Halton Services Limited

Parkfield House Nursing Home

Inspection report

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Ratings

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

Overall summary

Parkfield House nursing home provides long term accommodation with nursing care for up to 44 older people, some of whom were living with dementia. Staff received training in dementia so that they understood how to support people appropriately. There were 27 people living in the service at the time of the inspection.

This inspection was unannounced and took place on 4 and 5 August 2015.

During our last inspection on 7 and 9 January 2015 the provider was not meeting the legal requirements in relation to the safe management of medicines, ensuring that people were assessed if they had restrictions in place, such as bed rails, supporting staff and having effective systems in place to assess and monitor the quality of service provision. At this inspection we found the provider had made improvements and was now meeting some of the legal requirements. However, we

Summary of findings

identified there were still continued shortfalls with how medicines were managed in the service and therefore people were at risk because their medicines were not always managed in a safe way.

The service had a new manager who started the end of June 2015. They were in the process of applying to be the new 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.

We also found at this inspection that care plans contained information about people's needs but these were sometimes contradictory and some lacked sufficient detail to enable nurses and care workers to provide personalised care. There were activities taking place but it was not evident that these were always linked to people's interests and preferences.

The provider had procedures to help identify and deal with abuse and the different members of the staff team had been trained in these. The provider had taken appropriate action and liaised with other agencies to investigate safeguarding concerns.

We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA). DoLS are in place to ensure that people's freedom is not unduly restricted. Where people were at risk and unable to make decisions in their own best interests, they had been referred for assessment under DoLS. People's capacity had also been considered and assessed to ensure they were supported and where possible encouraged to make daily choices and decisions.

There were enough staff to meet people's needs and to keep them safe. Appropriate checks were carried out for the different staff who worked in the service before they were employed.

The different staff members told us they received regular training and support to gain new skills and make them more competent in their roles.

People and relatives told us that they were happy with the food and drink provided. They were supported appropriately to eat and drink sufficient amounts to meet their needs.

The nurses and care workers worked with other healthcare professionals if there were concerns about a person's safety or welfare so that people's individual needs could be met.

People and relatives were happy to talk with the manager and to raise any concerns that arose. People, relatives and the different staff members told us that the manager was approachable, visible and supportive. One relative told us the service provided a "high standard of care and nursing for people." A second relative said the care workers and nurses were, "very attentive."

There were systems in place to monitor the quality of the service being provided to look at where improvements could be made to ensure people received a safe and caring service. Some of the new audits had only recently been introduced and so would require more time to ensure these were effective in picking up any issues within the service.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to person-centred care.

We also found a breach of the legal requirement in relation to the management of medicines. We have taken action against the provider and will report on this when our action has completed.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe. We found the provider did not have suitable arrangements to protect people against the risks associated with the management of medicines.

There were safeguarding procedures in place and the different staff members understood what abuse was and knew how to report it.

There were enough nurses and care workers to care for and support people. Risks were identified and appropriate steps taken to keep people safe and minimise the risks they might face.

Is the service effective?

Good

The service was effective. Improvements had been made to support staff through training and regular one to one and group supervision.

People and/or their relatives had been involved in making decisions about their lives. This took into consideration the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA).

People's capacity had also been considered and assessed to ensure people where possible were encouraged to make daily choices and decisions.

People told us they enjoyed the food provided and that they had choices. We observed people had a positive experience at meal times and those who needed encouragement to eat were supported in a patient and unhurried way.

People were all registered with a local GP and were supported to access community health services including chiropodist and optician according to their needs.

Is the service caring?

Good

The service was caring. People's privacy was respected.

People using the service and their relatives commented positively on the nurses and care workers employed in the service.

There were positive relationships between people who used the service and the different members of staff and relatives confirmed they had no concerns about the care people received.

Is the service responsive?

Requires improvement

The service was not always responsive. Some people's health and personal care needs had not been fully assessed or recorded. Although care files were being audited there was inconsistent and contradictory information in many of the care files viewed and therefore people might not be supported appropriately.

Summary of findings

There was a complaints policy and procedure in place which the provider followed.

Is the service well-led?

