centred care plan when people arrived. There were discussions with people, relatives and social and healthcare professionals where possible to complete a care plan that reflected the needs and preferences of that individual. The staff we spoke with were aware of people's health and support needs and were able to tell us about people's preferences and interests.

We looked at a random selection of care plans and found they were person centred and addressed a wide range of people's social and healthcare needs. They identified people's needs and preferences under headings such as, 'My plan,' 'My morning routine,' 'My bathing preferences, 'My involvement' and so forth. The care plans also contained relevant risk assessments for each person. Care staff and nurses were responsible for updating care plans and completing the daily log. A random sample was audited every month. We found care plans in the dementia support unit were more person centred than care plans in the nursing unit where there was a tendency to emphasise on clinical needs.

People were supported to follow their interests and activities and facilities were provided for people's welfare, enjoyment and stimulation. Activities enhanced the lives of people and reduced the risk of social isolation and loneliness. The service employed a full time activities coordinator and an assistant and they ensured a weekly activities programme was clearly displayed throughout the building in communal areas. In the nursing and residential units all the talk was about the ladies night that was being held on the Friday evening with opportunity to dress up for a meal and with family and friends present.

The activities coordinator was provided with a room that had a large table and a kitchen area. Activities for small groups could take place there and if appropriate the cooking facilities could be used. The service had a minibus that was available to take people on trips out. The service was supported by an Association of Friends who, amongst other things, funded chiropody treatment and keep fit classes. The Association of Friends had created a corner shop with signage, posters, scales and sweet jars from the 1950s to the early 1970s. Prices were in displayed in pounds, shillings and pence. The service had a hairdressing facility and a library. Books were also available in quiet areas on the floors in each unit. The hairdressing facility had a side room where various therapies and treatments were provided. There were well maintained gardens and courtyards around the building including an impressive roof top garden. The dementia support unit had its own secure garden. There were various reminiscence areas for people to enjoy.

People were confident that they could raise any matters of concern with staff or the manager. One person said, "I've never needed to complain. If something upset me, I would complain. There are meetings for residents. They would try to sort out a problem." Another person said, "I've never had anything serious to complain about." One person said, "I've never needed to complain about anything serious." People were provided with a service user guide when they first came to live at the service and the complaints procedure was clearly outlined. The service had policies and procedures to deal with complaints. Staff were aware of the complaints procedure. Staff told us that any concerns or complaints were addressed at the outset and formal complaints were rarely made. The manager and deputy both said that they had an open door policy and tried to address any concerns at an early stage.

Meetings for people using the service were held on a regular basis and provided an opportunity to discuss service provision and any general matters of concern in relation to the day to day running of the home. We asked people whether they met with members of the management team to discuss any concerns. One person said, "There are residents meetings and it's always full."

Good

Is the service responsive?

Another person said, “There are relatives meetings, quarterly.” One person told us, ““I know there are meetings for relatives, but I don’t go.” One person said, “I’ve been to the relatives meetings.” People were also had the opportunity to complete survey cards once a quarter that were assessed annually by an independent company. The approachability of staff and management and the opportunity to meet as a group encouraged people to raise concerns and expect an appropriate response. This also provided the service with a forum for feedback about people’s experiences in order to improve the care and treatment provided. We saw example of how the service had taken action to improve the service provided as a result of the feedback they received.

Requires improvement

Is the service well-led?

Our findings

The service was not always well-led. We found care records were too lengthy and lacked logical progression. Although information was generally up to date it was not easy to find because records were not regularly archived. We found parts of the record were not always put back in the right place; additional records were inserted in an ad hoc manner; some parts were incomplete; some records had not been reviewed; and, entries were not dated. We saw one record relating to pressure ulcer management where, as the result of poor records, the agency nurse on the nursing floor wasted time ordering and chasing up a specific type of dressing that was needed that day. The sections in one care record on 'life history,' 'cultural and spiritual needs' and 'things I enjoy' had not been completed and the same care plan stated the person could communicate verbally when they could not. In three care plans we found they had not been reviewed since June 2015 where the norm for this service was to review care plans every month. In one care file there was a list of prescribed medicines for a person but it was not dated to show how current the list was. In these examples there was a risk staff did not have access to records that would support them to provide safe and appropriate care.

The staff who completed care records knew where information was and were well aware of people's needs because they were dealing with those people and their care plans on a daily basis. The knowledge staff displayed and the detailed information exchanged at handovers allayed our concerns to some extent and we concluded this was a matter of record keeping. This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the manager who informed us the provider was considering a computerised system called iCare where care records would be entered and updated by staff using computer terminals. This would make sections of the care plans far easier to locate and maintain and update. In the meantime, the manager was looking at ways of improving the content of care records and the way management supervised care records. Under the previous management team 10% of care records were audited each month. That system was inadequate. The new manager was also looking at staff training and the line of supervision.

The manager was appropriately qualified and registered with CQC. The manager was supported by a deputy manager. People and staff told us they were both regularly seen out and about on the units. The new manager was known to nearly everybody we with spoke with despite only being there for a month. The deputy manager was well known and as a registered nurse often helped out on the nursing unit. One person told us, "The manager is a lady." Another person said, "I know the manager and she comes in and has time to say hello." One person told us, "If I need to see the manager or the finance lady, I can go to them. It's an open door policy." Another person said, "I've seen and met the manager." One person told us, "I've met the manager briefly. She seems very nice. The home is run well." Another person said, "I do honestly think this home is well run." One relative told us, Yes, I think the home is managed well". Another relative said, "I think this home is managed very well." Members of staff commented positively about the new manager. A member of staff said, "I am very happy working here. The management is very supportive. The home seems to be operating well."

The manager and deputy carried out a wide range of audits to monitor and assess the quality of service provision. The audits covered all aspects of service delivery such as the administration of medicines, infection prevention and control and general risk assessments. There were also quarterly audits carried out by the provider. We saw an internal audit had been carried out early in September 2015 in the week preceding our inspection. The audit identified areas of concerns and actions to address them. The issues we have mentioned about care records were identified in this audit. The service also provided people with quarterly questionnaires that fed into an annual survey conducted by an independent company Ipsos MORI. Detailed feedback from the survey was provided each year to the provider with a summary published on 'Your Care Rating' website.

The new manager planned to have regular staff meetings to discuss the running of the service, changes in policies, procedures and legislation and to encourage feedback from staff. The manager had only been in post for a short period of time and the staff meetings that had so far taken place were introductory. We reviewed CQC records and were satisfied that statutory notifications were submitted in a timely manner.

Requires improvement

Is the service well-led?

The provider had a number of residential care and nursing homes. Learning from accidents and incidents, statutory notifications, safeguarding, audits and surveys were assessed at both a location and provider level. Where good or poor practice was identified action was taken and information shared to improve service provision.

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 How the regulation was not being met: Records relating to the care and treatment of each person were not fit for purpose. Regulation 17(2)(c)