Requires improvement

The service was not always well-led. There had been changes to the manager since the last inspection in January 2015. The new manager needed time to introduce new practices and systems to ensure the service was running safely and effectively.

There were systems in place to monitor the quality of the service and these had identified the main areas that needed to be addressed. Although the checks had not identified the issues we found in relation to medicines.

People using the service and staff were encouraged to give their opinions about the service and these were listened to and acted on where required.

Parkfield House 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 checked 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 4, 5 and 10 August 2015 and was unannounced.

Before the inspection we looked at all the information we had about the service. This information included the statutory notifications that the provider had sent to the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us. We also contacted the local authority's quality assurance and safeguarding team for their views about the service.

During the inspection we spoke with the manager, a nurse, three care workers, a chef, four people who used the service, a visiting tissue viability nurse, GP, one relative and one visitor. We also met with several members of the staff team during their staff meeting, these included, nurses, care workers, two activity co-ordinators, housekeeping/ domestic staff and kitchen catering staff. Shortly after the inspection we received feedback from three relatives and viewed feedback from relatives who had used a care homes website to post their online comments about the service.

We used different methods to obtain information about the service. As the majority of people were not able to contribute their views to this inspection, we used the Short Observational Framework for Inspection (SOFI) to observe care and interactions between people and staff. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We looked at nine people's care records. We reviewed records relating to the management of the service including medicines management, staff records and incident and accident records.

Requires improvement

Is the service safe?

Our findings

At the last inspection in January 2015, there was a breach of the regulation for medicines management. There were gaps in recording on some medicines records, so we were not sure if some doses of medicines had been administered. Two people had a delay in receiving their medicines due to supply issues. There were no detailed individual protocols in place for medicines prescribed to be given as required, or "PRN" to identify when the medicines should be administered to people particularly when they were not able to communicate. Due to staffing levels at night, we were not confident that people would receive their medicines on time. When medicines such as insulin required cold storage in a fridge to maintain its potency, both the minimum and maximum daily temperature was not monitored and recorded. The provider told us that the breach would be addressed by 25 May 2015.

At this inspection we found that some of the issues we found during the previous inspection had been addressed and we saw that there were no longer any gaps in the recording for oral medicines. The manager had also introduced a homely remedies policy. However, there were still gaps on medicines records for prescribed topical medicines such as creams, so we could not be certain that these had been administered. The manager had already identified this before our inspection, and showed us evidence that they had plans in place to implement a topical medicines application record, providing nurses with instructions on how to apply these creams, and nurses would use this to record when they applied prescribed creams.

When we looked at medicines records for seven people prescribed PRN medicines for sedation or pain, we found that there were no PRN protocols for these medicines on people's medicines records, or in the clinical room. The nurses on duty, who were from an agency, and were unfamiliar with people living at the service, did not have sufficient guidance on how to administer these medicines correctly and safely. We found that pain assessments had not been carried out or recorded on the day of the inspection for people prescribed "as required" pain relief. One person was prescribed a variable dose of a pain-relieving medicine. Nurses had administered 25 doses of this medicine in August 2015, however, they had not recorded the actual dose given for 23 of these doses. Therefore we were not confident that people's pain was being managed appropriately.

One person was prescribed a controlled drug for pain relief in patch form. The manufacturer's instructions with the patch said that the area of application must be rotated to protect people from the risk of side effects due to incorrect application. Records were not kept to demonstrate that nurses were rotating the patch site. Therefore the provider did not have arrangements in place for the safe administration of this controlled drug.

For six people, there were either no detailed instructions, or conflicting instructions, on how to administer medicines for covert administration. Medicines being given covertly would be given in way to hide it from the person if they usually refused to take their prescribed medicines for their well-being. This might mean medicines could be hidden, often in food, so that the person did not see it.

Nurses were using the same tablet crusher for several people, which had not been cleaned in-between use, and appeared not to have been washed for some time. This meant there were risks medicines powdered in the crusher might be contaminated with other medicines which they had not been prescribed.

The insulin pens in use for two people who required daily insulin injections were stored in the fridge, although there was an instruction on the insulin cartons that the insulin pen in use must not be stored in the fridge. This is because injecting insulin cold straight from the fridge can be painful or cause irritation to people.

Furthermore an antibiotic eye ointment in use for one person had expired. These were disposed of during the inspection when we pointed this out. Also an anti-histamine syrup for one person was prescribed to be administered at a dose of 10mls every day. We saw that nurses had given this medicine twice a day for 10 days until we queried it. This meant the person did not receive this medicine as prescribed placing them at risk of unnecessary side-effects.

We looked at the medicines fridge temperature monitoring records from June 2015 onwards, and saw that the provider had not taken the action they said they would following our last inspection, until 01 July 2015. Insulin for two people had been stored in the fridge during this time, which

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Is the service safe?

required storage at between 2˚ and 8˚C to remain effective. When the correct monitoring was started on 01 July 2015, nurses had recorded that the maximum temperature of the fridge was 18˚C throughout July 2015, which meant that the insulin may not have been stored correctly to remain effective.

We were concerned that the issues with medicines had not been picked up and addressed prior to our inspection through the internal medicine audits and arrangements to monitor the management of medicines.

The above relates to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager began to address the issues during the inspection which had an impact on people's safety, and they told us following the inspection that they had taken action within two days to address most of the remaining issues. However, we were not able to check whether all the issues were addressed and we were not assured that the provider's arrangements to manage medicines were adequate to make sure medicines were consistently being managed safely.

There were systems in place to respond to concerns and suspicions of abuse to help protect people's rights. Two people and a relative told us they were confident that it was safe for those living there. Care workers told us they had been trained in safeguarding and were able to provide definitions of different forms of abuse when asked. They were aware that the provider had policies and procedures for safeguarding and whistleblowing and all said they would report concerns or suspicions of abuse or neglect to their line manager. We saw evidence from training records that the various staff members, including the housekeeping staff had received safeguarding training. We had been notified of safeguarding concerns and records showed there had been one referral for 2015, the manager was aware that there needed to be clearer evidence of the outcome of any investigation or meetings held.

Body maps were seen in care files to monitor and record wounds and bruises and these had been completed correctly and dated.

There was a clear system for reporting accidents and incidents. Forms were all signed by the member of staff reporting the incident and countersigned by the manager with any comments or follow up action required. There was also a monthly analysis sheet and the manager confirmed they would analyse incidents over a period of time to see if there was a pattern or reason for particular incident so action could be taken to prevent these from happening again.

People were provided with safe care and treatment because risks to their wellbeing had been assessed and where significant risks were identified, action was taken to minimise these. Risks were assessed on an individual basis and covered a range of areas that set out the identified hazard and the control measures required to mitigate the risk. For example, these included how to support a person in the event of a fire, using an electric bed and a smoker had a risk assessment in place which was reviewed regularly.

Safety checks were carried out by external organisations on various areas of the service, including fire, electricity and gas safety. Weekly checks around the communal areas also looked at fire doors and the call bells and these had been completed up to the end of July 2015.

Comments from relatives on the environment were positive and included, that the service was, "a very nice residence inside and out" and the service, "always looks and smells clean and is inviting." We saw evidence of daily cleaning checks that had taken place and once a month a person's bedroom was deep cleaned. Domestic staff were observed using colour coded cleaning equipment and were able to explain how this was used for different parts of the service. The service had undergone refurbishment throughout since the previous inspection. We saw new flooring, rooms had been decorated and there was new furniture making the service more appealing, light and homely.

The provider had appropriate procedures for recruiting staff and assessing their suitability. We looked at the recruitment files for three members of staff and found that these included all the required documents and checks. These included, two references, criminal checks such as, the Disclosure and Barring Service checks and proof of the person's identity. On one nurse's file there was an unexplained gap in their employment history which the administrator addressed during the inspection as the nurse confirmed they had been working abroad.

Relatives said there were enough care workers and nurses working in the service. We observed care workers were available to attend to people's needs. Call bells were

Requires improvement

Is the service safe?

promptly answered and care workers were able to help people to move around the service and assist those who required help with eating. Those care workers we asked said there were sufficient numbers of care workers and nurses working in the service, although they told us more permanent nurses were needed. The housekeeping staff said they had told the previous manager and current manager that they needed additional cleaning staff as it was a large building to clean. The manager confirmed that she was in the process of recruiting more nurses and housekeeping staff. They were aware of the need, once new people were admitted to the service, that staffing levels needed to increase. There had been significant changes to the nursing staff team over the past year with a reliance on agency or bank staff to cover shifts. The manager had recently recruited nurses and was seeking to stabilise the nursing team so that people were supported by regular and familiar nurses. We saw from viewing the rota that on each shift there was always nursing staff working to provide clinical support to people and they were supported by a team of care workers, domestic, catering and administration staff.

Good

Is the service effective?

Our findings

At the last inspection in January 2015, there was a breach of the regulation in supporting staff. We found that several nurses and care workers had not always received an annual appraisal of their work. At this inspection we found that there had been improvements to one to one and group supervision and appraisals. During the staff meeting various members of the staff team confirmed they had received support through supervision, observations were carried out on their work and they said they had received an appraisal. One care worker said, "We're well supported now." A domestic staff member told us they enjoyed the job and took pride in it. We viewed a sample of appraisals on staff employment records. A supervision and appraisal plan had been developed so that the manager could easily see when these meetings needed to take place.

Also at the previous January 2015 inspection there was a breach in the regulation for consent to care and treatment as there were people with bed rails in place for their safety. However, appropriate applications had not been made to the Local Authority for a Deprivation of Liberty Safeguards (DoLS) assessment to ensure this restriction was in people's best interests. At this inspection we found that a request for DoLS assessments to be completed had been applied for everyone who had various restrictions in place. This included people who had bedrails or were not being able to leave the service freely and unsupervised. The manager had developed a form to monitor when these assessments had taken place along with their outcome.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The manager was fully aware of their responsibilities for making sure the least restrictive options were considered when supporting people and ensured people's liberty was not unduly restricted. They were aware of informing the Care Quality Commission (CQC) of the outcome of a DoLS assessment. Some of the care workers we asked had limited understanding of this legislation but we saw the various staff members, including catering and housekeeping staff had completed training in 2014 on DoLS and the Mental Capacity Act 2005. The manager confirmed that this training would be offered as a reminder for all staff and they would obtain further information on this subject to ensure it was available for them to access.

Consent forms were seen in care files for photographs, information sharing and personal property. Where people were considered to need bedrails this had been assessed and people's relatives had been consulted so that they were aware that these needed to be in place and the reasons why. The manager was in the process of checking with relatives and friends to ascertain who had Lasting Power of Attorney for Health and Welfare and ensure the service held a copy of this on file. Capacity assessments had also been completed and considered how to support the person in the best way and if they could make daily decisions. The care records were currently being audited to make sure they clearly documented who had a DoLS in place and if the person had any particular restrictions in their daily life.

Feedback from people and their relatives on the various staff who worked in the service was positive. Comments from relatives included, that care workers were "calm and competent," "most of the staff have a good understanding of dementia," and "I am quite happy that X is being cared for by professional and well trained staff." We saw evidence that new care workers would complete the new Care Certificate which the manager had all the necessary information on. There was an induction programme and this was for anyone new who started working in the service. Care workers and nurses spent time shadowing experienced care workers or nurses to ensure they felt able to work unsupervised. Those we asked confirmed they had received an induction and had ongoing and refresher training. We saw evidence of a sample of the training provided and this included, moving and handling, infection control, dementia and equality and diversity. The manager told us that she intended to address the issues where some care workers had not attended the mandatory training.

We looked at the meal provision in the service and we saw people's preferences were known and individual needs in relation to nutrition were recorded. One person told us, "The food's not bad you always have a choice." Relatives were positive about the meals and told us, "The food is tasty and is presented and served attractively," and "the food is very good." We saw that care workers supported people to eat their meals and sat next to people if they needed encouragement or assistance to eat.

There was a separate section in the care file which addressed eating and drinking needs and this identified any risks and nutritional requirements such as risks of

Good

Is the service effective?

choking or the need for a fortified diet. Daily food intake and fluid charts were maintained where nutritional status was poor and the records we viewed were up to date. People were weighed every month or on a weekly basis if at risk or if weight loss had been identified. Where one person had difficulty in swallowing. We saw evidence of a risk assessment, and a care plan describing the person's needs to have pureed food and thickened drinks. We observed that the person was receiving adequate nutrition and hydration according to their care plan. The care workers we spoke with showed knowledge of the person's individual needs and a desire to meet them.

Catering staff maintained a file with records of food preferences for each person along with dietary requirements and special needs such as pureed food, diabetic or vegetarian diet. Jugs of juice were available in all communal lounges and we saw that those people who were in their bedrooms had drinks provided. We observed that people were offered fresh fruit plates during the day and could have fresh fruit smoothies every day as an alternative.

There was a separate section in care files to record visits from external health care professionals such as opticians, dieticians, and dentists although the quality of record keeping was variable, which we spoke with the manager about. They devised a clearer health appointment form during the inspection so that care workers and nurses could easily record and locate health appointment information and follow up on any issues.

People were registered with a local GP practice and a GP visited the service on a weekly basis (or as required), for consultations with people or to conduct general health or medication reviews. There was a separate book to record issues or problems to be discussed and records of GP input and comments and this was well maintained and clear. We spoke with a GP who was positive about the service and told us, "Things have improved greatly, record keeping and communication in general is much better."

We also met with a tissue viability nurse (TVN) who confirmed that a suitable wound care plan had been put in place following their recommendations and that progress was being well monitored and care delivered as specified.

We noticed that the environment was pleasant and that the service had made the effort to show some dementia friendly areas, for example there was a dresser with old fashioned sweet in jars that people could have. There were a few reminiscence objects in places, and the use of colour contrast was evident in places for people to recognise different areas of the service, such as bathrooms. There were also memory boxes outside bedrooms. The manager told us they were hoping to continue with making the service more dementia friendly in order to meet the diverse needs of the people using the service.

Good

Is the service caring?

Our findings

Relatives were positive about all the various staff who worked in the service and spoke highly of the care and support that was provided. One commented that the care workers were, “all helpful and friendly,” whilst another relative said, “there is always a happy atmosphere each time I go there.” A visitor told us, “The staff are kind and caring.” We observed that care workers were gentle and patient when assisting people to move around the service.

Where possible people were able to contribute their views on the care they wanted or their relatives were consulted. People had attended review meetings if they felt able to, to look at their care. There was no-one currently accessing any local advocacy services and with the manager recently joining the service, they told us this was an area that would be looked into in case a person would benefit from this independent support.

People were helped to maintain relationships with those who were important to them, to protect them from social isolation. We saw one person being visited by their family whilst another person had a visitor whilst we were carrying out the inspection.

We observed that people’s privacy and dignity was respected and care assistants ensured that bedroom and bathroom doors were closed when delivering personal care. We saw that care workers always knocked on bedroom doors before entering. The care workers we spoke with described the methods they used to ensure that they respected people’s privacy and dignity such as closing door sand curtains and offering choices before helping people.

People living in the service were clean and well dressed and we saw that care and attention had been paid to hair grooming and choice of clothes for those less able to manage their own personal care. A hairdresser attended the home regularly and people could book appointments as wished.

Requires improvement

Is the service responsive?

Our findings

Each person had care plans for each different aspect of care which took account of physical, medical and social needs. The care plan outlined the needs and risks for that person, the goals and desired outcome of care and the support required. However, the care plans were not always accurate about people's needs and therefore could place people at risk of unsafe or inappropriate care.

We were told about the specific needs of three people. We found that their care plans did not have information about these particular needs and how to meet these needs. This was addressed during the inspection with the nurse in charge of auditing care files writing a care plan for these three individual's.

All the files we viewed, other than a file on a person who had recently been admitted to the service, which was accurate and easy to follow, contained repetitive information based on medical needs and not on people's individual likes and dislikes. Many documents were handwritten and difficult to read. One care file seen was disorganised and it was hard to locate information about the person. For example there was no date of admission recorded and many of the care plan evaluations gave no meaningful updates beyond "care plan continues, act in best interests." There was some evidence that care files reflected changes in circumstances or need but this was inconsistent and not always fully documented. For example the care plans for two people indicated that a daily food chart should be maintained although there was no evidence of weight loss. When we looked at daily food charts they had not been maintained regularly for these people. Another person's care file recorded that their blood glucose level should be monitored "monthly, weekly if possible." On this same care file the risk of falls was noted as "high" and also "medium". A care worker was able to explain how to support specific people and said that care workers tried to read the care plans but changes to record keeping had made this difficult.

Monthly evaluation forms were completed by nurses to provide information on progress, highlight any concerns and document any changes. However, although most evaluation sheets were up to date they did not always reflect changes suggested by other documentation in the care plan.

For example one person with a particular need, they had a behaviour diary in the care file which had been maintained for two months earlier in the year but the care plan did not indicate why this had been introduced, what the objective was or outcome and why it had been discontinued.

There was contradictory information on files relating to end of life wishes. For example on one file it said the person had a Do Not Attempt Resuscitation (DNAR) form yet this was not kept on the person's file. Whilst another file seen stated no DNAR in the end of life care plan although a DNAR form was present. Another care file named a relative as having Lasting Power of Attorney (LPA) in the end of life care plan although the DNAR form stated that there was no LPA. The DNAR forms that we did see were the original forms and all been signed by the GP and the person in charge, and discussions with the person or relative had been documented.

People had opportunities to participate in activities. However, we received mixed views about the activities and engagement between the care staff and people using the service. One person told us, "The staff don't really talk to you I just see them walking about. We could go out more there was only one trip last year." The service had its own transport although we were told the provider had the vehicle for two weeks and so this was not available for people. A relative we spoke with said that there was not much stimulation and "usually a lot of people slumped in chairs and not much happening when I visit." There was a schedule of planned activities in the reception area but this was a handwritten sheet which was not clearly displayed. There was no other information displayed to inform people what activities or events would be taking place.

We observed the experiences of three people living with dementia on the first floor. Music was being played and one person was singing and moving along to the songs. Her delight was validated by a care worker who invited her to dance. However, we observed that another person was sleeping on and off and the third person received very little attention despite trying to attract the attention of the care workers. The only visible items in the first floor lounge were a doll, some large Lego bricks and a wooden pegs and hammer toy. At times we saw that some care workers spent a good deal of time on paperwork and record-keeping in

Is the service responsive?

communal areas and not interacting with people. Activity coordinators were engaging at times with people but there was little attempt to undertake many activities on the first floor.

At the previous inspection we were informed that people's 'Life Story' was being produced for each person to give more background on their life and history, including family, hobbies and previous occupation. This would be completed with input from the person and/or their relatives. However, at this inspection we only saw this on one person's records.

The records of what people had taken part in each day were limited. For example, the records noted a person's participation as "responsive" or "not responsive", or the person was "given paper", or the person had a "one-to one." There was no clear indication of people's individual interests and what their abilities were and how these were met.

The above evidence relates to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In contrast we did receive some positive comments about the activities in the service. One relative told us that their family member went to a "jazz club and a library club," and that "the activities are one of the great strengths of Parkfield House. There is always something going on." Whilst another relative commented that there were "trips out to the theatre, lunch and library." We spoke with the activities coordinator who said there were normally two activities coordinators on duty during the week and one at weekends. They told us that there were a range of activities on offer inside and outside of the service, including weekly visits to the Salvation Army and supported attendance at faith services (the local Church and Mosque), as well as visits to other local care homes for coffee mornings. The activity coordinators confirmed they had registered with the National Association for the Provision of Activities (NAPA) which provided specialist training for this particular role. This would aim to give them more information and an awareness of the type of activities that could be provided to meet the varied needs of the people living in the service.

Prior to people moving into the service pre-admission assessments were carried out to ascertain whether the needs of the individual could be met by the service. The relatives we asked confirmed they had visited the service prior to their family member moving in and that the assessment had taken place. Relatives also told us that they had been involved in the development or review of their family member's care plan and one relative said the previous registered manager had been "responsive to my suggestions."

A new nurse had started working in the service and their main role was to review and audit all the care files. They told us that checks had been completed on approximately half of the people living in the service and they had found either inaccurate or missing information. We noted that those care plans that had been reviewed were easier to follow and were more consistent. We saw an example where a person's care file was accurate and easy to follow. They had a pressure sore which had been assessed by the tissue viability nurse and there was a comprehensive wound care plan in place with regular photographs and wound assessments which were chronologically ordered and up to date. Furthermore there was a clear plan for nutritional support and monitoring.

One person and a relative reported that the manager was visible and approachable and that they would be would be happy to discuss any concerns or queries if they had any. A relative told us, "I have never made a formal complaint as such because any concerns I have had have usually been taken seriously and attended to." Another relative said a concern they had previously raised was "dealt with immediately."

The service had a complaints policy and procedure and this was available for people and their relatives to see in the communal area of the service. We checked the complaints file for 2015 which had a log at the front showing that there had been three recorded complaints during the year. All complaints had been well documented and had been managed according to the complaints procedure. There were copies of all relevant correspondence and details of the investigations. It was clear that the response to each complaint had been appropriate and timely. All of the complaints had been resolved with letters of apology where the complaint had been substantiated.

Requires improvement

Is the service well-led?

Our findings

At the January 2015 inspection we found a breach in the regulation as the service did not have effective auditing and monitoring systems in place to identify if the care people received needed attention and/or improving. At this inspection there had been improvements to how issues were picked up and addressed. The provider was now carrying out monthly checks and the manager from the provider's other registered service had completed an audit on different areas of the service and made recommendations for the manager to address.

The new manager had been a manager at other registered services and was a registered nurse. They had various relevant health and management qualifications and were being supported by the manager of another registered service owned by the provider. The manager had in the six weeks of their employment identified areas needing to be improved and had started to introduce clearer audits and checks on different areas of the service. We saw the improvement plan the manager had been working on which demonstrated that they knew where the different aspects of the service required checking to ensure people's needs were being met. For example, the manager had identified that care staff needed to engage more with people and that carrying out regular audits on the care files would swiftly identify if there was incorrect or missing information on a person's file. The care records audits we saw were detailed and had picked up similar issues that we had found. However, these new checks and audits were still being implemented and needed more time to be embedded into the day to day running of the service to ensure they were effective, fit for purpose and could be sustained over a period of time.

Other audits were taking place such as daily cleaning checks and the manager was carrying out spot checks on an almost daily basis by walking about the service and viewing different rooms and seeing the different members of the staff team, carrying out their duties. The manager had also arranged for an external auditor to visit the service later in August 2015 for a more independent assessment of the quality of the service which might identify areas of improvement.

Feedback on the new manager was positive with comments from relatives and various members of staff that she was "approachable and visible." A relative confirmed that they were invited to "family meetings and special events" and that the newsletters were regularly sent out to them. A second relative told us that they had met with the manager and that they had, "responded both positively and knowledgeably to my comments and questions."

All members of staff we spoke with were positive about the culture and atmosphere in the service which they felt had improved since the change of management and was now more organised and efficient. They confirmed that there was good teamwork in the service and good communication between each other. They also commented that the manager "listens to us," and that they were "well supported now."

The service had different ways of gathering people's and relatives views on the service and informing them about changes. There was a post box with comments forms at the entrance for people to use. The manager was starting to update the brochure of the service as the information was out of date. The monthly newsletter was sent to relatives to keep them informed about the service. We saw evidence that meetings for people and their relatives had been held, which had been important when there had been a change in manager. The manager told us that they intended to continue to hold these meetings. Satisfaction questionnaires for relatives had been sent out and so far 12 had been returned. The comments were mixed but overall people were fairly satisfied with the service. One relative had commented that "I would not recommend the home until satisfied that better standards are properly in place". Whilst another relative was very satisfied with everything. Some of the comments said: "all the care staff who look after X are kind, caring and helpful, and have X best interests at heart". The manager told us they had not yet analysed the results but intended to do so.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered provider did not ensure that care or treatment was planned and delivered according to service users' needs and preferences. Regulation 9 (3)(b)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment had not been provided in a safe way and the registered person had not ensured the proper and safe management of medicines. Regulation 12 (1) (2)(g)

The enforcement action we took:
We have issued a Warning Notice on 26 August 2015 telling the provider they must take action to meet this Regulation by the 30 September 2015.